Management Reporting Part I: Standard Reports and Measurements

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Monitoring practice performance indicators at regular intervals enables physician and administrative leadership to assess the financial health of the practice, adjust to problems and develop process improvement initiatives. The more immediately information is measured and reported, the more effectively problems can be identified and addressed. Summary reports should be clear, concise and consistent so that trends can be identified over various periods of time and results of improvement changes tracked.

While one of the first goals of management reporting should be to develop a way to document "normal" performance so that aberrations can be quickly identified and corrected, a longer range goal should be comparative reporting with the performance of other radiology groups through the use of industry benchmarks. The latter is somewhat constrained by the lack of consistent, documented "best practices" information in radiology although there are efforts in progress to develop and document benchmark targets.

Top management in the practice, whether a physician, administrator or both cover that position, needs to accept responsibility for monitoring the reports referenced in this article. While that assignment can also be delegated to another staff member, the myriad details involved in a billing department often overwhelm those closer to the action so that the monitoring, analysis and initiation of follow-up to reports is too frequently set aside for more immediate crises. Rapid response to follow-up requests can be expected from nonexecutive staff members, but trend analysis and the initiation of problem resolution steps remain a responsibility of top management.

A Simple Process Improvement Measure

Daily Report: update of charge entry status

One of the first requirements for consistent cash flow is that charge entry be current and consistent. Lapses in charge entry can occur when other processes such as coding or data acquisition experience problems and cause bottlenecks and delays. Staffing fluctuations will also impact charge entry, especially in smaller practices where only one person performs data entry functions. Often problems in this area don't become evident until monthly reports reveal drops in collections—and that's several weeks (or months) after the problems actually occurred.

In many cases, today's radiology practices provide services to multiple sites of service, making it even more difficult to keep track of data intake and resulting problems with delays. Information can come into the billing department via courier, mail, overnight delivery, electronic transmission or, in many cases, by all of these means. Unless tracked routinely and diligently, it would not be unusual for a smaller site covered to literally disappear for a week or more without being noticed, especially if data is delivered on an erratic schedule to begin with.

Reporting of charge entry status can be as simple as an e-mail update or hand-written notation that identifies by site, the most recent date of charges entered. When delays occur, the reasons can quickly be determined and scheduled for follow-up action.

Keeping Tabs on Progress

Weekly report: charges and collections, with comparisons

The flow of charges and collections should follow a predictable pattern, with certain weeks of the month reflecting the payment patterns of key, large payers. Without these anticipated "peaks" if a key payer misses a check or two, the practice will quickly find itself in a disappointing collections month, so the goal of this report is to identify, in a timely fashion, when payment lags are occurring so that action can be taken before the month ends.
Monitoring the flow of charges and collections on a weekly basis enables practice management to begin developing a pattern of normal cash flow. Payments from Medicare and other large contracted payers will be evident in this report, as will delays in payments that could result from failure to successfully transmit electronic claims, payer computer problems or other issues that can sometimes be addressed within the month, and will at least set monthly collections expectations.

Charges and collections should be broken down by site and shown in comparison to the same week in the previous month as well as the same week last year. At the same time, projections for month end can be developed from the weekly progress reports. Dramatic variations can then be designated for immediate follow-up phone calls or internal research.

**The Indications of Success**

*Monthly report: exam volume, charges, adjustments, collections, refunds, write-offs*

The monthly report should provide a one-page summary of billing and collections activity and efficiency. Volume and charges should show a direct correlation on this report, with fluctuations in exam volume mirrored by corresponding ebbs and flows in billed charges.

The second level of correlation occurs in monthly collections, which lag behind charges from 30-90 days depending largely upon the level of electronic claims and remittance processes the practice utilizes. Based upon the practice’s profile, it will become possible to isolate problem areas, predict financial performance and identify areas for process improvement.

