



UNDERSTANDING THE NUMBERS

That Boost Practice Revenue



COOPERATIVE OF
AMERICAN PHYSICIANS

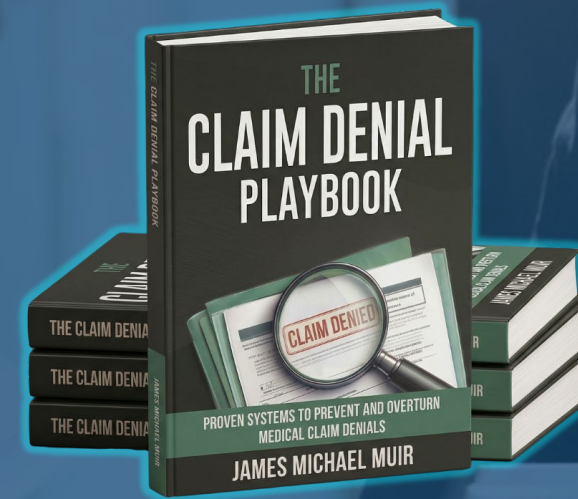
May 19, 2026



Meet Your Speaker

James Muir

- SVP Physician Services at UnisLink
- Founder and CEO of Best Practice International
- Bestselling author of **4 Books**
- 30+ years of RCM industry knowledge



Available On


Today's Agenda

Today's Conversation



- Industry Challenges
- Session Goal
- Why Measure KPIs
- When to Measure KPIs
- Which KPIs to Measure
- Calculating KPIs and What They're Good For
- How to Monetize Improvement

Top Practice Challenges

State of the Union: Physician Practices

MGMA Survey (Biggest Challenges)

58%

Staffing
Challenges

27%

Revenue
Challenges

20%

Expense
Challenges

4%

Technology/
Other Challenges



90% say costs are rising **faster than revenue**

Discover how to measure Key Performance Indicators (KPIs) and use them to improve practice financial performance.



Why should a practice know their KPIs?

“If you can't measure it, you can't improve it.”

- Peter Drucker

Why Focus on KPIs? The Benefits of Data



The Benefits of Data

Data Will Help You:

- Identify Areas That Are Underperforming
- Identify Areas That Are Losing Money
- Identify Areas That Are Performing Well
- Identify Areas That Are Profitable
- Identify Problems and Risk Areas
- Calculate the Financial Upside of Fixing the Problem
- Identify Why it is a Problem
- Identify How to Fix the Problem
- Identify the Full Potential of All Money Being Left on the Table



Key Insight

KPI performance can always be traced back to operational issues.

Key Insight

Without constant monitoring it's hard to know where to look for root causes of financial issues.

Trigger Events



It's time to look at your KPIs

Financial Triggers

- Cash Flow Drops
- Deposits are Down
- Reimbursement is down
- High % of AR Over 90 or 120 days
- High Days in AR
- Loss of Providers
- Addition of Providers
- Growth
- High Claim Denials

Administrative Triggers

- Loss of Key Billing Staff
- High Turnover in Business Office
- Growth and Scalability Issues
- Loss/Addition of Providers
- Reporting Challenges
- Lack of Transparency
- Change in Executive Leadership
- New Payer Contracts

Other Triggers

- Mergers and Acquisitions
- New relationships/affiliations
- New technologies available
- Medicare audit
- Vendor cyber-attack or security breach
- Other initiatives (higher value activities)
- Economic conditions

How Often Are You Benchmarking Data?



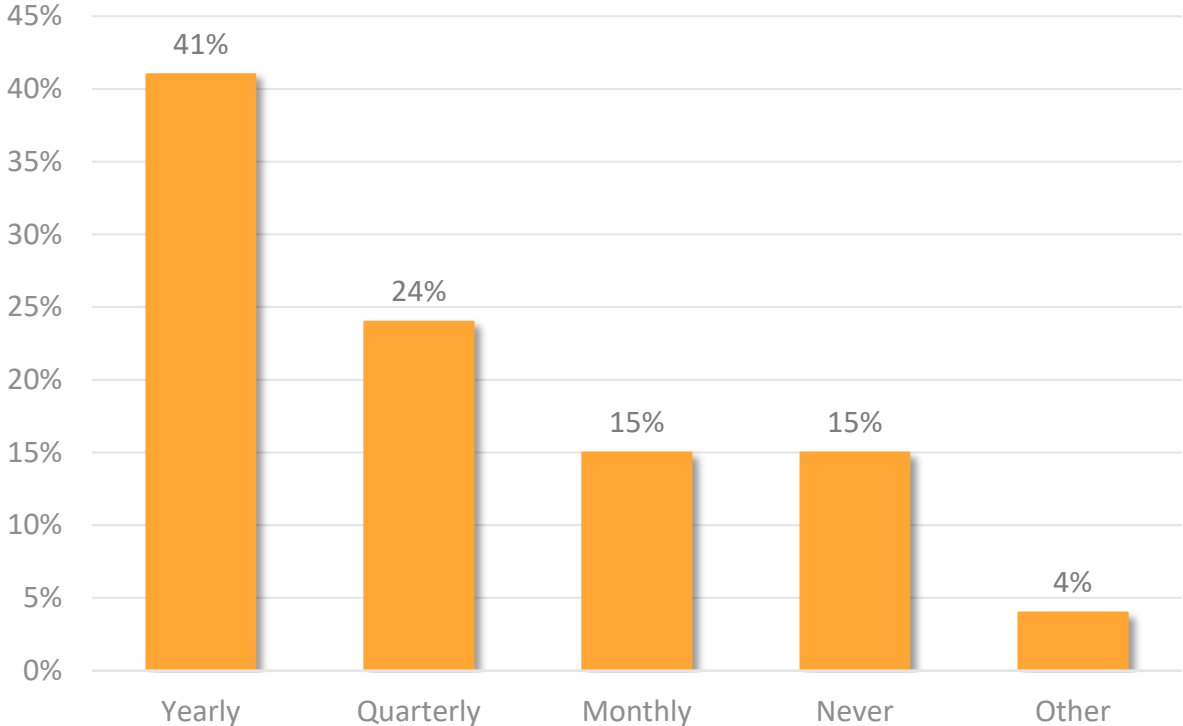
MGMAStat

39%

of medical groups benchmark their data versus external sources at least quarterly.

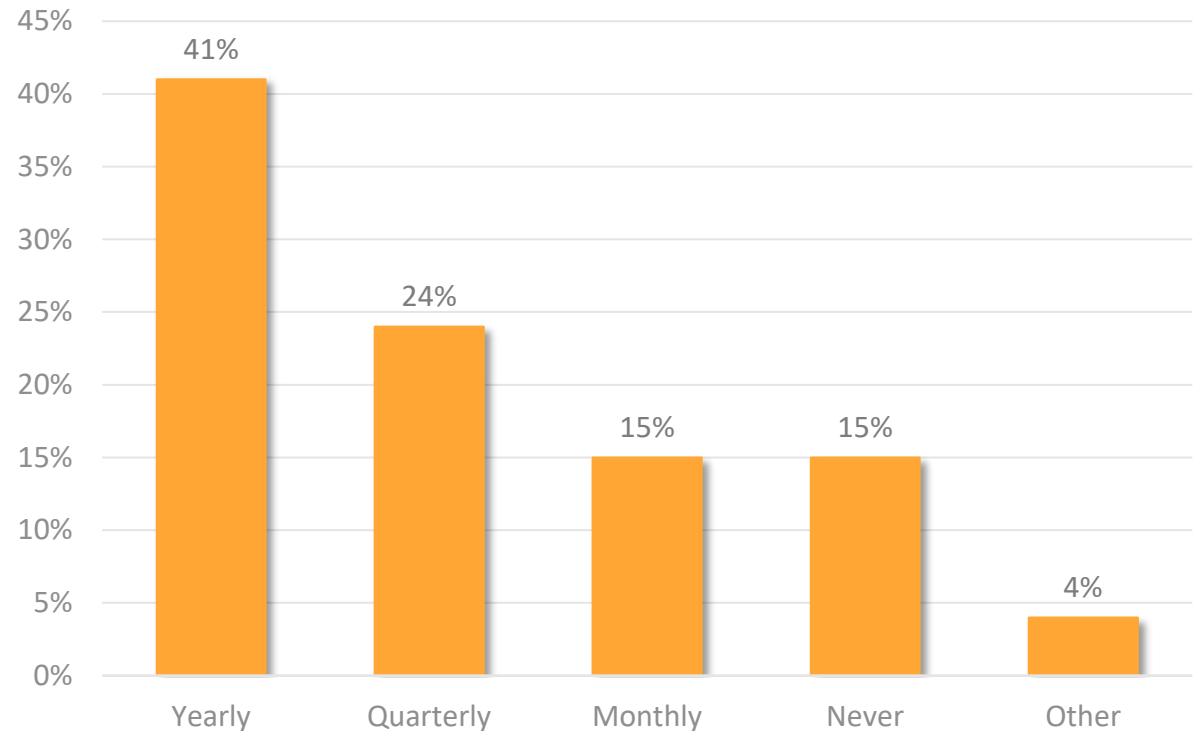
The graphic features a green background with a white speech bubble icon containing three dots. The text 'MGMAStat' is in white, and '39%' is in large yellow font. Below it, the text 'of medical groups benchmark their data versus external sources at least quarterly.' is in yellow.

How Often Are you Benchmarking Data



80% of groups look at their KPIs less than once a quarter.

How Often Are you Benchmarking Data



Key Insight

Key Performance Indicators should be looked at Monthly.

What KPIs should I be measuring?



