Retooling Accounts
Receivable Measurement

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Retooling Accounts Receivable Measurement

Many medical providers complain about the various forms of calculations used by their staffs, professional associations, peer groups and the “suits”. The suits, being business people, generally use Accounts Receivable Days Outstanding as the key metric for collection or turn of a medical provider’s accounts receivable. Regardless of the myriad of calculations – gross, net, business days, including/excluding credit balances – lower A/R Days Outstanding is generally more favorable unless you reduce A/R by aggressively adjusting off collectible account balances. However, to be more useful, A/R Days Outstanding, as well as most metrics, need consistency over time and a healthy balance of other complementary metrics.

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\text{Average monthly revenues} \times 365 \div \text{Net collectible A/R} = \text{A/R Days Outstanding}
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A/R Days Outstanding is usually defined as last twelve months’ revenues divided by the net collectible accounts receivable outstanding at a point in time multiplied by three hundred sixty five days. Some professional organizations use the last two months’ average revenues on a rolling basis. The determination of gross and net revenues are a key factor as most medical providers use gross charges in accounts receivables calculations and use a cash basis of accounting. These adjustments are very important and may have a significant affect upon the actual number. Many providers utilize a collection ratio to adjust gross charges to net revenues. However, credit balances, recoupments, self-pay, and re-aging of charges can materially affect the resulting ratio.

So, what should a medical provider do?

First, recognize that A/R Days Outstanding is a metric for what has happened in the past and unless used consistently over time, has relatively little value. The metric can make a provider feel good but does not drive cash collections.

Secondly, a practice should be wary of using collection ratios as a means of adjusting gross charges since payer and procedure mix changes along with the number of business days in the month can materially affect this calculation.

Thirdly, a practice should not base its A/R management objective on A/R Days but rather on cash collections. A/R Days Outstanding represents the outcome of all the revenue cycle processes, effective and not so effective, within a period of time. It should not be used as a goal. Cash collections resulting from a decline in A/R is the goal and, more importantly, increasing the cash collections per CPT code or per Relative Value Unit (RVU) should be the overarching goal of any medical provider’s revenue cycle.

Lastly, remove healthcare from the business analysis. What??? Convert to a manufacturing mentality in revenue cycle management? With the numerous financial metrics and various calculation methods available, a medical practice might be perceived to require a public company filing to adequately measure its overall financial performance. The best view of a medical provider’s performance is to remove the traditional healthcare bias from the financial performance and consider each CPT code as a discrete unit in manufacturing. What does that mean?

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\text{Net collection ratio} = \frac{\text{Cash collections}}{\text{Charges for the same period}}
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Manufacturers are mainly concerned with the process of producing each individual widget, including:

- the defect rate (denial rate)
- the time from start to completion (A/R days)
- the number of cycles (appeals) it takes to get a widget from production to the end user (balance due = $0.00)

Manufacturers are focused solely upon the time, cycles and cost required to complete the widget. They are not focused on revenues. Their revenues are the concern of another group of suits.

Now let’s look at some key considerations for a medical provider in adopting a manufacturing approach.

Conversion to a Manufacturing Mentality

- How many days does it take for your practice to complete the charge entry process?
- How many CPT codes are rejected by the clearinghouse or payer as a percent of total CPT codes?
- How many CPT codes do you produce each month? (Yes, yes, as in widgets or units, not the dollar charges!)
- How many CPT codes do you have in your A/R? (Again, not net or gross charges, but how many CPT codes have a balance due greater than $0.00?)
- How many CPT codes are denied by the payer each month on the first submission? (A denied CPT code is any CPT code with a $0.00 payment…more on this later.)
- What is the ratio of zero CPT codes each month to new CPT codes charged? (i.e. denial rate)
- How many CPT codes does your billing staff appeal each month?
- How many CPT codes in A/R are billed more than three times? (Obviously, the definition of insanity is pervasive in healthcare.)
- Calculate A/R days as the ratio of CPT codes in A/R versus the number of CPT codes charged in an average month.
- What is the cost per billing full-time equivalent (FTE) divided by the number of CPT codes appealed each month? (I bet the cost of CPT appealed is between $5.00 and $8.00.)
- What are you collecting per CPT code on an average basis?
- What are your collections per CPT code on office visits, surgeries, etc...?

A key controversial element of a manufacturing mentality lies in the definition of a denial. A zero dollar CPT code should be classified as a denial as the cost to process a zero CPT code is exactly the same as a CPT with a dollar payment. As with manufacturing, we are focused on the cost drivers in the process. Therefore, “applied to deductible” is a denial in manufacturing terms.

