Data Analysis…

You need to examine the obvious and not so obvious data.

BY JOHN V. GUILIANA, DPM, MS

There is nothing more important than data when it comes to understanding your financial and clinical dynamics. How data is used can either be obvious (commonly employed) or elusive (infrequently measured).

The Obvious Data

Production Report

It's obviously important to understand your daily, weekly, and monthly charges and collections by provider and by payer. Over-the-counter collections are also important.

New and Total Patient Visits

Many practices know how important it is to monitor their monthly new and total patient visits by providers. An adequate number of new patients are required to offset the normal attrition rate of the practice.

For the production report as well as the patient visit report, benchmarking both of those data sets against the same time frame of the prior year can help bring meaning to the report and help justify peaks and troughs based on normal annual variations.

Account Receivables (A/R) Management

Since your practice's crucial cash flow is dependent upon diligent AR management, it's obviously imperative to look at your total AR, their distribution according to aging from the date of service, and the status of aged claims. It's also important to be able to identify accounts receivable by payers, looking for any payer that might be problematic.

While the above data is frequently known by a practice manager or an administrator, there is often less obvious data that should be analyzed as well, to help create a full picture of the practice's dynamics.

An AR report is only meaningful when you also understand what is being written off.

The Not So Obvious Data

Adjustments or Write-offs.

An AR report is only meaningful when you also understand what is being written off. An AR report can be made to look either falsely good or falsely bad by indiscriminate write-offs, or failure to make timely adjustments respectively.

Gross and Net Collection Rate

An understanding of your adjustments will also allow you to compute an accurate net collection rate for the practice. While gross collection rate (collections/charges) x 100) can be used to monitor revenue cycle management efficacy from a high-level, it's the net collection rate (collections/charges + adjustments) x 100 that matters most since this metric removes variations caused by unrealistic fee schedules. A gross collection rate is dependent upon your fee schedule whereas the net collection rate is dependent upon your contracted rates. A practice with healthy revenue cycle management will have a net collection rate of at least 95%.

Days in Receivables

Being able to monitor and trend the average time it's taking for your

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claims to be paid (by payer) can serve as a great early indicator of revenue cycle management problems. To eliminate short-time variations, this report might be run only bi-annually (Accounts receivables/Collections) x Days. For example, if you choose to run this metric bi-annually, you will simply use your collections over the six month timeframe and multiply the quotient by 180 days. A healthy revenue cycle management often has days in receivables of less than 45-50 days.

New to Total Patient Ratio

This less obvious data will help you understand whether your practice is growing or in a state of stagnation (or decline). To offset the attrition of a healthy "mid-life" practice (not a new practice) will often require a new to total patient ratio of at least 10%.

Per Visit Revenue

Once far less obvious than it is today, a provider's per visit revenue (collections/total visits) is a measure of his or her level of comprehensiveness, the payer mix, and the efficacy of the practice's revenue cycle management. Since a high degree of variation might occur in short windows of time (vacations, holidays, etc.), this metric should be computed no more frequently than quarterly. It's important to look for upward and downward trends and rationalize them.

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Payroll Ratio

Proper staffing is essential to quality care as well as profitability. The simple formula (staff payroll and benefits/collections) x 100 helps you benchmark your staffing level against revenue. While typical payroll ratios have risen post-COVID, it's important to justify a payroll ratio greater than 30%. If you outsource your billing, be sure to add that percentage to your final number. And remember that operating too "lean" (i.e. a payroll ratio of 10%) might be just as ominous as being overstaffed. Low Payroll Ratios are frequent contributors to a loss of physician productivity as well as staff burnout.

CPT Utilization Ratios

Ratios frequently provide a great understanding of provider behaviors, yet they remain less utilized than other reports. These types of reports allow for a wide range of creativity, creating ratios that might be unique to your own practice niche. In a typical practice, individual provider ratios of great usefulness might include:

- Number of orthotics prescribed/number of patients with plantar fasciitis
- Number of injections administered/number of patients with plantar fasciitis
- Number of X-rays taken/total new patients
- Number of therapeutic shoes prescribed/number of patients with diabetes.
- Distribution ratios of E/M levels
- Distribution ratios of nail care coding (11721, 11720, 11719, G0127)

And this list can go on and on, depending upon what's most important to your unique practice.

Visit Break-Even Point

Likely the most under-utilized metric of all is an understanding of the practice's visit break-even point. This metric evaluates the per visit revenue generated by your most common CPT codes per payer and compares that to your practice's variable cost per encounter. This metric starts with running a report that shows your average reimbursement for each CPT code across your top 5 payers. You will then need to compute your variable cost per patient by turning your attention to your practice's profit and loss statement and adding up all of the variable costs over a 12 month period of time.

Variable costs are those costs that are directly dependent upon patient volume (staff wages, laboratory expenses, supplies, etc.).

Variable costs are those costs that are directly dependent upon patient volume (staff wages, laboratory expenses, supplies, etc.). Once you have that number, you simply divide it by the number of patient visits for the same 12 months. You now know your variable cost per patient, which for all practical purposes can be looked at as your break-even point.

Now simply compare each CPT code reimbursement (being sure to couple codes that are often billed together, such as an office visit and radiology) and compare those numbers to your break-even point. Look for either CPT codes or individual payers that provide minimal contribution margin.

Expanding your analysis of your practice data beyond that data which is obvious can assist you in making prudent decisions in your strategic planning. **PM**

Dr. Guiliana is a nationally recognized speaker and author on topics pertaining to medical practice management. He is a Fellow of the American Academy of Podiatric Practice Management and holds a Master's Degree in Healthcare Management. He has authored numerous columns in various journals and is the co-author of *31½ Essentials to Running Your Medical Practice,* as well as *The Million Dollar Practice…Keys to Success.* Dr. Guiliana is currently a Medical Director of Podiatry for Modernizing Medicine's award-winning technology. He can be reached at John.guiliana@modmed.com.