Top KPIs Every Practice Should Measure

Key Performance Indicator	Shorthand
Accounts Receivable Greater Than 120 Days	AR > 120
Days in Accounts Receivable	AR Days
Insurance Days in Accounts Receivable	Insurance AR Days
Patient Days in Accounts Receivable	Patient AR Days
Gross Collection Rate	GCR
Revenue Realization Rate	RRR
Net Collection Rate	NCR
Average Reimbursement per Encounter	ARE
Percentage of Claims Denied	Denial Rate / Initial / Final

Free Resource: KPI eBook



Scan the QR code below for a **FREE** eBook on the 7 Performance Benchmarks, exclusive for CAP Physician Members!



<https://bit.ly/4tY9Xjk>

7 Performance Benchmarks
Every Medical Practice Must Know

Your in-depth guide to a healthier revenue cycle

Step 2 → **Step 3**

Industry standard benchmark* < 40 Days

Top-tier benchmark: 28-32 Days

*See top 20 specialties chart in Appendix

\$18,000,000
\$2,000,000
5) \$49,315
41 days in A/R

40
\$100,000
30
\$1,000,000

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KPI – AR > 120



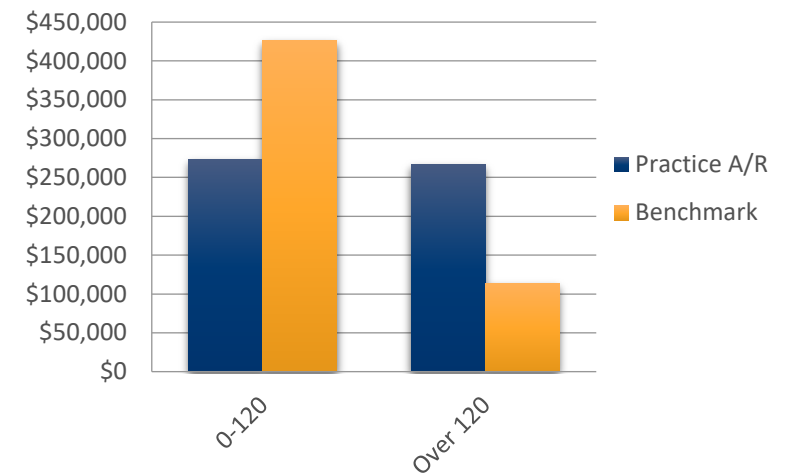
Definition: Total amount owed to practice for services rendered either by 3rd party insurance or patients that is 120 days old or older.

Benchmark: Less than 25% of your A/R should be over 120 days old. **Preferred is 9-15%**

Implications:

- Decreased Cash Flow (Delayed Revenue)
- Higher Risk of Nonpayment
- Increased Admin Costs (follow-up efforts, increased HR costs)
- Decreased Patient Satisfaction
- Compliance Issues
- Increased Financing Costs (if loans are required)
- Lower Practice Value

A/R > 120 Days Compared to Benchmark



Calculating A/R > 120



CALCULATION: Dollar Value of A/R >120 Days / Dollar Value of Total A/R

Example:

Total A/R = \$538,874

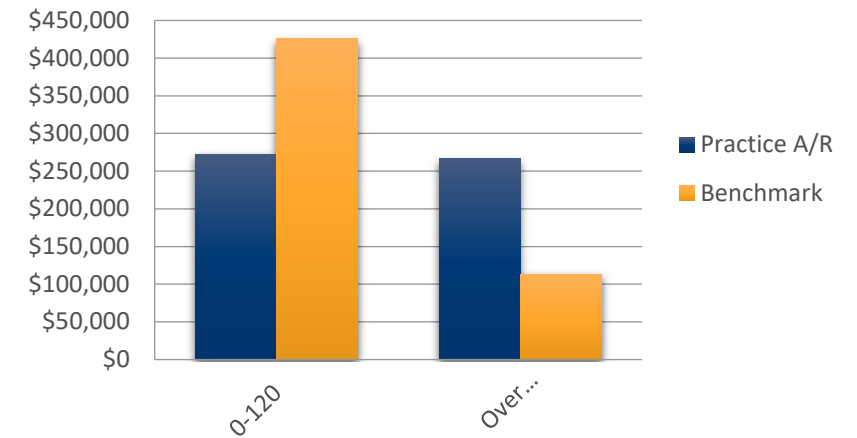
A/R > 120 = \$266,275

$\$266,275 / \$538,874 = 49\%$

Practice A/R	0-120	Over 120	Balance
No Unapplied Amt	\$272,599.33	\$266,275.16	\$538,874.49
Percentages	50.6%	49.4%	100%

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No Unapplied Amt	\$272,599.33	\$266,275.16	\$538,874.49
Percentages	50.6%	49.4%	100%

A/R > 120 Days Compared to Benchmark



Special Nuance – Calculating A/R > 120



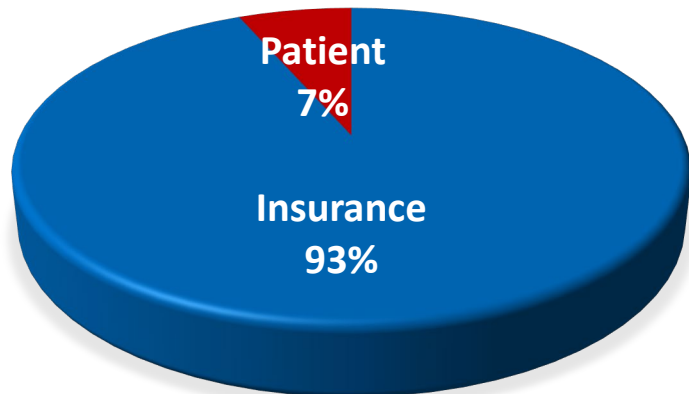
CALCULATION: Dollar Value of Patient A/R >120 Days / Dollar Value of Total A/R

CALCULATION: Dollar Value of Insurance A/R >120 Days / Dollar Value of Total A/R

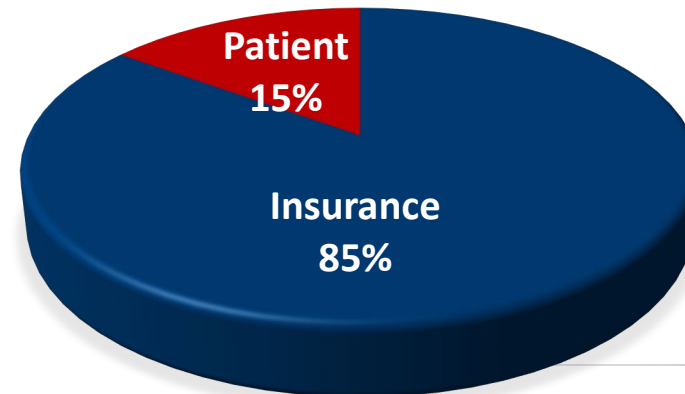
Aging by Responsibility

Responsibility	Current	31-60	61-90	91-120	121-up	Balance
Insurance	\$ 392,769.38	\$ 258,040.40	\$ 30,341.68	\$ 47,901.14	\$ 431,144.02	\$ 1,160,196.62
Patient	\$ -	\$ 740.00	\$ 2,750.99	\$ 1,982.00	\$ 75,577.73	\$ 81,050.72
Total	\$ 392,769.38	\$ 258,780.40	\$ 33,092.67	\$ 49,883.14	\$ 506,721.75	\$ 1,241,247.34

TOTAL AR BY RESPONSIBILITY



AR > 121 BY RESPONSIBILITY



Common Root Causes of Unhealthy AR > 120



- Errors in Claims Submission (Rejected Claims)
- Denied Claims
 - Insurance Verification Issues
 - Verification of Benefits Issues
 - Coding Issues
 - Inadequate Pre-authorization Processes
 - Credentialing Issues
 - Coordination of Benefits Issues
 - Insufficient Documentation
 - Medical Necessity Issues
 - Inadequate Claim Scrubber
- Inadequate Follow-Up / Denial Management
 - Inadequate Training Issue
 - Inadequate Staffing Issue (Insufficient Resources to Follow-up on Claims)
- Inadequate Patient Collection Processes
- Charge Lag is High (contributing factor)
- Inadequate or Unrealistic Write-off Policy
- Inadequate Documentation for Standard Operating Procedures



KPI – Days in A/R (AR Days)

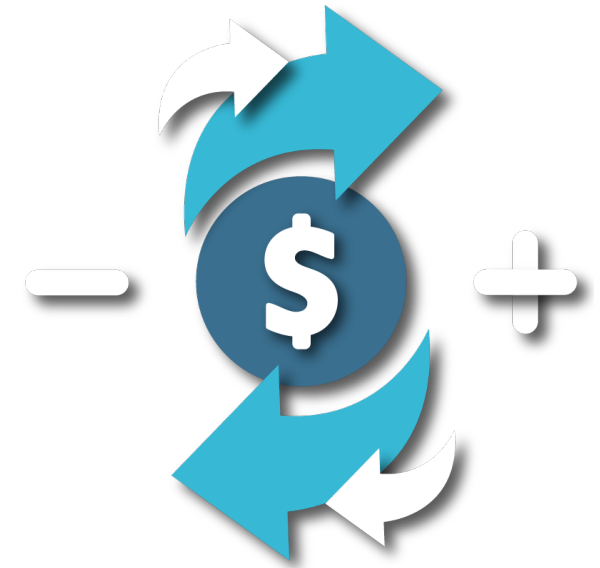
Definition: Average number of days it takes a practice to get paid.

Benchmark: 30 Days. For some specialties, a 40 Days is acceptable.

Preferred is < 30 Days.

