hfma™

Indicators of Revenue Cycle Excellence

2023 Edition

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Introduction and Data Sources

The MAP Keys® are strategic key performance indicators (KPIs) that set the standard for revenue cycle excellence in the health care industry. Developed by industry leaders led by HFMA, these industry-standard metrics define the essentials of revenue cycle performance in clear, consistent, and unbiased terms. These strategic keys now apply to hospitals and systems, ambulatory providers, physician organizations, post-acute care, health systems and integrated delivery systems. In other words, there is one set of keys equally applicable to all types of healthcare organizations. There are 29 MAP Keys (KPIs) for revenue cycle benchmarking divided into 5 major groups. These groups, Patient Access, Pre-Billing, Claims, Account Resolution and Financial Management, reflect the activities represented by the individual keys.

In the interest of transparency and promotion of the MAP Keys as the industry strategic benchmarking standard, HFMA provides detailed definitions with inclusions and exclusions as well as requisite data sources. These definitions are the basis for data reported by subscribers of the MAP App, HFMA's web-based benchmarking tool, as well as applicants of the MAP Award for High Performance in Revenue Cycle every year.

Data used to calculate the MAP Keys values is derived from a variety of finance and revenue cycle monthly reports. For each key, the most common source for the data has been included in the definitions document. In many cases, the source will be general ledger account(s), which is the preferred source as these numbers are easily audited and confirmed. Where A/R system or other system reports are used, archived copies of the source materials should be retained for audit and confirmation. Most importantly, unless the processing system changes, the same sources must be used each month.

Percentage of Patient Schedule Occupied

PURPOSE

Identifies opportunity to maximize utilization of scheduled availability.

VALUE

Measures available capacity.

EQUATION AND DATA SOURCE

$$\frac{\text{Number of patient slots occupied}}{\text{Number of patient slots available}} = \frac{\text{Scheduling System}}{\text{Scheduling System}}$$

POINTS OF CLARIFICATION

"Slots" Are Consistent In Size and Defined By The User

The slots reported should represent time attributed as available for professional and ancillary services provided to patients. Does not include slots blocked for non-patient activities.

Number of Patient Slots Occupied

INCLUDES

- Overbooked slots
- May exceed 100% (overbooking)
- Slots designated as cancellations and no-shows are included in the "occupied" count unless these designations have been removed and the slot is utilized for a scheduled service

EXCLUDES

- Slots blocked for non-patient activities

Number of Patient Slots Available

INCLUDES

- Actual number of available slots for use in reporting period
- Represent available time for patient services

EXCLUDES

- Slots blocked for non-patient activities

Pre-Registration Rate

PURPOSE

Trending indicator that patient access processes are timely and efficient.

VALUE

Indicates revenue cycle efficiency and effectiveness.

EQUATION AND DATA SOURCE

$$\frac{\text{Number of patient encounters pre-registered}}{\text{Number of scheduled patient encounters}} = \frac{\text{Patient Financial System}^{1}}{\text{Patient Financial System}}$$

POINTS OF CLARIFICATION

Number of Patient Encounters Pre-Registered

Total number of monthly encounters pre-registered prior to scheduled service. A successful pre-registration is defined as completion of at least all demographic and insurance data fields, and preferably completion of all patient demographic, insurance and financial data fields required for registration as defined by organizational policy. Encounters may be preregistered in-person, over the phone, or electronically.

INCLUDES

- Outpatient encounters; an outpatient account is defined as one encounter; e.g. a recurring account counts as one account and one encounter
- Inpatient admissions and observation cases (if scheduled in advance)
- Urgent care appointments, if scheduled (provider option)
- Canceled pre-registrations
- Accounts created from any departmental schedule that qualify for pre-registration per provider policy

EXCLUDES

- Unscheduled pre-admits, walk-ins, urgent care (if not scheduled) and Emergency encounters

Number of Scheduled Patient Encounters

Total number of monthly scheduled encounters. A "scheduled encounter" is defined as an encounter scheduled prior to service.

INCLUDES

- Outpatient encounters; an outpatient account is defined as one encounter; e.g. recurring account counts as one account and one encounter
- Inpatient encounters and observation cases (if scheduled in advance)
- Urgent care appointments, if scheduled (provider option)
- Canceled pre-registrations

EXCLUDES

- Unscheduled pre-admits, walk-ins, urgent care (if not scheduled) and Emergency encounters

1 Data can be drawn from scheduling systems integrated or a bolt-on to the PFS system

Insurance Verification Rate

PURPOSE

Trending indicator that patient access functions are timely and efficient.

VALUE

Indicates revenue cycle process efficiency and effectiveness.

