Management Reporting Part II: The Good, the Bad and the Indecipherable

Effective management reporting should at a minimum take the pulse of a group—that is, illustrate how effectively the practice is performing for a particular period of time. Beyond that, reporting should support critical management decisions and allow for:

- Early identification of potential problems through the use of key indicators and trend analysis.
- Data-driven management and marketing decisions, in support of the quality management theory that states, “You can’t manage what you can’t measure.”
- Quality improvement programs, based on clear identification of areas for improvement that can be turned into measurable work plans.
- Establishment of accountability and identification of training needs.

Practice administrators frequently lament that their physicians don’t want to spend time going over reports and what may appear to be endless numbers. On the other hand, radiologists complain that reports are vague, that they aren’t sure what they’re looking at and that they don’t know what questions to ask. Both sides have legitimate perspectives; however, this article assumes it is the job of the administrator to provide meaningful information.

What does that mean? It means first of all, there will be proactive information and a minimum of "I'll have to get back to you on that" responses. Why? Management reports inherently review past activity, and therefore timely decisions to correct problems have already been delayed by the reporting process itself.

For example: The monthly management report shows there is an unexplained drop in exam volume and charges for the month of April. However, April collections are strong.

April reports are run mid-month for the May shareholder meeting, which is held during the third week of the month. They are printed out two days before the meeting and hurriedly reviewed by the administrator, who has been working on an imaging center expansion plan for the meeting.

The administrator reviews the report in the meeting, notes that charges and exam volume are down, but points out that collections are up for the month.

The radiologists comment that April felt like an even busier month than March, but when asked by one of the physicians what happened to exam volume and the resulting charges, the administrator says, "I'll have to check into that and get back to you."

The administrator talks with the billing manager the next morning and she says, "I'll check into that and get back with you." The data entry supervisor is on vacation and due back Monday, so “checking” must wait until her return.

After reviewing several reports run over the weekend, the data entry supervisor and billing manager notice that an entire week of charges appears to be missing. As they dig further, they determine that a weekly download of hospital information did not transfer. However, data entry staff was working backlogged charges for two weeks and did not notice (or report) the gap in the acquisition of new information.

The group’s contact in the hospital information services department is tied up in department meetings for two days and is unavailable until Friday afternoon. She says she’ll check into the problem and get back to the billing manager.

During the first week in June, the hospital information services manager reports to the group’s billing manager that the charge information appears to be locked up in the hospital information system but that they’re working on the problem. When will it be fixed? "We’ll get back to you on that" is the reply.

May’s management reports are run on Friday of the second week in June and validate that collections are down for May. The billing manager states that the download problem, which involved charges for the first
week in April, has been fixed and that the missing charges should be captured the following week. The administrator reports on the problem and its resolution at the June shareholder meeting.

Missing April charges are available for entry during the last week in June. There is a question as to whether they can still be filed within the 60-day filing limit for two major health plans. (If not, that should become evident as a decline in revenue in reports presented at the July and August shareholder meetings.)

Can Information be Distorted or Hidden in Reports?
As most physicians suspect, the answer is "definitely." That’s one of the key reasons to be informed about what to look for in monthly for periodic management reports. In fact, the scenario illustrated above could actually be slanted favorably in a future report. Here’s how:

Filing deadlines are missed for claims totaling $175,000, and all are denied by the payer.

The practice management reports classify "timely filing" problems as an adjustment rather than a write-off. (Adjustments include amounts the practice doesn’t expect to collect, which are reduced from gross charges. For example, contractual allowances are included in adjustments.)

Adjustments for the month increase by $175,000 and show up on the August activity report after the claims were denied in July (and adjustments logged as August activity).

As a result, net charges for August are lower (charges – adjustments = net charges). The group experiences a fairly average month in terms of collections. Collections exceed the net charges, the manager reports a 103 percent collection rate and it appears there is a cause for celebration when in fact the practice probably lost between $58,000 and $132,000 in collected revenue, depending on the terms of the payer’s contract.

Deception or Inadequate Reporting?
In some cases, there may an attempt to hide revenue lost due to filing limits. Short filing deadlines, increasingly imposed by managed care plans, provide yet another excuse for insurance companies to deny payments and are the scourge of any billing operation. This definitely represents money you don't want to lose if the claims would otherwise pass muster and be paid.

More often than not, however, rather than attempting to hide the failure to file claims on time, the billing manager makes the best call possible in terms of where he or she feels that information should appear on the report and simply doesn’t communicate the details of his or her decision to the administrator. Or in other cases, the reports reflect "what has always been done," and nobody has drilled down through them line by line.

Does this loss of revenue represent a reason for disciplinary action? Perhaps in some cases, if this has been a repeat problem, but the group would be better served by working to improve the process. The easiest way is to develop more immediate pulse checks and establish accountability for monitoring them.

How could the problem have been caught more quickly? The practice administrator, billing manager and physician leadership can monitor two business vital signs:

- **Charge entry status; that is, what date of service was entered yesterday?** The goal is to have charge entry be as close to the date of service as possible, allowing for natural lag times for "verified" hospital information and internal processes such as data intake, sorting and coding. This step will provide more immediate feedback when charge delays are encountered, thereby getting problem resolution started much earlier. For example, in the previous scenario this step could have initiated activity before the first set of month-end reports was generated, saving 4-6 weeks and providing a better opportunity to generate claims within filing deadlines.

- **Daily and weekly reports of charge/collection status with comparisons to the prior month and the same month last year.** While this type of report would not necessarily detect lost charges, it will assist in monitoring other billing-related problems such as gaps in electronic downloads or
backlogs in internal processes. The object is to have a pattern of more immediate information available to supplement the regular month-end summary reports.

The practice administrator would thus be better prepared when explaining monthly summary reports, resulting in fewer "I'll get back to you" responses. Instead he or she could report, "Here was a problem and here's what we did to fix it." Not only would communication be more proactive, but the results would more likely be positive in terms of problem resolution and increased revenue. Everyone would win.

**Reporting is Critical**
Management reports must contain information that can help administrators and physicians identify problems at early stages and make strategic decisions such as whether to hire more physicians or develop new services.

It is equally important that administrators and managers review these reports regularly and carefully. Failure to stay on top of business frequently results in lost revenue. Those who aren’t constantly watching, monitoring and comparing can easily lose thousands of dollars and, too often, hundreds of thousands.

***********************************************************************************************************************************************

Please see Part I of this article for a list of the Radiology Business Management Association (RBMA) A/R standard definitions and formulas.
This article was provided by the RBMA. To learn more about the RBMA, call (888) 224-7262 or visit [www.rbma.org](http://www.rbma.org).