

Top 10 RCM KPIs Every Small Practice Should Track—And How to Fix Them

Introduction: Why RCM KPIs Are Your Practice's Lifeline

KPIs are quantifiable metrics of a healthcare organization that provide insights into various aspects of the revenue cycle. Analyzing the metrics can help practices identify areas for improvement and optimize revenue generation. For a small healthcare practice, it is essential to track the right Performance Indicators (KPIs) to identify the issues that hinder the practice's financial growth and implement targeted improvements.

This whitepaper will guide you through the top 10 RCM KPIs and help small practices identify what should be tracked to boost their overall financial performance. We are going to help you with some important, actionable, and practical strategies that can fix several issues and also optimise each metric. This whitepaper will help you maintain a steady cash flow, reduce administrative burden, and secure a prosperous future.

1. Days in Accounts Receivable (A/R)

What it is: This KPI tells us about the average number of days the practice gets the payments after the service is rendered. This KPI is considered a critical indicator of a practice's cash flow and efficiency.

Why it Matters: High A/R number days show that the practice's money is stuck, which can impact the operating budget and also its ability to invest in your business. Below 50 days are considered a healthy target for days in AR. More than that can cause cash flow problems.

How to Fix/Improve It:

- **Identify bottlenecks:** It is important to identify and categorize the A/R by specific payer, for eg, Medicare, commercial, and patient, to check where the biggest delays are and work accordingly.
- **Prioritize follow-up:** Practices should prioritize and focus on older and high-value claims first. There should be a dedicated RCM partner who can submit claims daily and automate the follow-ups and reminders to streamline this process.
- **Improve claim submission:** To decrease the AR day, it is important to submit clean claims the first time. Regular audits should be conducted to identify and correct common errors made in claim submission.
- **Accelerate patient collections:** To collect co-pays and deductibles upfront, practices should implement clear financial policies for patients and offer multiple payment options, including online portals and mobile payments, to motivate faster payments.

2. Clean Claims Rate

What it is: This metric shows the percentage of claims submitted to a payer that get paid without being denied or rejected in the very first attempt.

Why it Matters: This metric has a direct impact on another important metric, as a low clean claims rate directly impacts your Days in A/R. Every rejected or denied claim causes payment delays and increased administrative costs, and also requires manual rework.

How to Fix/Improve It:

- **Create SOPs for claim submissions:** To achieve a clean claim rate, you can use a checklist to verify all patient information, such as demographics, insurance details, and proper coding, before sending a claim to the insurance company.
- **Invest in robust software:** Technology is the key in this fast-paced era. Use billing software with built-in scrubbing tools that automatically flag common errors.
- **Stay up-to-date with coding guidelines:** To avoid mistakes, it is highly important to train your staff on the latest CPT and ICD-10 coding guidelines regularly.
- **Analyze rejection patterns:** To get rid of denials in the long term, you have to track the reasons for claim rejections and denials to identify recurring issues and address them at the source.



3. Denial Rate

What it is: Denial rate is the metric that shows the percentage of claims that are denied payment by an insurance company. This also measures your practice's billing and coding accuracy.

Why it Matters: It is highly important as it not only slows down payments but can also result in lost revenue if claims are not appealed or corrected promptly.

How to Fix/Improve It:

- **Categorize denials:** To lower the denial rate, you should track and analyze denial codes to understand the root causes. Are they due to incorrect patient information, lack of pre-authorization, or coding issues?
- **Create a denial management workflow:** You can also develop a clear, efficient process for appealing or correcting denied claims as soon as they are received.
- **Focus on pre-service processes:** To prevent denials due to coverage-related issues, you should verify patient eligibility and pre-authorization requirements before the appointment.



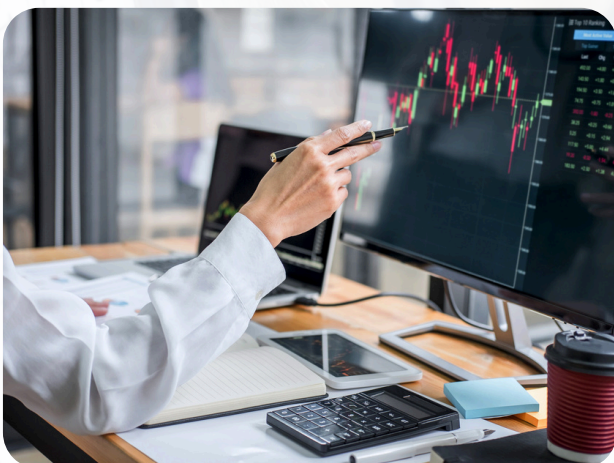
4. Net Collection Rate

What it is: This KPI tells us about the percentage of eligible or expected revenue that a practice collects. To calculate this, divide the total payments collected by the total amount of charges, minus contractual adjustments.

Why it Matters: This gives you a realistic view of your practice's financial performance. It gives you an idea of how much of your "billable" work is turning into cash. A strong net collection rate is 95% or higher.

How to Fix/Improve It:

- **Review payer contracts:** To achieve a decent net collection rate, you should understand your fee schedules and contractual write-offs to make sure you are accurately adjusting for them.
- **Strengthen your collections team:** You should equip your staff with the tools and training to effectively follow up on claims and patient balances to achieve better collections.
- **Address denied and underpaid claims:** To make sure that you get the full amount you are owed, you should have a system in place to identify and appeal underpayments from payers.



5. Patient Collections as a Percentage of Revenue

What it is: This KPI measures the portion of your practice's total revenue that comes directly from patient payments, including co-pays, deductibles, and co-insurance.