EQUATION

$$\frac{\text{Number of verified encounters}}{\text{Number of registered encounters}} = \frac{\text{Patient Financial System}^1}{\text{Patient Financial System}}$$

POINTS OF CLARIFICATION

Number of Verified Encounters

Total of monthly scheduled encounters that have been verified prior to or at time of service AND unscheduled verified encounters prior to final billing. A successful verification is defined by the individual organization policy.

INCLUDES

- Outpatient encounters; an outpatient account is defined as one encounter; e.g. recurring account counts as one account and one encounter
- Inpatient encounters
- Unscheduled book of business, i.e. all walk-in patients, emergency department patients, urgent care patients

Number of Registered Encounters

Total number of registered encounters reported in same reporting month as numerator. No type of registered encounter is to be excluded from the total – ALL encounters should be included.

INCLUDES

- Outpatient encounters; an outpatient account is defined as one encounter; e.g. recurring account counts as one account and one encounter
- Inpatient encounters

1 Can be drawn from scheduling systems integrated or bolt-on to the PFS system

Service Authorization Rate — Inpatient and/or Observation

PURPOSE

Trending indicator that measures what is actually authorized versus the total population that requires authorization.

VALUE

Indicates revenue cycle process efficiency and effectiveness.

EQUATION

$$\frac{\text{Number of IP/OBS encounters authorized}}{\text{Number of IP/OBS encounters requiring authorization}} = \frac{\text{Patient Financial System}^1}{\text{Patient Financial System}}$$

POINTS OF CLARIFICATION

Number of IP/OBS Encounters Authorized

Total monthly number of inpatient (IP) and observation (OBS) encounters that have been authorized prior to claim release. "Authorization" is defined as medical necessity approval obtained from the third-party payer for services ordered. A retro-authorization should be counted if completed before claim is released to the payer.

Number of IP/OBS Encounters Requiring Authorization

Total monthly number of inpatient and observation encounters that require authorization prior to service. "Authorization" is defined as medical necessity approval obtained from the third-party payer for services ordered. The denominator data should be calculated as the numerator (number of authorized encounters) and the number of encounters that were denied due to a lack of authorization.

1 Data may be drawn from scheduling systems integrated or bolted-on to the PFS system

Service Authorization Rate — Outpatient Encounter

PURPOSE

Trending indicator that measures what is actually authorized versus the total population that requires authorization.

VALUE

Indicates revenue cycle process efficiency and effectiveness.

EQUATION

$$\frac{\text{Number of outpatient encounters authorized}}{\text{Number of outpatient encounters requiring authorization}} = \frac{\text{Patient Financial System}^{1}}{\text{Patient Financial System}}$$

POINTS OF CLARIFICATION

Number of Outpatient Encounters Authorized

Total monthly number of outpatient (OP) encounters that have been authorized prior to claim release. "Authorization" is defined as medical necessity approval obtained from the third-party payer for services ordered. A retro-authorization should be counted if completed before claim is released to the payer. For the purposes of these keys, authorization and referral approval are considered the same activity.

INCLUDES

- Series accounts, initial encounter or subsequent encounter where a new authorization is required

EXCLUDES

- Inpatient and observation encounters

Number of Outpatient Encounters Requiring Authorization

Total monthly number of outpatient encounters that require authorization prior to service. "Authorization" is defined as medical necessity approval obtained from the third-party payer for services ordered. Data should be calculated as the numerator (number of authorized encounters) plus the number of encounters that were denied due to a lack of authorization.

INCLUDES

- Series accounts, initial encounter or subsequent encounter where a new authorization is required

EXCLUDES

- Inpatient and observation encounters

1 Data may be drawn from scheduling systems integrated or bolted-on to the PFS system

Conversion Rate of Uninsured Patient to Third-Party Funding Source

PURPOSE

Trending indicator of qualifying uninsured patients for a third-party funding source.

VALUE

Indicates organization's ability to successfully secure funding for uninsured patients and improve patient satisfaction.

EQUATION

$$\frac{\text{Total uninsured patients converted to third-party funding source}}{\text{Total uninsured discharges and encounters}} = \frac{\text{Accounts Receivable}^{1}}{\text{Accounts Receivable}}$$

POINTS OF CLARIFICATION

Total Uninsured Patients (Discharges and Encounters) Converted to Third-Party Funding Source[2, 3]

Total patient discharges and encounters approved in the reporting month.

INCLUDES

- Inpatients converted at any time
- Outpatients converted after discharge, including ED, should be counted
- Conversions of newborns from self-pay to Medicaid because mother has Medicaid
- Medicaid conversions where provider has received notification from Medicaid agency that coverage is in effect for the specified date of service

EXCLUDES

- Conversions awaiting Medicaid applications (pending approval status)

Total Uninsured Discharges and Encounters

The total number of uninsured discharges and encounters in the reporting month.

