Five Key Metrics for Financial Success in Your Practice
Many providers are under the impression they can assess the financial health of their practice by evaluating cash flow only. However, cash flow is just one factor. You don't have to be a finance expert to understand the other important metrics that should be calculated and reviewed when evaluating the revenue cycle.

The AAFP has put together a series of online education modules to help you understand the five key metrics in revenue cycle management. Obtain a better understanding of the following topics and why they are important for your practice:

- Days in Accounts Receivable
- Days in Accounts Receivable Greater Than 120 Days
- Adjusted Collection Rate
- Denial Rate
- Average Reimbursement Rate

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**Agenda**

1. Understand how to calculate:
   - Days in Accounts Receivable
   - Days in Accounts Receivable Greater Than 120 Days
   - Adjusted Collection Rate
   - Denial Rate
   - Average Reimbursement Rate

2. Apply why the metrics are important to your practice and how to avoid potential pitfalls of each calculation.
Revenue cycle management includes tracking claims, making sure payment is received, and following up on denied claims to maximize revenue generation. Several metrics can help you determine whether your revenue management cycle processes are efficient and effective.

The first metric is Days in Accounts Receivable (A/R). Days in A/R refers to the average number of days it takes a practice to collect payments due. The lower the number, the faster the practice is obtaining payment, on average.

**Best Practice Tip**
Days in A/R should stay below 50 days at minimum; however, 30 to 40 days is preferable.
Calculating Days in A/R

First, calculate the practice’s average daily charges:

Add all of the charges posted for a given period (e.g., 3 months, 6 months, 12 months).

Subtract all credits received from the total number of charges.

Divide the total charges, less credits received, by the total number of days in the selected period (e.g., 30 days, 90 days, 120 days, etc.).

Next, calculate the days in A/R by dividing the total receivables by the average daily charges.
Sample Calculation

(Total Receivables - Credit Balance)/Average Daily Gross Charge Amount (Total Gross Charges/365 days)

- Receivables: $70,000
- Credit Balance: $5,000
- Gross Charges: $600,000

\[
\frac{($70,000 - ($5,000))}{($600,000/365 \text{ days})} = 39.54 \text{ days in A/R}
\]

Example:

Receivables: $70,000
Credit balance: $5,000
Gross charges: $600,000

Math: \[\frac{[$70,000 - ($5000)]}{($600,000/365 \text{ days})} = 39.54 \text{ days in A/R}\]
Other Considerations

Understanding your practice’s revenue cycle will help you anticipate income and address issues preventing timely payments. Keep the following in mind when evaluating your revenue cycle and A/R processes:

**Slow-to-pay carriers.** Some insurance carriers take longer to pay claims than the overall average number of days in A/R. For example, if your practice’s average days in A/R is 49.94, but Medicaid claims average 75 days, this should be addressed.

**The impact of credits.** Be sure to subtract the credits from receivables to avoid a false, overly positive impression of your practice.

**Accounts in collection.** Accounts sent to a collection agency are written off of the current receivables, and the revenue may not be accounted for in the calculation of days in A/R. Be sure to calculate days in A/R with and without the inclusion of collection revenue.

**Appropriate treatment of payment plans.** Payment plans that extend the time
patients have to pay accounts can result in an increase in days in A/R. Consider creating a separate account that includes all patients on payment plans and determine whether your practice should or should not include this “payer” in the calculation of days in A/R.

**Claims that have aged past 90 or 120 days.** Good overall days in A/R can also mask elevated amounts in older receivables, and therefore it is important to use the “A/R greater than 120 days” benchmark.
Calculating accounts receivable (A/R) greater than 120 days will give you the amount of receivables older than 120 days expressed as a percentage of total current receivables. This metric is a good indicator of your practice’s ability to collect timely payments. Factors that can influence timely payment include your payer mix and/or your staff’s efficiency in addressing denied or aged claims. High or rising percentages indicate there may be problems with your practice’s revenue cycle management.

**Best Practice Tips**

The amount of receivables older than 120 days should be between 12% and 25%; however, less than 12% is preferable.

To get the most accurate picture of your practice’s financial standing, base your calculations on the actual age of the claim, i.e., the date of service, not the date on which the claim was filed or when it changes hands from one financially responsible party to another (primary insurance to secondary insurance; insurance to patient).
Calculating A/R Greater Than 120 Days

To calculate:

- Divide the dollar value of accounts receivable that is greater than 120 days by the dollar value of total accounts receivable.
- Multiply by 100.
Sample Calculation

• (Dollar value of accounts receivable greater than 120 days/total dollar value of accounts receivable) X 100

• Receivables 121 to 150 days = $114,000
• Receivables 151+ days = $145,000
• Total receivables = $2,120,000

• ($114,000 + $145,000/$2,120,000) x 100
• $259,000/$2,120,000 x 100
• 0.1222 x 100
• Accounts receivables greater than 120 days: 12.22%

Sample Calculation

(Total Receivables Greater Than 120 days/Total Receivables) X 100

Example:
Receivables 121 to 150 days: $114,000
Receivables 151+ days: $145,000
Total receivables: $2,120,000

Math: ($114,000 + $145,000/$2,120,000) x 100 = ($259,000/$2,120,000) x 100 = 0.1222 x 100 = 12.22%

Receivables greater than 120 days: 12.22%
Problems to Avoid

Using the charge entry date to age claims

- It is critical to base calculations of this metric on the age of the claim (e.g., date of service).
- Be careful of the re-aging approach.
The adjusted collection rate represents the percentage of reimbursement collected from the total amount allowed based on contractual agreements and other payments, i.e., what you collected versus what you could have/should have collected. This metric shows how much revenue is lost due to factors in the revenue cycle such as uncollectible bad debt, untimely filing, and other noncontractual adjustments.

