

Using Revenue Cycle Management Reports to Guide Policy and Process
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There are many reports and policies that should be in place within a medical practice to protect the practice from lost revenue, fraud or abuse allegations, accounting errors, or theft. A sampling of these is listed below along with a brief description of why each is an important tool for identifying areas of weakness or potential loss for the practice.

- 1) Year end or last 12 months (by practice and by physician if possible) including:
 - a) Gross charges
 - b) Contractual write-offs and/or net charges
 - c) Bad debt/charity write-offs
 - d) Refunds

Why? To determine what percentage of fee schedule charges are actually collected. What percentage of adjustments are due to contractual obligations and what percentage to bad debt or charity? How often is money refunded and is there a way to reduce this?

- 2) Aged trial balance reports for last 3 months or if not available, total accounts receivable balance report for last 3 months

Why? The older the account balance, the less likely you are to collect the money. Between 20-30% of claims are denied on first submission and 50% of these are never resubmitted. Accounts must be quickly billed and aggressively followed to maintain a good balance. This report also indicates payer trends and may allow for quick action when an individual payer is not paying in a timely manner. Some payers are more difficult to work with than others. Often a higher balance of money over 90 days indicates either a problem with the payer or a lack of follow-up activity by billing staff.

- 3) Average days to bill report for the last month.

Why? Delays in entering charges and submitting claims equate to free financing. One survey indicates that 29% of charges are 30 days old before submitted to the payer. This report provides a glance at how much time elapses from the date a service is provided until the charge is entered and billed from the practice management system. High days to bill may indicate a delay in completion of physician documentation, a backlog in charge entry or a need for workflow changes.

- 4) Daily electronic claims submission report

Why? It costs about \$8.00 for the average practice to submit a claim. If claims submission must be repeated due to inaccurate patient information, use of outdated codes, or incorrect insurance information, this cost may be significantly higher. Use this report to identify the reasons that initial claims submissions are rejected and then identify processes that may reduce the errors (e.g., pre-visit insurance verification).

- 5) Current accounts receivable by payer/responsible party

Why? Knowing who owes you money and in what percentages may inform your decisions on payer contracts, collection activities, and internal billing processes. This report is especially useful for identifying how effectively patient balances are being

collected. If patient balances are more than a small percentage of the total accounts receivables, it may be time to change patient statement cycles or to adopt more aggressive policies for collection at time of service.

6) Credit balance report

Why? This report identifies accounts that have credit balances and identifies overpayments that may need to be refunded and potential payment or charge posting errors. Failure to promptly refund overpayments by government or private payers may lead to recoupment from payments due on other patient accounts. Often such refunds are related to patients having another insurance plan that should be billed for primary payment. Timely filing limits may become exhausted if claims are not promptly re-filed to the correct payer.

7) Report of contractual rates by payer

Why? This report provides a comparison of the rates paid for your most common services by contracted payers. Viewing all contractual rates at a glance may change perceptions regarding which payers are more or less valuable to your practice, identify those payer contracts that need revision, or indicate whether closing your patient panel to a particular plan makes sound business sense.

8) Report of E/M code usage by physician (e.g., # of 99214' billed) for last 6 months (include primary diagnosis billed if possible)

Why? This report allows for trending of physician billing patterns for E/M services in the same manner that payers trend the data. This data should be reviewed in the context of the nature of the patient's conditions and the completeness of the physician documentation to support codes billed. (Beware that this knowledge does come with responsibility to take corrective action if incorrect coding is identified. However, such action is part of the Office of the Inspector General's recommended compliance plan for small practices and can also lead to recognition of under-coded or under-documented services that may be corrected to bring in additional revenue.)

9) Report of top 25 non-E/M services billed (exclude codes 99201-99444)

Why? This report helps to identify the non-E/M services most often provided in your practice and allow for identification of the profitability of providing these services and may also be useful in identifying missed charges (e.g., vaccine codes billed without codes for the administration). Cross-referencing of this report to the accounts payable for related supplies may also be useful in determining any costs that are not supported by payments (e.g., is there product waste due to expiration?).

10) Reports or process policy showing reconciliation of payments received, payment entry, and daily deposits

Why? Checks and balances to deter employee embezzlement and accounting errors are often missing in the small practice. Every function involving practice receipts and expenses should include safeguards and cross-checks to protect the practice (e.g., every patient receives a receipt for their payments in the office and management routinely balances the receipt book to the patient accounts and deposit slips).