1 Includes vendor reports for outsourced accounts
2 Conversion is counted once valid coverage is verified.
  – Must be a third-party funding source; conversions to Charity Care are not counted.
  – Third-party funding sources may include COBRA, Medicaid, worker's compensation, Third-Party liability (TPL), Supplemental Security Income (SSI), local government programs, etc.
  – Qualifying assumptions:
    a) Funding source was identified accurately at time-of-service.
    b) Funding source identified is new and not a registration error correction.
3 All conversions approved in the reporting month are included in the numerator regardless of discharge date.

Point-of-Service (POS) Cash Collections

PURPOSE

Trending indicator of point-of-service collection efforts.

VALUE

Accelerates cash collections and may reduce collection costs.

EQUATION

$$\frac{\text{Patient POS payments}}{\text{Total self-pay cash collected}} = \frac{\text{Accounts Receivable}^{1}}{\text{Accounts Receivable}}$$

POINTS OF CLARIFICATION

Patient Point-of-Service (POS) Payments

Point-of-service payments are defined as:

1. Patient cash (self-pay cash) for a **current encounter** which is collected prior to, at the time of service, and up to seven days after discharge; and
2. Patient cash (self-pay cash) for a prior encounter which is collected prior to or at the time of a new service.
   Note: Payments on prior balances do not count as POS if received any time after the time of a new service; thus, the seven-day window does not apply to prior balances.

INCLUDES

- All posted POS payments, including undistributed payments (debit transactions only)
- Cash collected on prior encounters, including cash collected on bad debt accounts, at the current pre-service or time-of-service visit
- Pre-admit dollars captured in the month payment is posted rather than received
- Combined hospital/physician payments, if included in denominator[2]

EXCLUDES

- Refunds; cash refunded to the patient should not be considered
- Routine payment plan payments unless collected at time of service

Total Self-Pay Cash Collected

Total cash collected for patient responsibility for the reporting month

INCLUDES

- All patient cash collected for the month reported from patient cash account (debit transaction only)
- All posted self-pay payments, including undistributed payments
- Bad debt recoveries
- Loan payments
- Combined hospital/physician payments, if included in the numerator[2]

1 Alternative data source is the general ledger transaction code applied to patient POS cash and the general ledger total for all patient (self-pay) cash collected during the month.

2 If reporting combined hospital and physician data, report all qualified POS collections; within MAP App, segregate hospital and physician payments into their respective hospital data and ambulatory data segments.
If reporting at the health system or integrated delivery system level, all self-pay cash collected across the system is included.

Days in Total Discharged Not Final Billed (DNFB)

PURPOSE

Trending indicator of claims generation process.

VALUE

Indicates RC performance and can identify performance issues impacting cash flow.

EQUATION

$$\frac{\text{Gross dollars in discharged not final billed (DNFB)}}{\text{Average daily gross patient service revenue}} = \frac{\text{Unbilled A/R}}{\text{Income Statement}}$$

POINTS OF CLARIFICATION

Gross Dollars in Discharged Not Final Billed (DNFB)

Gross dollars in A/R for all patient accounts (inpatient and outpatient accounts) discharged but not yet final billed for the reporting month. Refers to accounts in suspense (within bill hold days) and pending final billed status in the patient accounting system.

This is a snapshot at month-end.

INCLUDES

- Recurring accounts (i.e., interim bills) as long as they have been discharged but not final billed
- Accounts discharged and held during a system "suspense period"
- Ambulatory services charged but not final billed (held in system suspense)
- Charges that are considered "late" but are generated for accounts in DNFB status should be included

EXCLUDES

- In-house accounts
- Accounts in FBNS (Final Billed Not Submitted to Payer)
- Late charge bills
- Rebills

Average Daily Gross Patient Service Revenue

Monthly gross patient service revenue divided by number of days in the reporting month. This is a single month daily average, not a three-month rolling average.

Days in Final Billed Not Submitted To Payer (FBNS)

PURPOSE

Trending indicator of claims impacted by payer/regulatory edits within claims processing tool (claims scrubber tool).

VALUE

Track the impact of internal/external requirements to clean claim production which impacts positive cash flow.

EQUATION

$$\frac{\text{Gross dollars in FBNS}}{\text{Average daily gross patient service revenue}} = \frac{\text{Claims Processing Tool}}{\text{Income Statement}}$$

POINTS OF CLARIFICATION

Gross Dollars In Final Bill Not Submitted To Payer (FBNS)

Gross dollars from initial 837 claims held by edits in claims processing tool that have not been sent to payer. Snapshot should be taken no later than 11:59pm on the last day of the month.

INCLUDES

- Initial claims only[1]
- All 837 claims
- Claims rejected during submission process by payer (not denied)

EXCLUDES

- In-house accounts
- Accounts in DNFB (Discharged Not Final Billed); see DNFB Key for definition
- Rebills and late charge bills (based on bill type codes)

Average Daily Gross Patient Service Revenue

Monthly gross patient service revenue divided by number of days in the reporting month. This is a single month daily average, not a three-month rolling average.