Implications:

- Decreased Cash Flow (Delayed Revenue)
- Higher Risk of Nonpayment
- Increased Admin Costs (follow-up efforts, increased HR costs)
- Decreased Patient Satisfaction
- Compliance Issues
- Increased Financing Costs (if loans are required)
- Lower Practice Value



**Days in AR
Cash Flow Metric**

WARNING

Low AR Days doesn't mean you are collecting all the money you could be collecting.

This metric must be combined with Net Collection Rate to be fully meaningful.

Calculating Days in A/R



CALCULATION: Total Receivables / (Average Daily Charge Amount)

STEP 1: Determine your total current receivables, then subtract any credits. Credits are funds owed by the practice to others. They offset receivables; therefore, you must subtract credits from receivables.

STEP 2: Determine your average daily charge amount by dividing total gross charges for the last 12 months by 365 days

STEP 3: Divide the total from Step 1 (receivables) by the total from Step 2 (charge amount)

EXAMPLE:

Total Billed Charges (12 months) = \$18,000,000
Total Accounts Receivable = \$2,000,000

RESULTS:

$\$18,000,000 / 365 = \$49,315 = \text{Avg Charges per day}$
 $\$2,000,000 / \$49,315 = 41 \text{ is the Days in AR}$

Common Root Causes of Unhealthy Days in AR



- Errors in Claims Submission (Rejected Claims)
- Denied Claims
 - Insurance Verification Issues
 - Verification of Benefits Issues
 - Coding Issues
 - Inadequate Pre-authorization Processes
 - Credentialing Issues
 - Coordination of Benefits Issues
 - Insufficient Documentation
 - Medical Necessity Issues
 - Inadequate Claim Scrubber
- Inadequate Follow-Up / Denial Management
 - Inadequate Training Issue
 - Inadequate Staffing Issue (Insufficient Resources to Follow-up on Claims)
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KPI – Average Revenue Per Encounter (ARE)



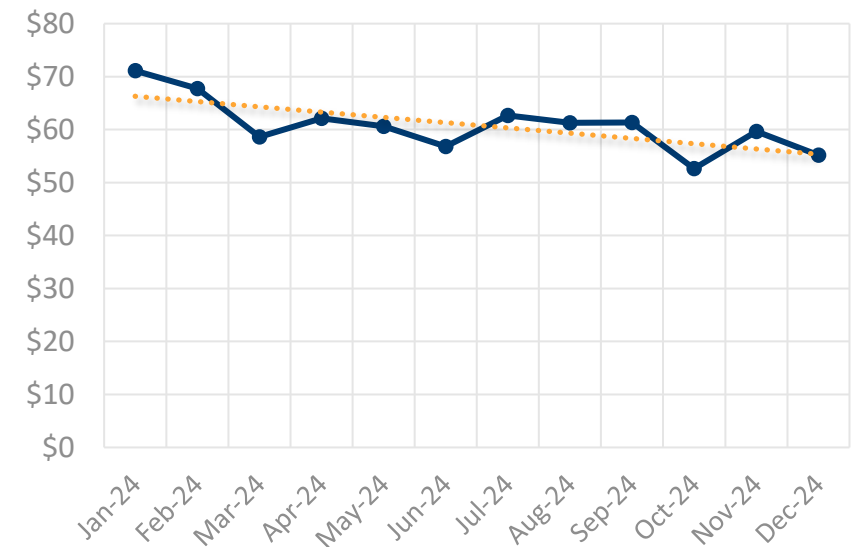
Definition: The average amount the practice collects per encounter.

Benchmark: Varies by specialty. MGMA is a good source for this data.

Implications:

- Low Margins
- Decreased Cash Flow (Delayed Revenue)
- Increased Reliance on Volume
- Staffing Catch-22 (lower rev constrains staffing hires)
- Technology Catch-22 (constrains investments)
- Lower Practice Value
- Long-term Sustainability

Average Revenue Per Encounter



Calculating Average Revenue Per Encounter (ARE)

CALCULATION: Total Revenue / Total Number of Encounters = Average Revenue Per Encounter

Tips:

- Revenue and Encounters must come from the same period
- Best run over 12-month period
- Best trended monthly

Period	ARE
24-Jan	\$71
24-Feb	\$68
24-Mar	\$59
24-Apr	\$62
24-May	\$61
24-Jun	\$57
24-Jul	\$63
24-Aug	\$61
24-Sep	\$61
24-Oct	\$53
24-Nov	\$60
24-Dec	\$55

EXAMPLE:

Total Revenue (12 months) = \$18,000,000
Total Encounters (12 months) = 77,922

RESULTS:

$\$18,000,000 / 77,922 = \231 ARE

Common Root Causes of Unhealthy ARE

- Errors in Claims Submission (Rejected Claims)
- Denied Claims
- Inefficient/Inadequate Billing Processes
 - Denials & Appeals
 - Insurance Follow-up
- Poor Payer Mix
- Poor Coding Practices
- Too Many Low-complexity Services
- Outdated Fee Schedule
- High Percentage of No-shows and Cancelations
- Inadequate Patient Collection Processes



KPI – Percentage of Claims Denied (Denial Rate)



Definition: Percentage of claims denied by payers out of the total claims submitted.

Initial Denial Rate: Percentage of claims denied by payers upon first submission.

Final Denial Rate: Percentage of claims that remain denied after all appeals have been exhausted.

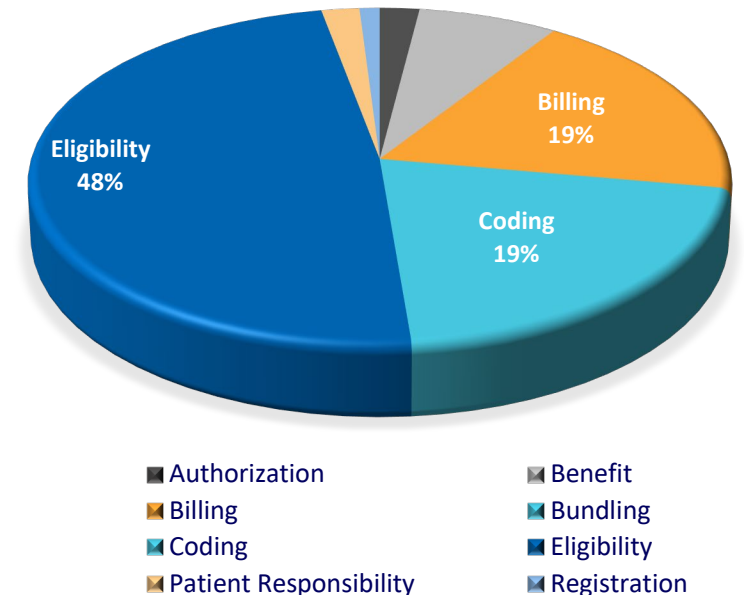
Benchmarks:

- **Initial Denial Rate:** 6-10%
- **Final Denial Rate:** 2-5%

Implications:

- Decreased Cash Flow (Delayed Revenue)
- Higher Risk of Nonpayment
- Increased Admin Costs (follow-up efforts, increased HR costs)
- Decreased Patient Satisfaction
- Increased Financing Costs (if loans are required)
- Lower Practice Value

DENIALS BY CATEGORY



Calculating Denial Rates



Initial Denial Rate: Total Number Denied Claims / Total Number of Claims Submitted

Final Denial Rate: Number of Denied Claims After Appeals / Total Number of Claims Submitted

Tips:

- Many practice management systems do not report denials well
- Consider getting data from your clearinghouse
- Focus on initial denials
- Avoid duplication
- Measure both percentage and dollar values (Dollar-Based Denial Rate)
- Run at least monthly



EXAMPLE:

Total Denied Claims (1 Month) = 562
Total Claims (1 Month) = 7013

RESULTS:

$562 / 7013 = 8.01\%$ Denial Rate

Common Root Causes of Unhealthy Denial Rates

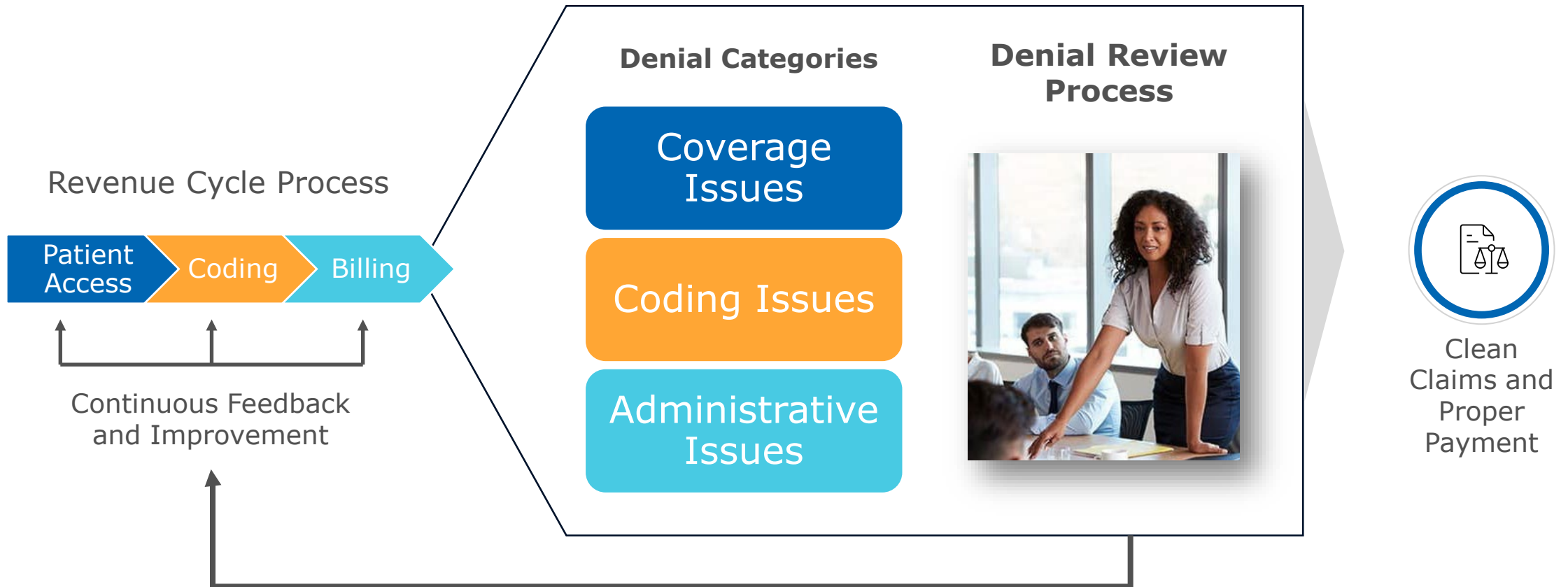


- Insurance Verification Issues – CO-27, others
- Verification of Benefits Issues – CO-167
- Coding Issues – CO-11, CO-4
- Missing or Incorrect Information – CO-15
- Inadequate Pre-authorization Processes – CO-15
- Credentialing Issues
- Coordination of Benefits Issues – CO-22
- Timely Filing – CO-29
- Duplicate Service – CO-18
- Insufficient Documentation
- Medical Necessity Issues
- Fee Schedule Contract Issues – CO-45
- Incorrect Place of Service
- Inadequate Claim Scrubber



Denial Review and Feedback

Prevent the root cause of denials to ensure claims are submitted cleanly the first time.



KPI – Gross Collection Rate (GCR)



Definition: Percentage of Gross Charges Collected

Benchmark: 35-65%

(As a standalone metric GCR is highly variable and **not** relevant)

Implications (if trending downward):

- Indicator that something is wrong in practice operations and that deeper investigation is needed.
- Decreased Cash Flow (Delayed Revenue)

Gross
Collection
Rate

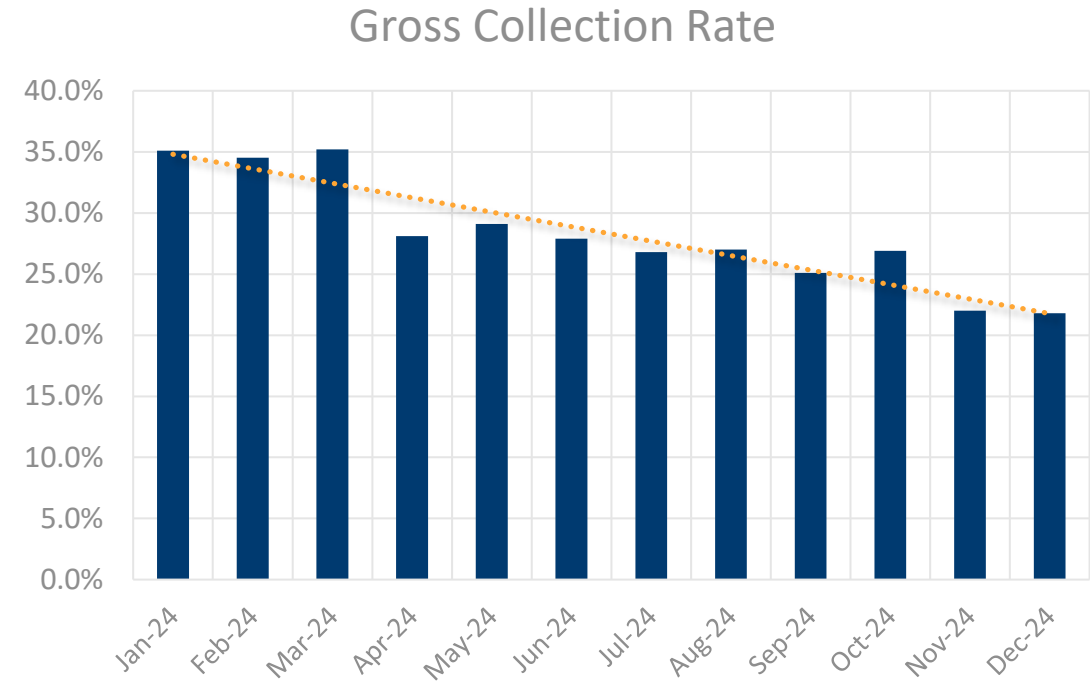
Calculating Gross Collection Rate (GCR)



Gross Collection Rate: Total Charges / Total Payments

Tips:

- Charges and Revenue must come from the same period
- Best run over 12-month period
- Best trended monthly



EXAMPLE:

Total Charges (12 Months) = \$1,000,000
Total Payments (12 Months) = \$400,000

RESULTS:

$(\$400,000 / \$1,000,000) = 40\%$ GCR

NOTE: Fee Schedules Greatly Impact GCR

- Very High Fee Schedules Produce Lower GCR
- Very Low Rates – Fee schedules may need to be reviewed
 - you may be charging less than the allowed amount
- High Variance From Internal Benchmark – GCR by payer
- Under-coding
- Underperforming Insurance Collections
- Underperforming Patient Collections
- Inadequate Follow-up / Denial Management
- Ineffective Front-end Operations



KPI – Revenue Realization Rate (RRR)

Definition: Percentage of Charges either collected or adjusted off. (regardless of reason)

Benchmark: 99-100%

(For reporting periods 90+ days in the past.)

Implications if Low:

- Not all work is being done in a timely fashion
 - Claims Processing
 - Payment Posting
 - Adjustments
- Indicator of Inefficient Processes
- Decreased Cash Flow (Delayed Revenue)
- Higher Risk of Nonpayment



Revenue Realization Rate - Nuances



Caution: Because we're using ALL Adjustments vs Contractual Adjustments in this formula...

If the Number is High (Ideal Scenario #1)

- Practice is billing out timely
- Claims are adjudicated (contractual adjustments are made)

$$RRR = \left(\frac{\text{Payments} + \text{Adjustments}}{\text{Total Charges}} \right) \times 100$$

Number is High (Non-Ideal Scenario #2)

- Practice is billing out timely
- Claims are adjudicated (contractual adjustments are made)
- Patient balances are NOT collected (patient adjustments are made)

Number is High (Non-Ideal Scenario #3)

- Practice is billing out timely
- Claims are adjudicated and denied (disguised contractual adjustments or adjusted as uncollectible)
- Patient balances are NOT collected (patient adjustments are made)

Key Insight

Each KPI only tells part of the story.

KPIs must be looked at together to determine the complete story.

KPI – Net Collection Rate (NCR)

Definition: Percentage of payment collected from the total amount allowed to be collected based on contractual agreements.

What percentage of your collectable dollar did you actually collect?
(including both insurance and patient sources)

Benchmark: 95-96%

Implications if Low:

- Loss of Revenue
- Decreased Cash Flow (Because of Lost Revenue)
- Lower Margins
- Increased Admin Costs (follow-up efforts, increased HR costs)
- Increased Financing Costs (if loans are required)
- Lower Practice Value



Calculating RRR and NCR



Revenue Realization Rate: (Payments + Adjustments) / Charges

Net Collection Rate: Payments / (Charges – Contractual Adjustments)

Example:

Total Billed Charges (12 months) = \$27,000,000

Total Contractual Adj. (12 months) = \$15,500,000

Total Non-contractual (12 months) = \$ 950,000

Total Payments (12 months) = \$10,200,000

You do the math: What's the NCR and RRR?

$(\$10,200,000 + \$15,500,000 + 950,000) / \$27,000,000 = 98.70\%$ **RRR** (Revenue Realization Rate)

$\$10,200,000 / (\$27,000,000 - \$15,500,000) = 88.69\%$ **NCR** (Net Collection Rate)

Root Causes of Unhealthy RRR and NCR



Revenue Realization Rate (RRR)

- Inefficient Billing Coding Process
- High Claims Denial Rate
- Inefficient Patient Collection Process
- Inefficient/Ineffective Coding Process
- Poor Patient Intake Process
- Staffing Shortages
- Overwhelming Workloads/Backlog
- High Charge Lag
- Insufficient/Unrealistic Write-off Policy
- Inadequate Documentation for Standard Operating Procedures

Net Collections Rate (NCR)

- Errors in Claims Submission (Rejected Claims)
- Denied Claims (see Denial Rate)
- Underperforming Insurance Collections
- Underperforming Patient Collections
- Inadequate Follow-up / Denial Management
- Ineffective Front-end Operations
- Under-coding
- Unsubmitted/Late Claims
- Credentialing Issues

Key Insight

All KPIs are inter-related.