For maximum effectiveness, the report needs to compare data for a series of months and most summary reports are set up on a 12-13 month running pattern. The 13-month version enables the practice to compare monthly performance with that of the same month in the previous year.

The summary report also allows for documentation of trends in adjustments, which represent mainly the contractual allowances negotiated for the practice but will also include other variance categories. The most important aspect of measuring adjustments is to determine whether various types of activity are classified as adjustments or write-offs. There are variations in this definition, influenced by capabilities (or limitations) of the billing computer system and by internal decisions concerning how variations are reported. It will be important to document what is included in the adjustment categories and to question categories that should perhaps be more appropriately tracked as write-offs.

Use of the Radiology Business Management Association (RBMA) Standard Definitions (sidebar) will standardize the calculation of key indicators and better provide for benchmark definition and comparison.

While there are differing opinions among practice administrators and billing companies regarding the classification of adjustments and write-offs, the general rule of thumb is to use the following two questions:

- Does this category represent money you knew in advance you wouldn’t collect? This covers areas such as contractual allowances, capitation adjustments or medical necessity denials that must first be denied by a primary payer before they can be billed to a secondary source. Money you know you won’t collect becomes an adjustment and should be deducted from gross charges so you can predict billed amounts that should actually be collectable (net charges).
- Does this category represent money you expected to collect, but were unable to? Reasons may include bankruptcy, financial hardship write-offs, hospital charity write-offs and patient accounts turned over to the collection agency. Money you expected to collect but didn’t is classified as a write-off.

The following line items should appear on the summary report spreadsheet, shown by month with year-to-date totals:

- Exam volume
- Gross charges (as entered by staff for the month)
- Adjustment amounts
- Net charges (charges less adjustments)
- Gross collections
- Refunds
- Net collections (gross collections less refunds)
- Gross collection percentage (gross collections/gross charges)
- Net collection percentage (net charges/net collections)
- Accounts receivable (as of end of reporting month)
- Days in A/R (A/R divided by average charges per day)
- Write-off amount
- Write-offs as a percent of gross charges

**Practice Financial overview**

*Monthly report: comparison of income sources and expense categories*

The goal of this report is to provide physicians and management with a one-page "practice-at-a-glance" summary. The top half of the report identifies all income areas for the practice, by site and type (for example, type will identify professional vs. global fees, income from outside reading contracts, nonphysician revenue sources and interest earned).

The second half of the report identifies major expense categories and can include such areas as physician costs, administrative overhead, billing and collection costs, imaging center expenses and other expense areas the practice would like to monitor such as business development or quality programs.

**Other practice reports and measurement areas**

*Monthly or quarterly reports: monitoring and evaluation of various practice activity areas*

It is important to measure other aspects of the practice from time to time, with the intervals dependent upon issues affecting the group or changes that are occurring in the marketplace. These include, but are not limited to:

- Payer mix by volume, charges and collections
- Modality by volume, charges and collections
- Performance by site (charges, collections, volume by site)
- Multi-year trends in each of these areas
- Referring physician trends
- Utilization of new services
- Inpatient/outpatient/emergency room proportions

At times, you will accumulate a series of reports that seem to be informational only; that is, they are interesting to review but don't seem to contain actionable information. True, sometimes reports document performance over a period of time and there is little change. In this case, they can probably be produced over less frequent intervals as historical documentation of practice activity.

On the other hand, from time to time this data can be used as the starting point to dig down into areas for further information or to identify opportunities for improvement. In other words, reports can provide a "before" scenario for the identification of new goals and data for measurement. In early stages of process improvement, it's possible to make changes that can produce large percentage improvements and later, those percentages will diminish to the .5-1 percent range. However, in a multi-million dollar business, which most radiology practices represent, those changes are still worth identifying and seeking.