1 Initial claims are defined as claims never released to the primary payer for adjudication and payment

Days in Total Discharged Not Submitted To Payer (DNSP)

PURPOSE

Trending indicator of claims generation and submission process.

VALUE

Indicates revenue cycle performance and can identify performance issues impacting cash flow.

EQUATION

$$\frac{\text{Gross dollars in DNFB + gross dollars in FBNS}}{\text{Average daily gross patient service revenue}} = \frac{\text{KPI PB1 + PB2}}{\text{Income Statement}}$$

POINTS OF CLARIFICATION

Gross Dollars In DNFB + Gross Dollars In FBNS

Automatically combines DNFB dollars from DNFB (PB-1) and FBNS dollars from FBNS (PB-2) to calculate the total dollars in claims discharged but not submitted to the payer

Average Daily Gross Patient Service Revenue

Monthly gross patient service revenue divided by number of days in the reporting month. This is a single month daily average, not a three-month rolling average.

Total Charge Lag Days

PURPOSE

Trending indicator of charge capture workflow efficiency.

VALUE

Impacts cash flow.

EQUATION

$$\frac{\sum \text{days from revenue recognition (posting date) less date of service date (by Charge/CPT code)}}{\sum \text{Count of Charge/CPT codes billed}} = \frac{\text{Patient Financial System}}{\text{Patient Financial System}}$$

POINTS OF CLARIFICATION

Sum of Days From Revenue Recognition Date Less Date of Service

The number of days between the date of service and the date of revenue recognition (posting) for each charge code on the claim. This is also known as the elapsed days between revenue posting date and service date. This is not a total of the charges but rather a count of days.

Sum of the Count: Charge Codes/CPT Billed

This is a count of the number of charge codes billed, not a summation of dollars billed.

Clean Claim Rate

PURPOSE

Trending indicator of claims data as it impacts revenue cycle performance.

VALUE

Indicates quality of data collected and reported.

EQUATION

$$\frac{\text{Number of claims that pass edits requiring no manual intervention}}{\text{Number of claims accepted into claims processing tool for billing}} = \frac{\text{Claims Processing Tool}}{\text{Claims Processing Tool}}$$

POINTS OF CLARIFICATION

Number of Claims That Pass Edits Requiring No Manual Intervention

Aggregate daily total of claims in the claims processing tool requiring no manual intervention for reporting month the first time the claim is scrubbed.

INCLUDES

- Primary, secondary and tertiary claims – all applicable 837 claim types

EXCLUDES

- Claims "warned" because intervention is required
- Claims directly submitted to a third-party payer, thereby bypassing the claim edits
- Claims "warned" in processing tool for print and hardcopy submission

Number of Claims Accepted Into Claims Processing Tool For Billing Prior To Submission

Aggregate daily total of claims in the claims processing tool downloaded for reporting month.

INCLUDES

- Primary, secondary and tertiary claims
- Claims "warned" because intervention other than printing is required

EXCLUDES

- Claims not accepted into the claims processing tool, including direct submissions to third-party payers
- Claims "warned" in processing tool for print and hardcopy submission should be removed

Late Charges as a Percentage of Total Charges

PURPOSE

Measure of revenue capture efficiency.

VALUE

Helps identify opportunities to improve revenue capture, reduce unnecessary cost, and accelerate cash flow.

EQUATION

$$\frac{\text{Gross charges with post date >3 days from service date}}{\text{Total gross charges}} = \frac{\text{Patient Financial System}}{\text{Patient Financial System}}$$

POINTS OF CLARIFICATION

Gross Charges With Post Date >3 Days From Service Date

Absolute value of debit and credit charges at transaction level of detail with a post date greater than 3 days from the service date.

1. Absolute value of late debits + absolute value of late credits = total late charges; total late charges are not "net" of late charge credits; in other words, credits are not subtracted from debits.
2. Posting window is service date + 3 days; in other words, if post date minus service date is greater than 3 days, then it is a late charge; late charges begin on the 4th day after service date."Service Date" is defined as the date a specific service is performed, not the account date or discharge date.
3. Charges posted within the month, includes charge corrections as well as changed modifiers.
4. Excludes charges reclassified based on a change in the assigned patient type and insurance type.
5. Excludes system-identified date changes resulting from a change in payer class.

Total Gross Charges

Total gross patient charges for the reporting month.

Aged A/R as a Percentage of Billed A/R

PURPOSE

Trending indicator of receivable aging and collectability.

VALUE

Indicates revenue cycle effectiveness at liquidating A/R.