Example: A reduction in Denial Rate will:

- Accelerate Cash Flow
- Reduce AR Days
- Lower Aging Over 120
- Improve Gross Collection Rate
- Raise Revenue Realization Rate
- Raise Average Revenue Per Encounter
- Improve Net Collection Rate
- Lower Staffing Costs (Practice Overhead)

KPI Utility – When to use each KPI



All KPIs are useful for assessing practice operations

Key Performance Indicator	Cash Flow	Billing / Collection Efficiency	Identifying Problem Areas	Identifying Problem Payers	Notes
Accounts Receivable Greater Than 120 Days (AR > 120)	Y	Y	Y	Y	<ul style="list-style-type: none"> Run by payer and patient balance Evaluating Staffing Efficiency Evaluating Workload Challenges
Days in Accounts Receivable (AR Days)	Y	Y	Y	Y	<ul style="list-style-type: none"> Run by Insurance & Patient Financial Planning
Gross Collection Rate (GCR)		Y	Y		<ul style="list-style-type: none"> When Trended Over Time Monitoring Practice Financial Health Estimating Collectable Revenue Financial Planning
Revenue Realization Rate (RRR)	Y	Y		Y	<ul style="list-style-type: none"> Evaluating Staffing Efficiency Evaluating Workload Challenges
Net Collection Rate (NCR)		Y	Y	Y	<ul style="list-style-type: none"> Evaluating Billing and Collection Effectiveness
Average Reimbursement per Encounter (ARE)		Y	Y	Y	<ul style="list-style-type: none"> Provider Performance Monitoring Financial Projections Service Line Performance/Profit
Percentage of Claims Denied (Denial Rate / Initial Denial Rate / Final Denial Rate)	Y	Y	Y	Y	<ul style="list-style-type: none"> Root Cause Analysis Process Optimization Evaluating Front-End Processes Payer Strategy

A blue-tinted photograph of a business meeting. In the foreground, a person's hands are visible, one holding a pen over a clipboard and the other gesturing. In the background, another person's hands are clasped together near a laptop. The overall scene is professional and collaborative.

Calculating Improvement Potential

How Much Improvement is Possible?

Determining how much improvement is possible is unique for every practice.

- Every practice is unique
- Improvement potential can be calculated using your practice KPIs
- The Patti Peets Method™



Patti Peets

What is a Net Collections Rate (NCR)



NCR allows you to measure the amount of revenue you collected vs. the amount you should have collected.

- **Net Collections Rate (NCR)** – The percentage of reimbursement achieved out of the reimbursement allowed based on contractual obligations with payers and other payments.
 - What percentage of your Total Collectable Dollar did you actually collect?
- **Formula:** $\text{Total Payments} / (\text{Charges} - \text{Contractual Adjustments})$

Net Collections Rate Nuances



To calculate an accurate Net Collection Rate, adhere to these guidelines:

- Includes Patient Payments
- Only Use Contractual Adjustments
 - Using **all** adjustments (including bad debt for example) will skew your NCR upwards.
 - Using all adjustments is a different KPI known as Revenue Realization Rate.
- Run 90 days in arrears to allow for time for adjudication.
 - Or if growth is generally flat, use a rolling average of 12 months.
- Run a Separate Adjustment Report
 - This will allow you to more easily determine which adjustments are contractual.
- Significant credit balances can artificially skew NCR upwards.

The Patti Peets Net Collections Method™



How to calculate the financial value of improvement possible for your practice.

Steps:

1. Calculate your Net Collection Rate

2. Using the same data:

- Divide Total Payments by your Net Collections Rate
- This gives you the value of a 100% NCR

3. Using Your New 100% NCR Value:

- Multiply by 95%, 96%, 97%, and 98% Net Collection Rates
- This is the total value of your receivables at each rate

4. Determine the Difference

- Subtract your original Total Payments from New Higher NCR Total
- This is the dollar value of improving your NCR to that rate

Formulas:

NCR

- $\text{Total Payments} / (\text{Charges} - \text{Contractual Adjustments})$

NCR at 100%

- $\text{Total Payments} / \text{NCR}$

Value at X% NCR

- $\text{NCR at 100\%} * X\%$

Value of Difference

- $\text{Value at X\% NCR} - \text{Total Actual Payments}$

Example



From Charge Summary	Charges	Total Payments	Contractual Adjustments
June 2023 – May 2024	\$19,287,830	\$6,665,630	\$9,998,840

Net Collection Rate	71.76%
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Value of Receivables at 100%	\$9,288,990
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	Payments at New NCR	Total Actual Payments	Value of Difference
Value at 95% NCR	\$8,824,540.50	\$6,665,630	\$2,158,910.50
Value at 96% NCR	\$8,917,430.40	\$6,665,630	\$2,251,800.40
Value at 97% NCR	\$9,010,320.30	\$6,665,630	\$2,344,690.30
Value at 98% NCR	\$9,103,210.20	\$6,665,630	\$2,437,580.20

Monetized Value of Improving NCR = \$2.1 - \$2.4M. A 30+ percent boost in revenue.

Same services, same volume

What is an RCA?

Revenue Cycle Assessment – An analysis of the key performance indicators, trends and processes associated with medical practice revenue cycle performance.

KPI Summary



- Key Performance Indicators Compared
 - Your Practice
 - Your Peers
 - Best Performing
- Document Improvement Opportunities
- Document Risk Areas
- Monetized Financial Improvement Potential

Key Performance Indicator	Your Practice	Peers	Best Performing
Denial Rate	11.8%	6%	1%
Net Collection Rate	91.1%	94.5%	99%
AR Over 120	15.3%	10.5%	4%
Days in AR	39	33	26

Key Performance Indicators



Up to 25 Key Performance Indicators

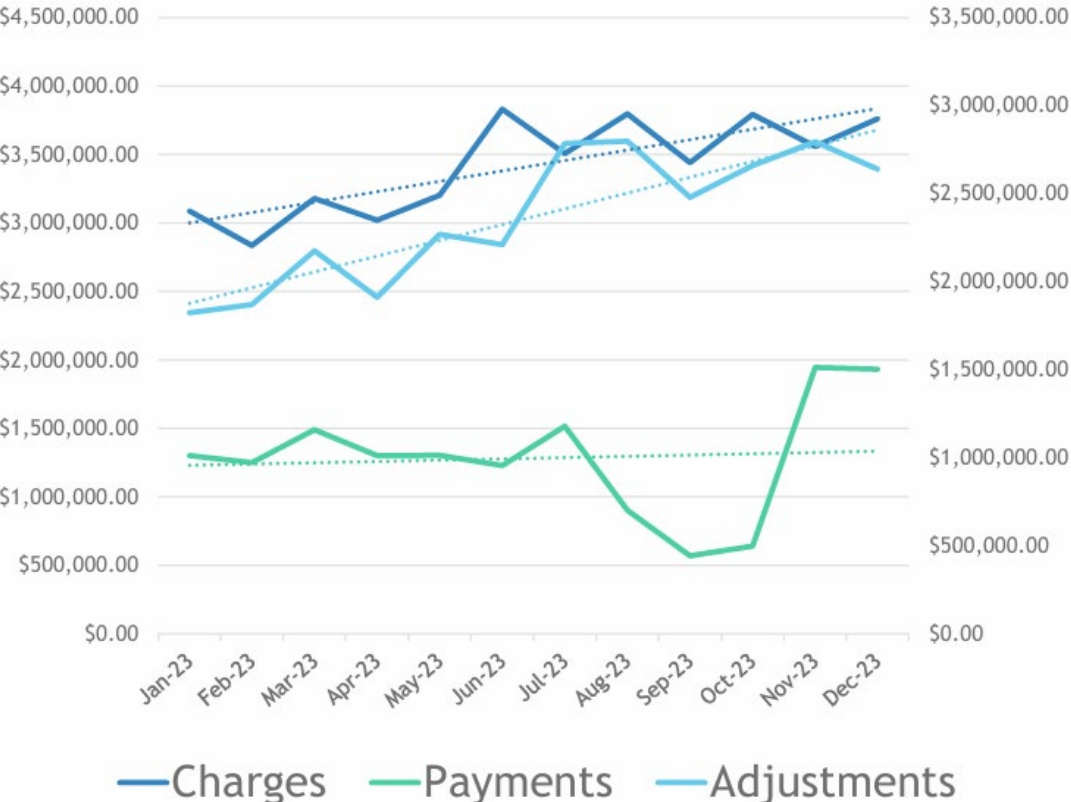
Metric	Client	Benchmark	KPI Definition and Calculation
Gross Collection Rate	31.8%	35-45%	Illustrates the percentage of gross collections. If this number is lower than 35%, review process unless charges are set very high in comparison to Medicare allowable. Calculation: Total of Payments on specific dates / Charges for those same dates. (90 Day lookback on charges)
Revenue Realization Rate	94.7%	99-100%	Measures the effectiveness of collecting all possible reimbursement and processes for billing, collecting, and adjustments. Calculation: Sum of Payments and Adjustments (both insurance and patient) / Charges. (90 Day look back on charges)
Net Collection Rate	90.5%	97-98%	Measures the effectiveness of collecting all possible reimbursement. Calculation: Sum of Payments / Charge Value (Charges less expected contractual adjustments). Note: Difficult to calculate if all claims have not been adjudicated. (90 Day lookback on charges)
Adjusted Net Collection Rate	81.1%	97-98%	Same as above, adjusted for variances found in data. Calculation: Sum of Payments / Charge Value (Charges less expected contractual adjustments). Note: Difficult to calculate if all claims have not been adjudicated. (90 Day lookback on charges)
Avg Reimbursement Per Encounter	\$78	\$117	Measures the effectiveness of collecting all possible reimbursement. Calculation: Sum of Payments / Number of Encounters (can also be done by procedure)
AR Over 120 Days	46	30	Calculates the number of days it takes for a bill to be paid. Calculation: Total AR > 120 / Total AR
Denial Rate	23%	2-4%	Indicates the percentage of claims denied. Calculation: Total Encounters Denied / Total Encounters (unpreventable denials excluded)