This article was provided by the Radiology Business Management Association (RBMA). To learn more about the RBMA, call (888) 224-7262 or visit [www.rbma.org](http://www.rbma.org).
RBMA A/R Standard Definitions & Formulas

I. Charges

Gross Charges: The Full Dollar Value of All Services Rendered to Patients

Ideally, where the practice has more than one fee level (by contractual requirement) for any given service, it would record all services at the rate established for patients who are not provided services under a fee-lowering contract. This may be a natural approach for practices that employ accrual accounting and seek to record allowances against gross charges (which are recorded as revenue).

Practically, because a practice may wish to avoid unnecessary complexity in A/R and, more generally in its accounting systems, the actual charges for all patients serves as the proxy for gross charges. For example, many nonparticipating Medicare providers enter the difference between the practice’s normal charge and the nonparticipating fee schedule limiting charges.

II. Offsets

A. Adjustments: Amounts That are Never Expected to be Collected

Charity Adjustment: The difference between the gross charge and the amount (if any) that will be received patients as provided for under a prospective charity arrangement. These would not be classified as bad debt because the charity status is known at the time of service. An example might be services provided to a community “free clinic” for children in which the practice serves as a provider of services.

Contractual Agreement: The difference between the gross charge and the amount paid under terms of a contract covering the patient. Examples include the amount in excess of the Medicare “allowed amount,” any amounts in excess of the Medicaid allowance or the difference represented in a discount to a PPO or indemnity insurance company.

Courtesy Adjustment: The difference between the gross charge and the required payment for service to patients covered by a practice policy for these patients. Examples are discounts to other physicians and their families and discounts to hospital employees.

Employee Discounts: The difference between the gross charge and the amount received under the policies for a practice’s own employee.

Capitation Adjustment: Where a practice receives capitation payments for services rendered to a patient, the difference between the normal gross charges for all services and the amount actually received.

B. Write-Offs: Amounts That Were Expected to be Collected, but Which the Practice was Unsuccessful in Collecting

Settlement Write-Offs: The difference between the gross charge and the amount collected (if any) from a patient or third party, which would have been collected under ordinary circumstances. Examples might be a partial payment from a patient who underwent bankruptcy proceedings and is legally released from paying any but a small percentage of the charge or a PPO that liquidated and paid only a portion of the amount owed under the terms of its contract.

Bad Debt Write-Offs: The difference between the gross charge and the amount collected from a patient, where the difference is not covered by any other adjustment or write-off. An example is the account assigned to a collection agency for collection. Any amounts received from the work of a collection agent are included in gross collections, and are not netted against this write-off amount.

III. Collection Expense

All costs identified as incurred in the process of collecting, recording and transmitting charge information plus the costs of collecting, posting and depositing payments for these services.

Standard Formulas

Collections = (Payments Received) – (Refunds and Returned Checks)

Adjusted Charges = (Gross Charges) – (Total Adjustments)

Gross Collection Percentage = (Collections)/(Gross Charges) x 100
Adjusted Collection Percentage = (Collections)/(Adjusted Charges) x 100

Average Daily Billings = (Average Monthly Gross Charges)*/30 *Best to use multi-month (6-12) average

A/R Days Outstanding = (Total A/R Balance)/(Average Daily Billings)

Write-Offs as % of Gross Charges = (Total Write-Offs)/ (Gross Charges) x 100

Adjustments as % of Gross Charges = (Total Adjustments)/ (Gross Charges) x 100

Total Receivables Aged:
(Dollars 0-30 Days)/(Total A/R Balance) x 100 = % of A/R at 0-30 Days
(Dollars 31-60 Days)/(Total A/R Balance) x 100 = % of A/R at 31-60 Days
(Dollars 61-90 Days)/(Total A/R Balance) x 100 = % of A/R at 61-90 Days
(Dollars 91-120 Days)/(Total A/R Balance) x 100 = % of A/R at 91-120 Days
(Dollars 121-150 Days)/(Total A/R Balance) x 100 = % of A/R at 121-150 Days
(Dollars > 151 Days)/(Total A/R Balance) x 100 = % of A/R at > 151 Days