EQUATION

$$\frac{\text{0-30, 31-60, 61-90, 91-120, > 120 days}}{\text{Total billed A/R}} = \frac{\text{Aged Trial Balance}}{\text{Aged Trial Balance}}$$

POINTS OF CLARIFICATION

Billed A/R By Aging Category (0-30, 31-60, 61-90, 91-120, > 120 days)

Total billed A/R[1] amount for all payers in each aging category, aged from discharge date (inpatient) or date of service (outpatient/ambulatory/physicians). Aging buckets are mutually exclusive categories and must sum to 100%.

INCLUDES

- Only active billed debit balance accounts; "active billed accounts" are only those accounts that are open
- Series accounts/recurring accounts
- Includes accounts outsourced to a third party but not classified as bad debt accounts, as, for example, early out accounts and payment plan accounts

EXCLUDES

- Active billed credit balance accounts; these should be removed from the data[2]
- Discharged Not Final Billed (DNFB) accounts; see DNFB Key for definition
- In-house accounts
- In-house interim-billed accounts
- Any account not yet billed to the payer or patient (not considered part of billed A/R)

Total Billed A/R

Total billed A/R[1] amount for all payers in reporting month, aged from discharge date (hospitals) or date of service (ambulatory/physicians).

INCLUDES

- Only active billed debit balance accounts; "active billed accounts" are only those accounts that are open
- Series accounts/recurring accounts
- Includes accounts outsourced to a third party but not classified as bad debt accounts, as, for example, early out accounts and payment plan accounts

EXCLUDES

- Active billed credit balance accounts; these should be removed from the data[2]
- Discharged Not Final Billed (DNFB) accounts; see DNFB Key for definition
- In-house accounts
- In-house, interim-billed accounts
- Any account not yet billed to the payer or patient (not considered part of billed A/R)

1 Billed A/R at the account level; does not include In-house or DNFB.
2 The exclusion applies to the total account balance, not to individual payer and patient components of the balance. Only if the total account balance is a credit should it be excluded.

Aged A/R as a Percentage of Billed A/R by Payer Group

PURPOSE

Trending indicator of receivable collectability by payer group.

VALUE

Indicates revenue cycle effectiveness at liquidating A/R by payer group.

EQUATION

$$\frac{\text{0-30, 31-60, 61-90, 91-120, >120 days by payer group}}{\text{Total billed A/R by payer group}} = \frac{\text{Aged Trial Balance}}{\text{Aged Trial Balance}}$$

POINTS OF CLARIFICATION

Billed A/R By Payer Group By Aging Category (0-30, 31-60, 61-90, 91-120, > 120 days)

Total billed A/R[1] amount by payer in each aging category, aged from discharge date (hospitals) or date of service (ambulatory/physicians/post acute). Aging buckets are mutually exclusive categories and must sum to 100%.

INCLUDES

- Only active billed debit balance accounts; "active billed accounts" are only those accounts that are open
- Series accounts/recurring accounts
- Includes accounts outsourced to a third party but not classified as bad debt accounts, as, for example, early out accounts and payment plan accounts

EXCLUDES

- Active billed credit balance accounts; these should be removed from the data[2]
- Discharged Not Final Billed (DNFB) accounts ; see DNFB Key for definition
- In-house accounts
- In-house interim-billed accounts not billed at month-end
- Any account not yet billed to the payer or patient (not considered part of billed A/R)

Total Billed A/R By Payer Group

Total billed A/R[1] amount by payer in reporting month, aged from discharge date (hospitals) or date of service (hospitals/ambulatory/physicians).

INCLUDES

- Only active billed debit balance accounts; "active billed accounts" are only those accounts that are open
- Series accounts/recurring accounts
- Includes accounts outsourced to a third party but not classified as bad debt accounts, as, for example, early out accounts and payment plan accounts

EXCLUDES

- Active billed credit balance accounts; these should be removed from the data[2]
- Discharged Not Final Billed (DNFB) accounts; see DNFB Key for definition
- In-house accounts
- In-house, interim-billed accounts not billed at month-end
- Any account not yet billed to the payer or patient (not considered part of billed A/R)

1 Billed A/R at the account level; does not include In-house or DNFB.
2 The exclusion applies to the total account balance, not to individual payer and patient components of the balance. Only if the total account balance is a credit should it be excluded.

Aged A/R as a Percentage of Total A/R

PURPOSE

Trending indicator of receivable aging and collectability.

VALUE

Indicates revenue cycle effectiveness at liquidating A/R.

EQUATION

$$\frac{\text{Unbilled, 0-30, 31-60, 61-90, 91-120, > 120 days}}{\text{Total A/R}} = \frac{\text{Aged Trial Balance}}{\text{Aged Trial Balance}}$$

POINTS OF CLARIFICATION

Unbilled and Billed A/R By Aging Category (Unbilled, 0-30, 31-60, 61-90, 91-120, > 120 days)

Total A/R[1] amount for all payers in each aging category, i.e., in-house and DNFB, and billed A/R by discharge date. Aging buckets are mutually exclusive categories and must sum to 100%.