Transactional Trending

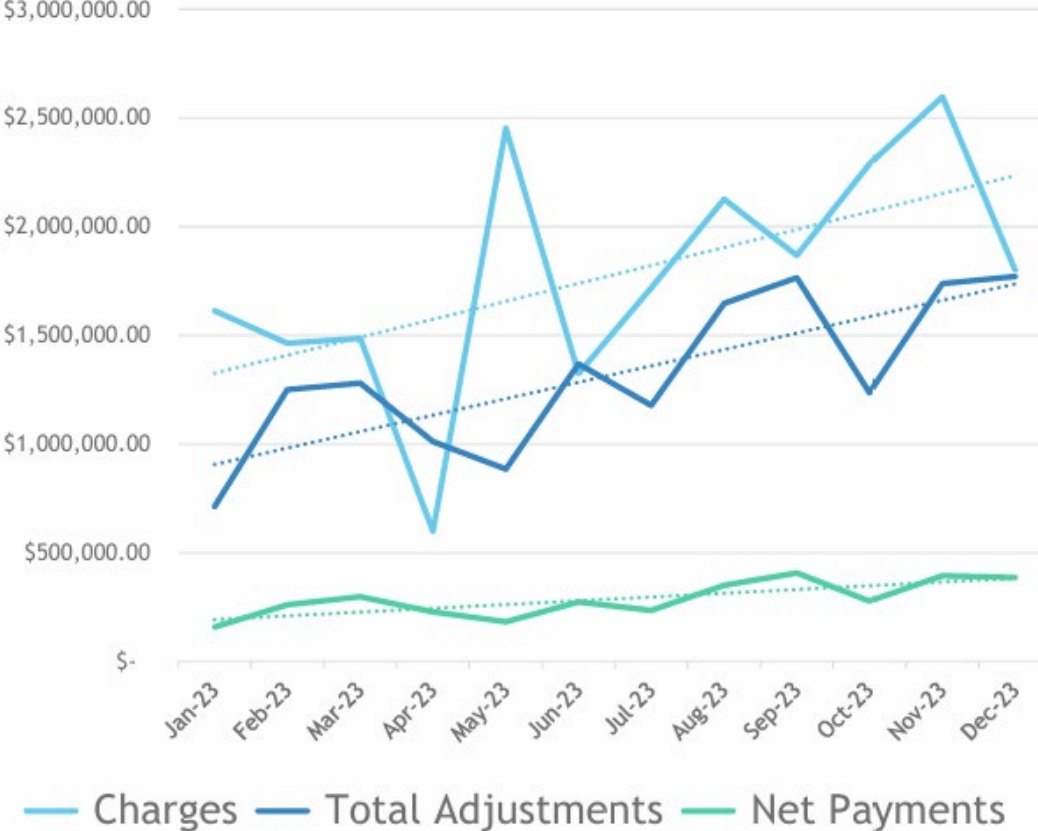


Transactional Trending Identifies Potential Risk Areas and Areas for Further Focus

Transactional Trending



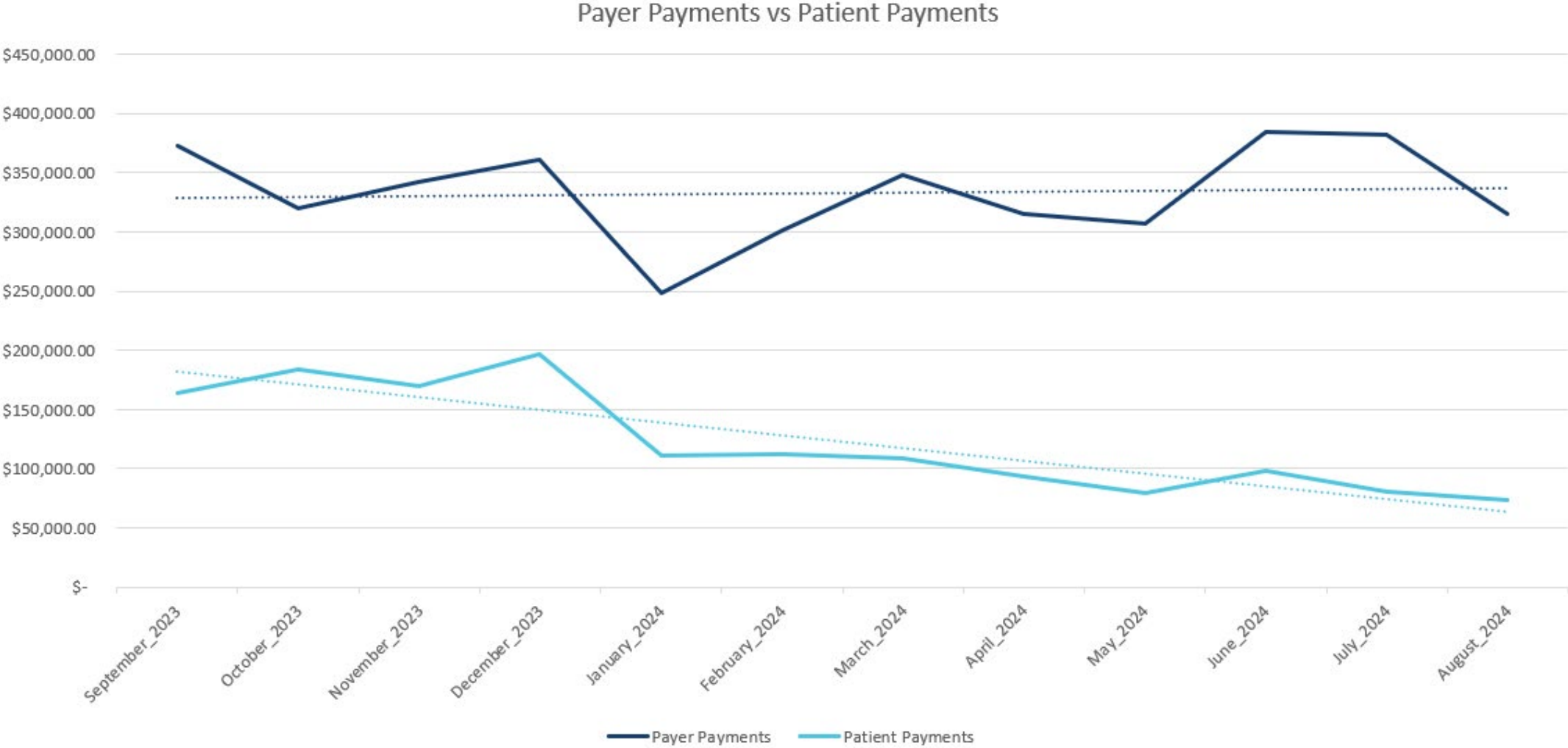
Transaction Trending



Transactional Trending



Transactional Trending Identifies Potential Risk Areas and Areas for Further Focus

