



ARMA
ARIZONA MEDICAL
ASSOCIATION

Medical Practice Billing Reports and Ratios for Success

Billing Reports and Ratios

Billing reports and financial indicators are some of the lifelines to ensuring your practice is performing optimally. Your practice should run several reports on a regular basis to be sure it is performing well financially. Our practice resource department has put together several lists of reports that you should consider running daily, monthly, and annually. The information from these reports will be used to calculate practice financial ratios.

Daily

- Missing charge report - to identify appointments that were booked and checked in, but no charges entered
- Charges, payments, and adjustments - to balance against payments posted that day
- Report of no-shows and cancellations - to establish reminders to bring patients back in. Medico-legal reasons as well as patient satisfaction

Monthly

- Income and expense statement
- Accounts receivable aging - by payer
- Unpaid claims report - detail level - use to work outstanding claims
- Productivity - charges, payments, adjustments, and encounters by provider

Annually

- Operating expense report
- Income and expense statement
- Accounts receivable aging report - by payer
- Procedure analysis - frequency, by provider
- Unpaid claims report
- Productivity - charges, payments, adjustments, and encounters by provider - compare month over month, year over year
- Fee schedule review

Reports include:

- **Charges, payments, and adjustments** — This report will help you to identify trends in production and claims payments compared with other periods. Run the report for the month, by date of service.
- **Aged accounts receivable** — This report reflects balances outstanding from both insurance carriers and patients. The categories are typically 0-30 days outstanding, 31-60 days, 61-90 days, 91-120 days, and more than 120 days from the date of service. You also might sometimes run the report from the date of charge entry, for example, when determining whether a payer is processing claims in accordance with prompt payment regulations.

- **Patient accounts receivable** — This is a report of only patient AR. It identifies patient accounts that are past due and provides a tool for evaluating time-of-service collection efforts.
- **Credit balances** — The practice is required to refund overpayments to payers as well as patients within 30 days, so this report needs to be run monthly and worked in a timely manner.
- **Physician productivity** — These reports break down charges per physician, per procedure code. Compare month over month and year over year to identify trends in demand as well as physician availability.
- **Coding analysis** - Services performed for a particular time period by provider. Itemized by CPT code.
- **Payer mix** - reflects charges and collections per payer category. Most meaningful if payer categories are aligned with insurance contracts.

Key Financial Indicators

Several key pieces of information need to be tracked frequently. The billing reports are tools that will help you to calculate the key metrics.

- **Gross collections ratio:** the percentage of gross charges collected. This ratio is affected by the practice fee schedule, insurance company allowable schedules, and patient collection efforts.

$$\frac{\text{Total collections}}{\text{Total Charges}}$$
- **Net collections ratio:** the percentage of adjusted charges collected. Payments (minus refunds) divided by charges (minus adjustments) for the selected period. A ratio higher than 100 percent will identify periods when there were many refunds, or possibly times when many patient accounts were turned over to collections. A stable ratio, when the practice is working through all steps of the revenue cycle and getting good results, is between 95 percent and 99 percent.

$$\frac{\text{Total Collections} - \text{Refunds}}{\text{Total Charges} - \text{Adjustments}}$$
- **Days in AR:** total accounts receivable divided by the practice's average daily charge amount. This figure provides an estimate of the length of time it takes to collect one day's worth of adjusted charges.

$$\frac{\text{Total Accounts Receivable}}{\text{Average Daily Charges}^*} \qquad \qquad \qquad * \text{Annualized charges}/365$$
- **Charge entry lag:** how long it takes, on average, to enter a day's charges. Delays in charge entry delay payments and may cause some claims to be written off due to contractual timely filing requirements.

$$\frac{\text{Sum of lag times}}{\text{Count of charges}}$$

- **Denial rate:** how many claims are denied, as a percentage of total claims. A high rate of denials should prompt the practice to evaluate claims submissions and determine where corrections are needed on the front end.

$$\frac{\text{Number of denied claims}}{\text{Total claim count}}$$

- **Point-of-service collection rate:** how often front desk staff collect payments at the time of service. This number should be close to 100 percent. Most patients will have some financial responsibility, and if the front desk is running efficiently, staff will be collecting regularly at the time of service.

$$\frac{\text{Number of times staff collects payments}}{\text{Total number of appointments}}$$

- **Operating margin:** operating income divided by the net revenue. This number explains how much of the practice revenue goes to cover expenses. Increased revenue and decreased expenses affect the operating margin.

$$\frac{\text{Total Operating Expenses}}{\text{Total Revenues - Refunds}}$$