Unbilled is defined as revenue in-house and discharged not final billed (DNFB).

INCLUDES

- Only active debit balance accounts; "active accounts" are only those accounts that are open
- Series accounts/recurring accounts
- Includes accounts outsourced to a third party but not classified as bad debt accounts, as, for example, early out accounts and payment plan accounts

EXCLUDES

- Active credit balance accounts; these should be removed from the data[2]

Total A/R

Total A/R amount for all payers in reporting month.

INCLUDES

- Only active debit balance accounts; "active accounts" are only those accounts that are open
- Series accounts/recurring accounts
- Includes accounts outsourced to a third party but not classified as bad debt accounts, as, for example, early out accounts and payment plan accounts

EXCLUDES

- Active credit balance accounts; these should be removed from the data

1 Includes in-house and DNFB, billed A/R in standard aging categories.
2 The exclusion applies to the total account balance, not to individual payer and patient components of the balance. Only if the total account balance is a credit should it be excluded.

Aged A/R as a Percentage of Total A/R by Payer Group

PURPOSE

Trending indicator of receivable collectability by payer group.

VALUE

Indicates revenue cycle effectiveness at liquidating A/R by payer group.

EQUATION

$$\frac{\text{Unbilled, 0-30, 31-60, 61-90, 91-120, > 120 days by payer group}}{\text{Total A/R payer group}} = \frac{\text{Aged Trial Balance}}{\text{Aged Trial Balance}}$$

POINTS OF CLARIFICATION

Unbilled and Billed A/R by Payer Group by Aging Category (Unbilled, 0-30, 31-60, 61-90, 91-120, >120 days)

Total A/R[1] amount for all payers in each aging category, i.e., in-house and DNFB, billed A/R by discharge date. Aging buckets are mutually exclusive categories and must sum to 100%.

Unbilled is defined as revenue in-house and discharged not final billed (DNFB).

INCLUDES

- Only active debit balance accounts; "active accounts" are only those accounts that are open
- Series accounts/recurring accounts
- Includes accounts outsourced to a third party but not classified as bad debt accounts, as, for example, early out accounts and payment plan accounts

EXCLUDES

- Active credit balance accounts; these should be removed from the data[2]

Total A/R by Payer Group

Total A/R amount by payer in reporting month, i.e., in-house and DNFB, billed A/R aged by discharge date.

INCLUDES

- Only active debit balance accounts; "active accounts" are only those accounts that are open
- Series accounts/recurring accounts
- Includes accounts outsourced to a third party but not classified as bad debt, as, for example, early out accounts and payment plan accounts

EXCLUDES

- Active credit balance accounts; these should be removed from the data

1 Includes in-house and DNFB, billed A/R in standard aging categories.
2 The exclusion applies to the total account balance, not to individual payer and patient components of the balance. Only if the total account balance is a credit should it be excluded.

Remittance Denial Rate

PURPOSE

Trending indicator of % of claims denied.

VALUE

Indicates provider's ability to comply with payer requirements and payers' ability to accurately pay the claim; efficiency and quality indicator.

EQUATION

$$\frac{\text{Total number of claims denied}}{\text{Total number of claims remitted}} = \frac{\text{Accounts Receivable}^{1}}{\text{835 Files and/or Paper Remittance}}$$

POINTS OF CLARIFICATION

Total Number of Claims Denied

Total claims adjudicated monthly at claim level. Denials are defined as "actionable denials" – those denials that may be addressed and corrected within the organization and may result in appropriate reimbursement.

INCLUDES

- Only payments containing a denial code on the remittance advice[2]
- Both initial claim denials and subsequent appeal denials
- Zero payment and partial payment accounts containing a denial indicator

EXCLUDES

- Denials for patient responsibility
- RAC recoupments
- Denials for duplicate claims
- Shadow/encounter claims

Total Number of Claims Remitted

Total claims remitted monthly. Remitted claims can be received electronically or through paper process. If 835 data is not accessible, use total insurance payment volumes at the account level. Any report that counts line item detail should not be used; this metric uses the claim as the correct unit to count.

1 Billed A/R = electronic 835/paper source as remit

2 An actionable denial is a denial of a claim for reimbursement that can be addressed by taking specific actions to correct the issue and resubmitting the claim for reconsideration.
A denial that can be corrected by the healthcare provider or the patient by providing additional information, correcting errors, or resolving any issues that caused the denial. Once the necessary actions have been taken, the corrected claim can be resubmitted for reconsideration and potential approval. Examples of actionable denials may include incomplete or inaccurate patient information, lack of documentation, coding errors, or missing supporting documentation.

