

TOP TEN: Key Performance Indicators (KPIs) and Benchmarks

A medical practice must be able to recognize certain factors involved in maintaining its cash flow to remain a viable, growing business.

To begin, we have identified 10 primary reasons claims are denied. These reasons can be utilized to establish benchmarks and Key Performance Indicators (KPI) for the practice.

A practice may experience more denials in one area than another. When this occurs, policies to strengthen this area of the business office will become a priority.

Auditing of the area may take precedent over some other duties in the office. Keeping this in mind, duties must be delegated appropriately so that focus is not lost on the business office as a whole.

Top Ten Denial Indicators

1. (Tie) Invalid insurance information & Invalid Patient Demographic information
2. Documentation needed/missing
3. Provider information incorrect/invalid
4. Invalid diagnosis code(s)
5. Invalid procedure code(s)
6. (Tie) Modifier(s) missing/incorrect & Service(s) not authorized
7. Referring MD information invalid/missing
8. Place of service invalid
9. Invalid date of service
10. Secondary insurance information incorrect.

**Note* If your practice does not experience any of these denial types, it is good to establish a tracking system to determine what types of denials your practice is experiencing. Please ensure that you establish categories to help you identify the most problem areas for current and future use.*

Effective Collections Protocol

The following situations can help you to establish benchmarks for your practice to ensure that all areas of the billing process are maximized.

KPI	Your Answers
1. Service Volume	
a. Based on the procedure codes, how many billable services are provided?	
b. What is the mix of services?	
c. Charge Entry Process?	
d. What is the lag time for charges entered with respect to the date of service?	
2. Has the staff been trained to:	
a. effectively enter the data?	
b. Familiar with insurances - order of primary, secondary insurance;	
c. Identify the responsible party for the claim – W/C, Automobile, Grants - to ensure that the bill is sent in a timely manner?	
d. Verified information for the carrier?	
3. Practice Fees	
a. How often is the fee schedule reviewed?	
4. Prepare an audit.	
a. Identify the top 10-30 codes via EOBs from a sample of payers.	
b. Do the allowances match the fees?	
5. Coding	
a. Have the codes and/or levels of codes that you bill been adjusted to allow lower or no reimbursement?	
6. Payer Makeup	
a. What is your payer mix - Medicare, Medicaid, managed care, W/C, self- pay - (based on charges) for your top 5-10 payers during the past 12 months?	
b. Has your payer mix shifted towards payers with lower allowance schedules?	
7. Adjustments	
a. How often are adjustments made on accounts?	
b. Who gives write-off approval?	
c. Is it in writing and what is the monetary limit?	
d. Have the contractual adjustments been validated?	

KPI	Your Answers
e. What is the amount of contractual adjustments over a consecutive 6-12 month period?	
f. What is the amount of non-contractual adjustments made during the past 12 months?	
g. Excessive Denials?	
8. What is the percent of claims that are denied during:	
a. The first submission?	
b. Follow-up	
9. Protocol?	
a. What is the follow-up policy regarding insurance once the claim is received ("appeal" process)?	
b. What is the follow-up policy regarding insurance follow-up after the claim is submitted but has not been paid?	
c. What is the policy regarding patient follow-up, to include statements, telephone calls, and payment plans?	
10. Front End Processes	
a. What percent of denials occur based on the registration process (demographics or insurance)?	
b. Is verification of insurance and benefits eligibility performed on a regular basis for all patients?	
c. What is the policy for collecting the patient's portion of the bill at the time of service (co-payment, co-insurance, balance)?	
d. Is the policy enforced and with what measures? If the policy is not being enforced, have you considered establishing protocol for this?	
e. Are past-due balances being collected at the time of service?	
11. Payment Posting Processes	
a. How often are payments posted once they received in the office?	
b. Is the appropriate staff entering the payments properly? Are the adjustments categorized correctly?	
c. How soon does the staff respond to denials or partial payments?	
d. How is this tracked?	