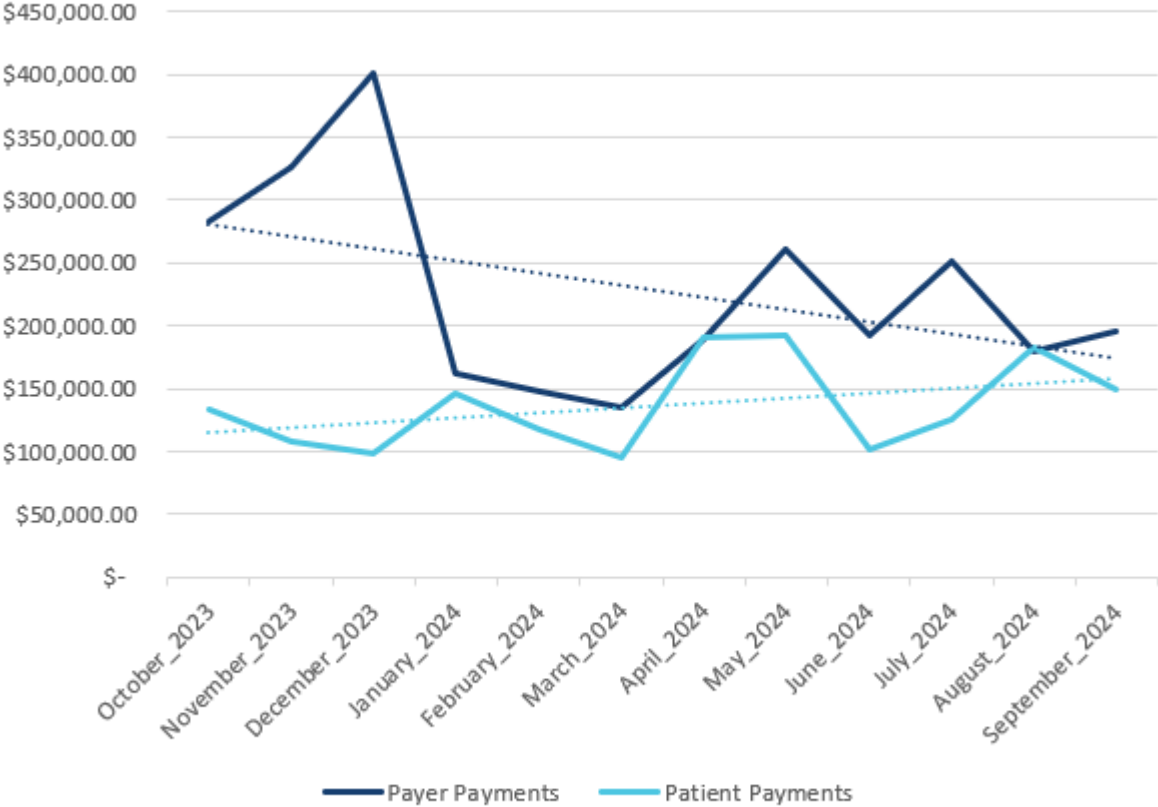


Transactional Trending

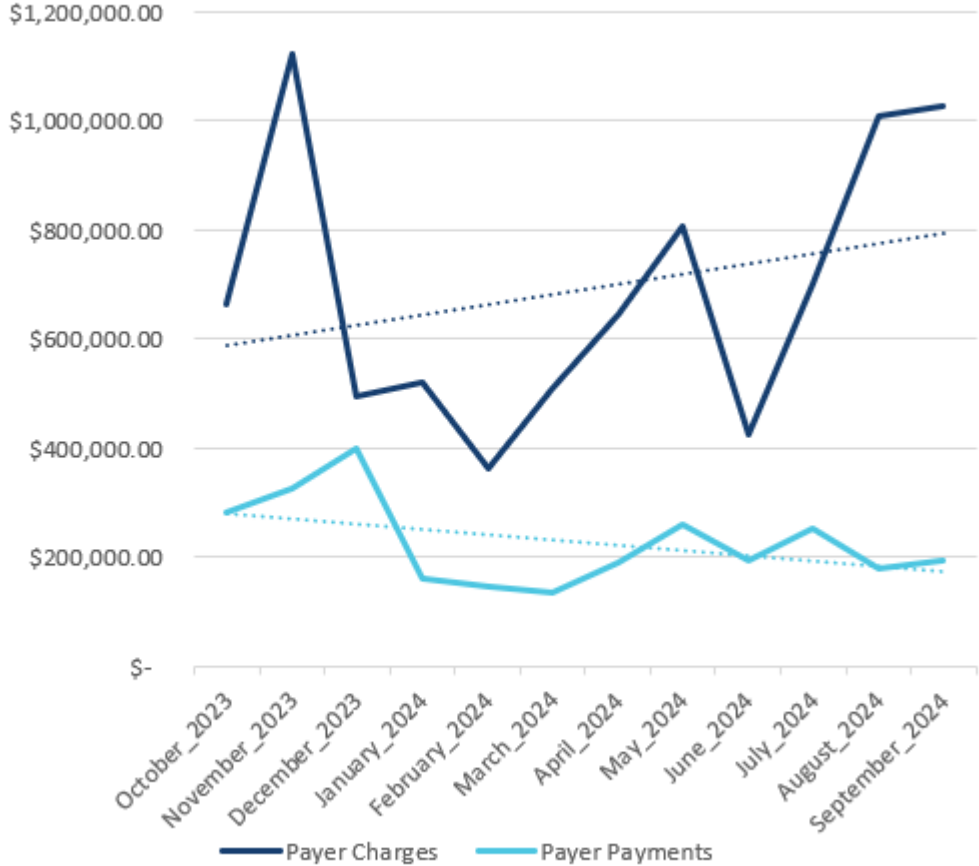


Transactional Trending Identifies Potential Risk Areas and Areas for Further Focus

Payer Payments vs Patient Payments



Payments vs Adjustments



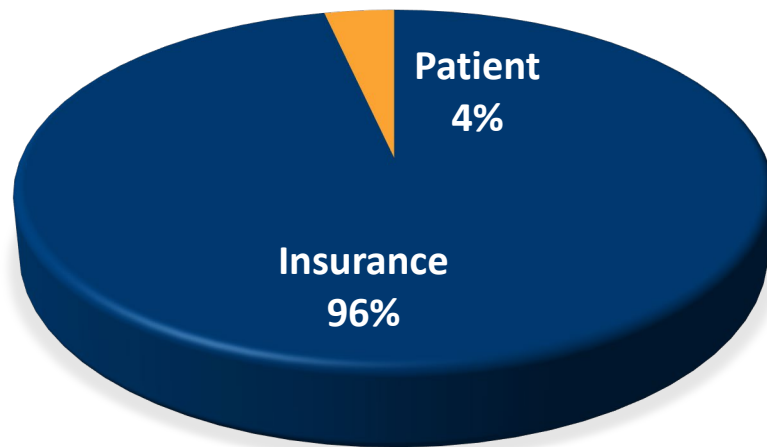
Aged Balances by Patient and Payer



Aging by Responsibility

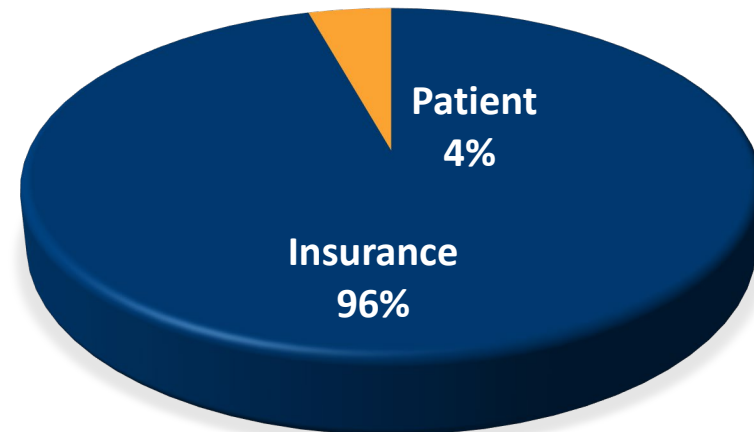
Responsibility	Current	31-60	61-90	91-120	121-Up	Balance
Insurance	\$2,073,259.22	\$275,608.33	\$155,651.54	\$192,039.48	\$2,707,369.91	\$5,403,928.48
Patient	\$19,646.16	\$22,762.48	\$17,301.44	\$14,301.71	\$122,375.75	\$196,387.54
Total	\$2,092,905.38	\$298,370.81	\$172,952.98	\$206,341.19	\$2,829,745.66	\$5,600,316.02

A/R BALANCE BY RESPONSIBILITY



■ Insurance ■ Patient

A/R BALANCE BY RESPONSIBILITY
AR>120



■ Insurance ■ Patient

Accounts Receivable – AR > 120

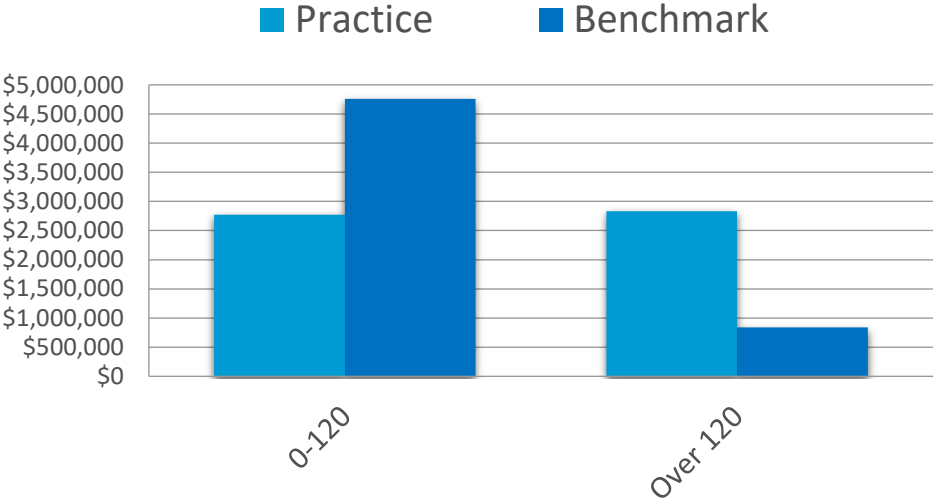


Net Value at Risk of AR Over 120 Not Getting Collected

Practice A/R	0-120	Over 120	Balance
Balance	\$2,770,570.36	\$2,829,745.66	\$5,600,316.02
Percentages	49.5%	50.5%	

A/R	0-120	Over 120	Balance
Benchmark	\$4,760,268.62	\$840,047.40	\$5,600,316.02
Percentages	85.0%	15.0%	

Total AR > 120



Impact of A/R over 120 Days	
Current A/R Over 120	\$2,829,745.66
Benchmark A/R Over 120	\$ 840,047.40
Difference	\$ 1,989,698.26
Net Value at Risk	\$ 691,491.69

Difference Xs (%patient 100%) + (%insurance x GCR)

Accounts Receivable – Days in AR



Net Value at Risk of AR Days Over Benchmark

Days in A/R Calculation			
A/R Balance		\$ 5,600,316.02	
CHARGES	All Payments	All Adjustments	GCR
\$ 44,258,809.98	\$ 14,029,656.82	\$ 28,712,350.80	31.70%
1 Day Average Charge	\$121,257.01		
Days in A/R	46		
Benchmark	28		
Current A/R	\$5,600,316.02		
Total A/R at Benchmark	\$3,395,196.38		

Impact of Days in AR	
Current A/R	\$ 5,600,316.02
Benchmark A/R Over 120	\$ 3,395,196.38
Difference	\$ 2,205,119.64
Net Value at Risk	\$ 764,137.49

Difference Xs (%patient 100%) + (%insurance x GCR)