Why it Matters: This KPI becomes more important as the patient's responsibility for healthcare costs increases. A low percentage may indicate issues with your front-desk collections or patient billing processes.

How to Fix/Improve It:

- **Train front-desk staff:** To achieve higher patient collections, you should empower your staff to accurately collect co-pays and outstanding balances at the time of service from patients.
- **Communicate clearly:** To gain patients' trust and get your correct amount from them, you should be transparent about their financial responsibility and provide accurate estimates for services.
- **Offer payment plans:** Provide flexible multiple payment options for larger balances to make it easier for patients to pay.



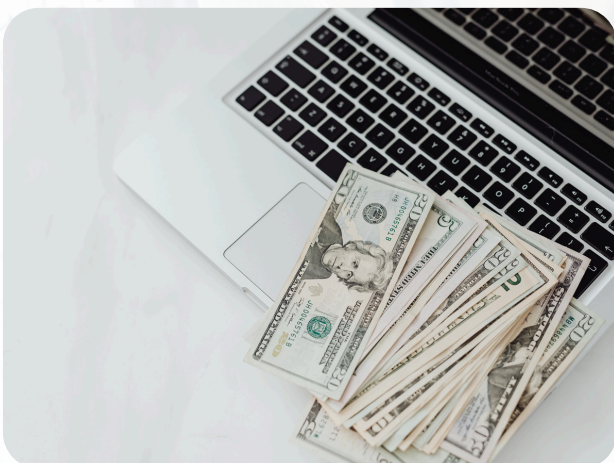
6. First Pass Ratio

What it is: In comparison to the Clean Claims Rate, this is a more precise measure of your billing efficiency. It calculates the percentage of claims that are paid correctly on the first submission, without any manual intervention or rework.

Why it Matters: It is a very important metric as a high first pass ratio (over 90%) shows your RCM process is highly efficient and your staff is spending less time on tedious rework. This frees up the resources and accelerates the cash flow in your practice.

How to Fix/Improve It:

- **Integrate systems:** To achieve a high First Pass Ratio, make sure your EHR and billing systems are well-integrated to minimize data entry errors.
- **Automate wherever possible:** Leverage the latest technology to automate claim scrubbing, eligibility verification, and other manual steps.
- **Conduct regular staff training:** Providing continuous education to your staff on coding changes and payer requirements is essential for maintaining a high first-pass yield.



7. Average Time to Reimbursement

What it is: This is the important metric that tracks the average number of days it takes to receive payment for a claim, from the date of service to the date the payment is posted.

Why it Matters: This metric plays an important role as this is a holistic measure of your entire RCM cycle. A long average time to reimbursement can signal inefficiencies in any part of the process, from claim submission to payment posting.

How to Fix/Improve It:

- **Focus on the entire cycle:** Multiple factors can improve your Average time of reimbursement, like clean claims rate, denial rate, and Days in A/R, etc.
- **Streamline payment posting:** Use electronic remittance advice (ERA) and electronic funds transfer (EFT) to speed up payment and posting, which in turn helps in improving the average time to reimbursement.



8. Patient No-Show Rate

What it is: This KPI tells us about the percentage of scheduled patient appointments that are missed without prior cancellation or rescheduling. These rates can vary widely based on multiple factors like appointment type, specialty, and patient demographics.

Why it Matters: No-shows represent a significant loss of potential revenue and a waste of your staff's time. Practice overall efficiency is disturbed by a high no-show rate.

How to Fix/Improve It:

- **Implement appointment reminders:** To reduce the no-show events at a remarkable rate, you should use automated text, email, or phone call reminders.
- **Enforce a no-show policy:** To lower the no-show rate, you can also establish and communicate a clear policy regarding missed appointments, which may include a fee.
- **Analyze data:** Identification of patterns in your no-show data, such as specific days or times, can help you adjust your scheduling accordingly.



9. Denial Appeal Success Rate

What it is: This metric measures the percentage of denied insurance claims that are successfully overturned (i.e., paid) after an appeal is submitted.

Why it Matters: It is important as it recovers lost revenue that would otherwise be written off. It indicates the effectiveness of your denial management and billing team, and it reduces the need to send bills to patients unnecessarily, improving patient satisfaction

How to Fix/Improve It:

- **Build a Denial Reason Library:** To improve the denial appeal success rate, you should track denial codes and reasons by payer and develop customized response strategies for each of them.
- **Appeal Within Timely Filing Limits:** You should automate the alerts for appeal deadlines and also set internal escalation processes for urgent cases.
- **Use Specific, Evidence-Based Appeal Letters:** To improve the denial appeal success rate, you should use evidence-based appeal letters that include clinical justification, coding guidelines, and contract language.



10. Bad Debt Rate

What it is: This metric represents the percentage of total charges that a healthcare practice is unable to collect from patients or payers and ultimately writes off as uncollectible. It contributes to revenue loss.

Why it Matters: This metric is important as it directly affects the cash flow and profitability of the practice. It signals inefficiencies in patient billing, collections, or financial counseling.

How to Fix/Improve It:

- **Verify Patient Eligibility and Benefits Upfront:** To reduce bad debt rate, use real-time eligibility tools before the visit, estimate patient responsibility early, and communicate it.
- **Have Clear Financial Policies:** To lower the bad debt rate, you should share policies in writing and have patients sign them. Also set expectations about payment timelines and consequences for non-payment.



Conclusion: Take Control of Your Financial Health

By actively tracking and managing these 10 RCM KPIs, you can move from a reactive to a proactive approach to your practice's finances. You'll gain a clear understanding of where your revenue cycle is strong and where it needs attention.

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