Manufacturing Scoreboard

- **Date of service to date of charge entry of two days or less.**
  For hospital-based physicians, three days or less post discharge.

- **CPT reject rate of four percent submitted.**
  NPI and PQRI are two acronymic processes that have significantly increased these reject rates from four percent to sometimes as high as ten percent. Credentialing also creates a much higher reject rate for new medical providers.
• **A/R days on a per CPT basis of 30 days.**

A 60 day A/R turn would be defined as average monthly CPT codes charged of 100 with 200 CPT codes in A/R. This methodology demonstrates the amount of work required to resolve the account and is not affected by payment splits, allocations, recoupments, credit balances or fee schedule changes. It represents work to be completed.

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\text{Average # of CPT codes charged} \times \text{Total CPT codes in A/R} \times 365 = \text{A/R Days Outstanding on CPT basis}
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• **First-pass denial rate of ten percent or less on a CPT code basis with solid reporting of these manufacturing metrics.**

We generally see from 30 to 40 percent of CPTs denied by the payer across the industry. The complexities of denials are generally due to specialty (e.g. post-operative note requirements) and the timing of the year can affect all specialties (deductibles in the beginning of the calendar year). I am sad to report that no manufacturer can survive with a ten percent error rate!

• **With a denial-based A/R tool, a billing FTE can appeal from 150 to 250 CPT codes per day.**

Generally, we see that an account-based billing department can appeal 25 accounts per FTE per day. With an average of two CPT codes per visit or account, then an average FTE can appeal 50 CPT codes per day. **With an average total cost of $50,000 per billing FTE, the cost of appeal at 50 CPT codes per day would be $4.17 per CPT code. Using a denial-based A/R tool, the cost of appeal can be reduced by over three to four times. Try calling an insurance company on an account to see how long the process takes.**

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\text{Salary, benefits, fixed cost allocation for A/R staff} \div \text{# of CPT codes appealed or resolved} = \text{Cost of appeals}
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These new process-oriented A/R measurement tools illustrate how we must use cash collections in addition to A/R Days Outstanding to measure the effectiveness of the A/R follow-up function as well as the cost and capacity of the department. In accordance with a manufacturing mentality, we must change our focus from “working accounts” to “resolving accounts,” or eliminating the causes of CPT code denials.

**Summary**

A/R Days Outstanding is an historical financial performance metric for many medical providers. This metric has many deficiencies in its calculation and must be used in a consistent and well-defined manner. By converting from a dollar-denominated, healthcare A/R approach to a manufacturing mentality, you have a much better view of financial performance. The key component of this transition requires a new language surrounding medical practice financial metrics. Units, cycle times, day lags, reject rates, denial rates, CPT per FTE per day, and collections per CPT code are the language of the new healthcare financial performance metrics. While the traditional A/R Days Outstanding has its place, these new metrics will provide medical groups with tremendous insight into their costs, effectiveness and efficiency of their financial performance. By the way, once you gain proficiency in CPT code or units analysis, RVU analysis is your next worthwhile measurement tool to acquire in truly managing healthcare financial performance.
John R. Thomas
President and Chief Executive Officer

John Thomas has been with MedSynergies since its inception in 1996, when he began as senior vice president and managing director of development. While at MedSynergies, Mr. Thomas has held positions such as senior vice president and chief financial officer, and has been a member of the board of directors since 1999.

Prior to joining MedSynergies, Mr. Thomas was the vice president of the newly formed HealthCare Finance Group for Bank One. He was also the assistant vice president for Texas Commerce Bank, where he focused on hospitals and emerging healthcare markets.

Mr. Thomas is a national speaker on topics such as revenue cycle management, billing and collections processes, capitalization, and turnarounds.

Mr. Thomas received his Master of Business Administration, with honors, from the University of Texas Graduate School of Business. While at the University of Texas, he focused on finance and management and was selected as the Sword Scholar and received the Dean’s Academic Award. Mr. Thomas received his Bachelor of Arts from the University of Arkansas.

About MedSynergies, Inc.

Now serving 2,300 healthcare providers in 37 states, MedSynergies provides revenue cycle services and integrates leading software programs into the daily operations of healthcare organizations. Founded in 1996, MedSynergies serves physicians in hospitals, specialty medical groups, ambulatory surgical centers, rehabilitation centers, and independent practice associations (IPAs). Based in Irving, Texas, the company has regional offices across the United States. For more information on MedSynergies, please visit www.medsynergies.com.