Denial Write-Offs as a Percentage of Net Patient Service Revenue

PURPOSE

Trending indicator of final disposition of lost reimbursement where all efforts of appeal have been exhausted or provider chooses to write off expected payment amount.

VALUE

Indicates provider's ability to comply with payer requirement and payer's ability to accurately pay the claim.

EQUATION

$$\frac{\text{Net dollars written off as denials}}{\text{Average monthly net patient service revenue}} = \frac{\text{Patient Financial System}}{\text{Income Statement}}$$

POINTS OF CLARIFICATION

Net Dollars Written Off As Denials

Total dollars written off as a denial in the reporting month, net of recoveries

INCLUDES

- Denied RAC dollars resulting from lost appeals or choosing not to appeal
- Dollars must be stated at net
- Only payments containing a denial code on the remittance advice

EXCLUDES

- Denials for plan excluded (non-covered) services
- Denials for patient responsibility

Average Monthly Net Patient Service Revenue

Most recent three-month average[1] of total net patient service revenue. Net patient service revenue is defined as gross patient service revenue minus contractual allowances, minus charity care provision, then minus the provision for doubtful accounts. **Note: Gross patient service revenue does not appear on the audited income statement.**

INCLUDES

- Medicare Disproportionate Share Hospital (DSH) payments
- Medicare Indirect Medical Education (IME) paid on a MS-DRG basis

EXCLUDES

- Medicaid Disproportionate Share Hospital (DSH)
- 340B drug purchasing program revenue if NOT recognized as a patient receivable in the patient accounting system
- If reporting hospital data, any state or county subsidy, ambulance services, tax and match type assessments, retail pharmacy, post acute services and ambulatory, including physician practices/clinics, unless Medicare recognized provider-based status clinics
- If reporting ambulatory data, any state or county subsidy, tax and match type assessments, post acute care services and hospital services, and physician practices/clinics which are Medicare recognized provider-based clinics already included in the hospital data reported. If not reporting hospital data, or not including Medicare recognized provider-based clinics in hospital data reported, the exclusion of these clinics does not apply
- If reporting post acute care data, patient cash collected for ambulance, hospital and all ambulatory services
- **NOTE: For MAP App reporting, reporting at least two or more types of data (hospital, ambulatory or post acute care) at the parent level is required for health system level reporting.**
- Capitation and/or premium revenue related to value or risk based payer contracts

1 Most recent three months is defined as the month most recently ended plus the two months immediately before the most recently ended month.

Bad Debt

PURPOSE

Trending indicator of the effectiveness of collection efforts and financial counseling.

VALUE

Indicates organization's ability to collect accounts and identify payer sources for those who cannot meet financial obligations.

EQUATION

$$\frac{\text{Bad debt}}{\text{Gross patient service revenue}} = \frac{\text{Income Statement}^{1}}{\text{Income Statement}}$$

POINTS OF CLARIFICATION

Bad Debt

Total bad debt deduction as shown on the income statement for the reporting month. This is not the amount written off from A/R. Also called "Provision for Uncollectible Accounts", or "Provision for Bad Debt."

Gross Patient Service Revenue

Total gross patient service revenue for the reporting month

1 Alternative source is the general ledger transaction(s) as recorded in the allowance/ provision for doubtful accounts G/L account(s)

Charity Care

PURPOSE

Trending indicator of the administration of the provider's financial assistance policy.

VALUE

Indicates services provided under the provider's financial assistance policy.

EQUATION

$$\frac{\text{Charity care}^1}{\text{Gross patient service revenue}} = \frac{\text{Income Statement}}{\text{Income Statement}}$$

POINTS OF CLARIFICATION

Charity Care

Total charity care[1] as shown on income statement for the reporting month, not the amount written off from A/R.

Gross Patient Service Revenue

Total gross patient service revenue for the reporting month.

1 May be shown only as a footnote to the financial reports; does not include community benefit amounts.

Net Days in Credit Balance

PURPOSE

Trending indicator to accurately report account values, ensure compliance with regulatory requirements, and monitor overall payment system effectiveness.

VALUE

Indicates process failure in timely cash posting, incorrect posting or incorrect payment.

EQUATION

$$\frac{\text{Dollars in credit balance}}{\text{Average daily net patient service revenue}} = \frac{\text{Aged Trial Balance}}{\text{Income Statement}}$$

POINTS OF CLARIFICATION

Dollars In Credit Balance

Any patient account with a credit balance at the account level, reported as the absolute value of the credit balance.