**Best Practice Tips**

The adjusted collection rate should be 95%, at minimum; the average collection rate is 95% to 99%. The highest performers achieve a minimum of 99%.

Use a 12-month time frame when calculating the adjusted collection rate.

Keep fee schedules and reimbursement schedules on hand to get an accurate picture of what you should have been paid and avoid inappropriate write-offs.
Calculating the Net Adjusted Collection Rate

To calculate the net adjusted collection rate:

- Divide payments (net of credits) by charges (net of approved contractual agreements) for the selected time frame and multiply by 100.

- This calculation should be based on matching the payments to the charges that created them.
Sample Calculation:

(Payments – Credits) / (Charges – Contractual Agreements) x 100

Example:

Total payments: $500,000
Refunds/credits: $14,000
Total charges: $850,000
Total write-offs: $350,000

Math: ($500,000 – $14,000) / ($850,000 – $350,000) = $486,000 / $500,000 = 0.972 x 100
Adjusted collection rate: 97.2%
Problems to Avoid

- Including inappropriate write-offs in the calculation
- Not having access to your fee schedule or reimbursement schedule from each payer

Other Considerations

Inappropriate write-offs.
One of the most common mistakes when posting payments is applying inappropriate adjustments to charges.

For example, failing to distinguish between noncontractual adjustments and contractual adjustments results in a misleading view of how well your practice collects the money it has earned.

Categorizing noncontractual adjustments (e.g., “untimely claims filing” or “failure to obtain prior authorizations,”) will help reveal sources of errors and identify opportunities to improve revenue cycle performance.
Denial Rate: An Introduction

- Percentage of claims denied by payers
- 5% to 10% is industry average; however less than 5% is more desirable
- Reflection of the effectiveness of your revenue cycle management processes

The denial rate represents the percentage of claims denied by payers during a given period. This metric quantifies the effectiveness of your revenue cycle management processes. A low denial rate indicates cash flow is healthy, and fewer staff members are needed to maintain that cash flow.

Best Practice Tips
A 5% to 10% denial rate is the industry average; keeping the denial rate below 5% is more desirable.
Automated processes can help ensure your practice has lower denial rates and healthy cash flow.
Calculating the Denial Rate

To calculate the denial rate:

- Total dollar amount of claims denied by payers within a given time period, divided by the total dollar amount of claims submitted within the given time period.

Calculating Denial Rate

To calculate your practice’s denial rate, add the total dollar amount of claims denied by payers within a given period and divide by the total dollar amount of claims submitted within the given period.
Sample Calculation

(Total of Claims Denied/Total of Claims Submitted)

Example:
Total claims denied: $10,000
Total claims submitted: $100,000
Time period: 3 months

$10,000/$100,000 = 0.10
Denial rate for the quarter: 10%
Other Considerations

**Failure to identify mistakes prior to claim submission.** Mistakes made during coding and charge entry can result in claims that are adjudicated and rejected by a payer. Establishing an internal process to identify and correct any mistakes prior to claim submission will decrease denial rates and produce a healthier cash flow.

The denial rate represents the percentage of claims denied by payers during a given period. This metric quantifies the effectiveness of your revenue cycle management processes. A low denial rate indicates cash flow is healthy, and fewer staff members are needed to maintain that cash flow.
The average reimbursement rate represents the average amount your practice collects from the total claims submitted. When tracked over time and compared with historical practice results, it provides an accurate picture of your practice’s financial health. It also helps determine if your practice could realistically bring in more revenue. Claim-specific negotiated discounts, payment bundling, and bad debt can adversely affect average reimbursement rate.

**Best Practice Tip**
The industry average is 35% to 40%.
Calculating the Average Reimbursement Rate

To calculate the average reimbursement rate:
- Divide the sum of total payments by the sum of total submitted charges/claims.

To calculate the average reimbursement rate per encounter:
- Divide the sum of total payments within a given period by the number of encounters within the same time period.
Sample Calculation

(Sum of Total Payments/Sum of Submitted Charges/Claims)

- Sum of total payments: $200,000
- Sum of total charges submitted: $350,000
- $200,000/$350,000
- 0.57
- Average reimbursement: 57%

Sample Calculation

(Sum of Total Payments/Sum of Submitted Charges/Claims)

Sum of total payments: $200,000
Sum of total charges submitted: $350,000

Math: $200,000/$350,000 = 0.57

Average reimbursement: 57%
Sample Calculation: Average Reimbursement Per Encounter

- (Total Reimbursement / Number of Encounters in Time Period)
  - Total reimbursement: $100,000
  - Number of encounters: 800
  - Time period: 60 days
  - $100,000 / 800
  - $125 per encounter over the past 60 days

Sample Calculation
(Total Reimbursement/Number of Encounters in Time Period)

Last 60 days:
Total Reimbursement: $100,000
Number of encounters: 800

Math: $100,000 / 800 = $125 per encounter over the past 60 days
Other Considerations

**Calculating the average reimbursement solely for all payers together.** Calculate the average reimbursement rate for each payer to determine how each payer is compensating your practice. If possible, payments should be sorted by payer and procedure to determine the most common procedures submitted to each payer and the paid percentage for those procedures.