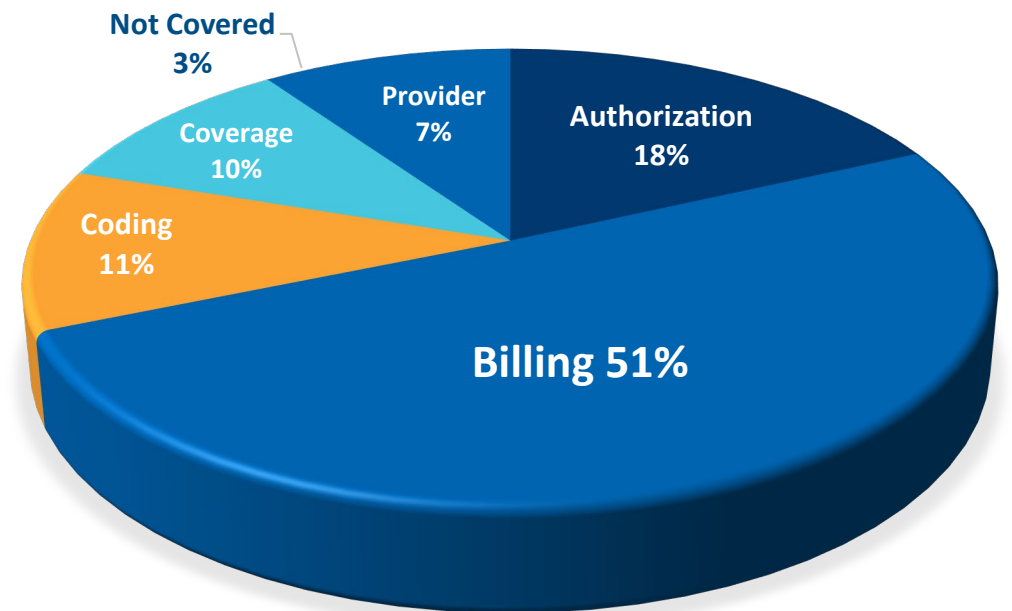
Denials by Functional Area



Denials by Functional Area Suggest Focus Areas for Improvement Initiatives

Row Labels	Sum of Charges	Sum of Adjustment
Authorization	\$549,531.85	\$338,208.89
Billing	\$1,530,531.93	\$1,492,086.55
Coding	\$345,870.52	\$262,302.47
Coverage	\$305,903.54	\$282,017.42
Not Covered	\$98,062.26	\$45,374.27
Provider	\$196,418.57	\$146,488.79
Grand Total	\$3,026,318.67	\$2,566,478.39

SUM OF CHARGES



Many Other Focus Areas

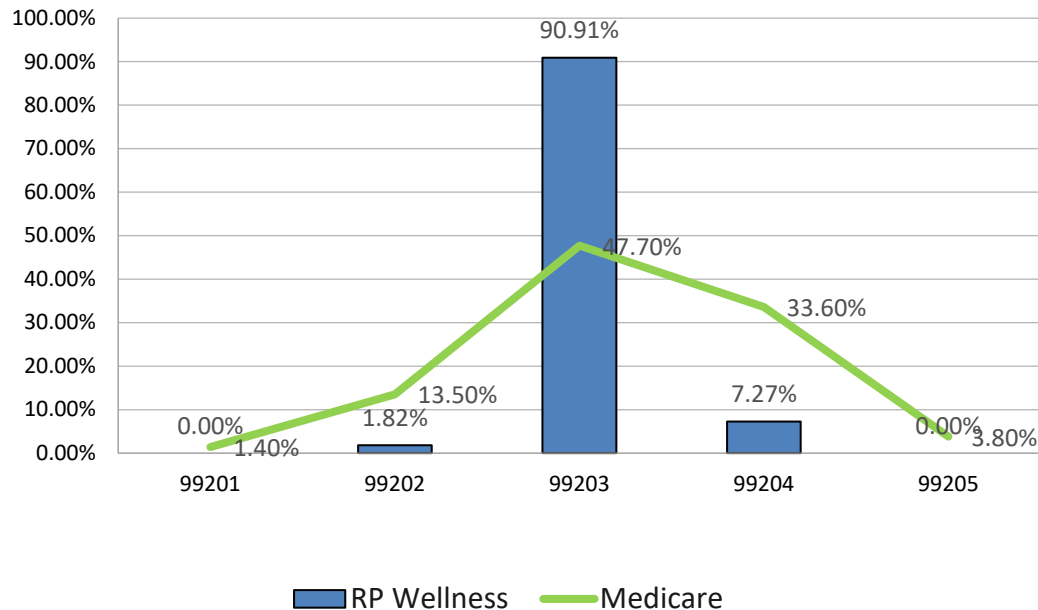


E&M Utilization – Established Visits

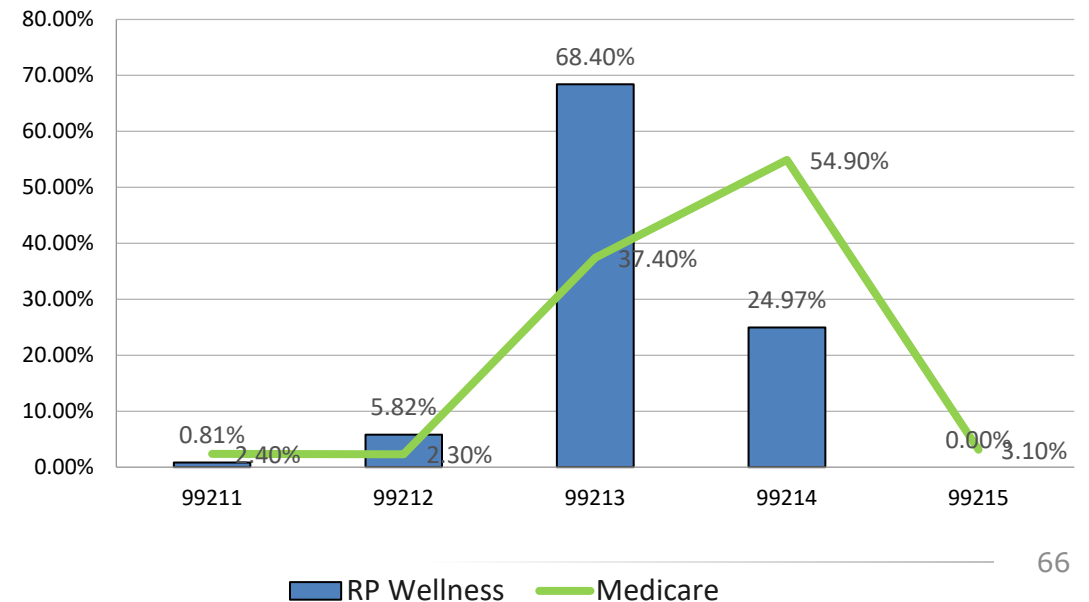
	Medicare		Practice		Variance
	Percent	Count	Percent	Count	
99201	1.40%	0	0.00%	0	-1%
99202	13.50%	1	1.82%	1	-12%
99203	47.70%	50	90.91%	50	43%
99204	33.60%	4	7.27%	4	-26%
99205	3.80%	0	0.00%	0	-4%
Totals	100.00%	55	100.00%	55	

	Medicare		Practice		Variance
	Percent	Count	Percent	Count	
99211	2.40%	12	0.81%	12	-2%
99212	2.30%	86	5.82%	86	4%
99213	37.40%	1,011	68.40%	1,011	31%
99214	54.90%	369	24.97%	369	-30%
99215	3.10%	0	0.00%	0	-3%
Totals	100.10%	1,478	100.00%	1,478	

New Patient E&M Utilization



Existing Patient E&M Utilization



Improvement Potential



GCR (Gross Collection Rate) = *Payments / Charges*
RRR (Revenue Realization Rate) = *Payments + Adjustments / Charges*
NCR (Net Collection Rate) = *Payments / Charges - Contractual Adjustments*

Non-Contractual vs Contractual (\$727,399 adjusted)							
Charges	Total Payments	Contractual Adj	Writeoffs	Non-Contractual	GCR	RRR	NCR
\$ 66,824,655.90	\$ 23,400,029.61	\$ 41,626,674.41	\$ (83,398.70)	\$ 286,919.60	34.89%	97.18%	92.53%

AAAI Data	Charges	Collections	Contractual	Credits
09/01/2022 - 08/31/2023	\$ 66,824,655.90	\$ 23,400,029.61	\$ 41,626,674.41	\$ (83,398.70)
		Benchmark		
Gross Collection Rate	<input type="text" value="34.89%"/>	45.30%		
Revenue Realization Rate	<input type="text" value="97.18%"/>	99.00%		
Net Collection Ratio	<input type="text" value="92.53%"/>	98.00%		
From Current NCR to benchmark		Improvement		
Collections at 98%	\$24,694,022	\$ 1,377,390.95		
Collections at 98.5%	\$24,820,012	\$ 1,503,380.86		

Every RCA is Unique



- Tailor Your Revenue Cycle Assessment



The screenshot displays a Microsoft PowerPoint interface with a ribbon menu at the top (File, Home, Insert, Draw, Design, Transitions, Animations, Slide Show, Record, Review, View, Help) and a grid of 30 numbered slides. The slides contain various data visualizations and reports, including:

- Slide 7: Back Office Processes - Don't let these tasks slip
- Slide 8: Your data - Intergy Practice Analytics
- Slide 9: Transactional Trending
- Slide 10: Transactional Trending
- Slide 11: Transactional Trending Summary
- Slide 12: Your data - Accounts Receivable Aging
- Slide 13: Accounts Receivable Aging
- Slide 14: Aging by Responsibility
- Slide 15: Aging by Payer
- Slide 16: Aging by Payer
- Slide 17: Accounts Receivable - AR > 120
- Slide 18: Accounts Receivable - Days in AR
- Slide 19: Accounts Receivable - Over Paid and UCI
- Slide 20: Accounts Receivable Summary
- Slide 21: Denials
- Slide 22: Your data - Denials
- Slide 23: Denials by Reason Description
- Slide 24: Denials by Reason Description
- Slide 25: Denials by Functional Area
- Slide 26: Denials by Reason Category
- Slide 27: Denials by Reason Category
- Slide 28: Denials by Reason Category
- Slide 29: Top CPT Codes and Top Payer
- Slide 30: By CPT code with Reason
- Slide 31: By Payer with Reason
- Slide 32: Denials Summary
- Slide 33: Your data - Reimbursement Data
- Slide 34: Reimbursement Report
- Slide 35: Collection Percentages (by Payer)
- Slide 36: Reimbursement Percentages

Revenue Cycle Analysis (RCA)



Complimentary Assessment

Scan the below QR code for a **FREE** Revenue Cycle Assessment, exclusive for CAP Physician Members!



<https://bit.ly/4cYM1F2>



Thank You

For More Information Contact: james.m@unislink.com

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