EXCLUDES

- Pre-service deposits
- In-house (not discharged) accounts
- Undistributed cash clearing accounts

Average Daily Net Patient Service Revenue

Most recent three-month daily average[1] of total net patient service revenue. Net patient service revenue is defined as gross patient service revenue minus contractual allowances, minus charity care provision, then minus the provision for doubtful accounts. **Note: Gross patient service revenue does not appear on the audited income statement.**

INCLUDES

- Medicare Disproportionate Share Hospital (DSH)
- Medicare Indirect Medical Education (IME) paid on a MS-DRG basis

EXCLUDES

- Medicaid Disproportionate Share Program (DSH)
- 340B drug purchasing program revenue if NOT recognized as a patient receivable in the patient accounting system
- If reporting hospital data, any state or county subsidy, ambulance services, tax and match type assessments, retail pharmacy, post acute services and ambulatory, including physician practices/clinics, unless Medicare recognized provider-based status clinics
- If reporting ambulatory data, any state or county subsidy, tax and match type assessments, post acute care services and hospital services, and physician practices/clinics which are Medicare recognized provider-based clinics already included in the hospital data reported. If not reporting hospital data, or not including Medicare recognized provider-based clinics in hospital data reported, the exclusion of these clinics does not apply
- If reporting post acute care data, patient cash collected for ambulance, hospital and all ambulatory services
- **NOTE: For MAP App reporting, reporting at least two or more types of data (hospital, ambulatory or post acute care) at the parent level is required for health system level reporting.**
- Capitation and/or premium revenue related to value or risk based payer contracts

See MAP Key FM-1 for additional definition and footnote information.

1 Most recent three months is defined as the number of days in the three months including the last month being reported. For example, data submitted for the three months ending June 30 includes April (30 days), May (31 days) and June (30 days) for a total of 91 days used to calculate the average daily net patient service revenue.

Net Days in Accounts Receivable (A/R)

PURPOSE

Trending indicator of overall A/R performance.

VALUE

Indicates revenue cycle (RC) efficiency.

EQUATION

$$\frac{\text{Net A/R}}{\text{Average daily net patient service revenue}} = \frac{\text{Balance Sheet}}{\text{Income Statement}}$$

POINTS OF CLARIFICATION

Net A/R

Net A/R is the net patient receivable on the balance sheet. It is net of credit balances, allowances for uncollectible accounts, discounts for charity care, and contractual allowances for third-party payers.

INCLUDES

- A/R outsourced to third-party company but not classified as bad debt
- Medicare Disproportionate Share Hospital (DSH) payments
- Medicare Indirect Medical Education (IME) paid on a MS-DRG account basis
- A/R related to patient specific third-party settlements; a "patient specific settlement" is a payment applied to an individual patient account
- CAH payments and settlements

EXCLUDES

- A/R related to non-patient specific third-party settlements; a "non-patient specific settlement" is payment that is not applied directly to a patient account; it may appear as a separate, lump sum payment unrelated to a specific account. Examples include Medicaid Disproportionate Share Hospital (DSH), CRNA, and Direct Graduate Medical Education (DGME) payments as well as cost report settlements.
- Non-patient A/R
- 340B drug purchasing program revenue if NOT recognized as a patient receivable in the patient accounting system
- If reporting hospital data, any state or county subsidy, ambulance services, tax and match type assessments, retail pharmacy, post acute services and ambulatory, including physician practices/clinics, unless Medicare recognized provider-based status clinics
- If reporting ambulatory data, any state or county subsidy, tax and match type assessments, post acute care services and hospital services, and physician practices/clinics which are Medicare recognized provider-based clinics already included in the hospital data reported. If not reporting hospital data, or not including Medicare recognized provider-based clinics in hospital data reported, the exclusion of these clinics does not apply
- If reporting post acute care data, patient cash collected for ambulance, hospital and all ambulatory services
- **NOTE: For MAP App reporting, reporting at least two or more types of data (hospital, ambulatory or post acute care) at the parent level is required for health system level reporting.**
- Capitation and/or premium revenue related to value- or risk-based payer contracts

Average Daily Net Patient Service Revenue

Most recent three-month daily average of total net patient service revenue. Net patient service revenue is defined as gross patient service revenue minus contractual allowances, minus charity care provision, then minus the provision for doubtful accounts. **Note: Gross patient service revenue does not appear on the audited income statement.**

Most recent three months daily average is defined as the number of days in the three months including the last month being reported. For example, data submitted for the three months ending June 30 includes April (30 days), May (31 days) and June (30 days) for a total of 91 days used to calculate the average daily net patient service revenue.

INCLUDES

- Medicare Disproportionate Share Hospital (DSH) payments
- Medicare Indirect Medical Education (IME) Paid on a MS-DRG basis

EXCLUDES

- Medicaid Disproportionate Share Hospital (DSH)
- 340B drug purchasing program revenue if NOT recognized as a patient receivable in the patient accounting system
- If reporting hospital data, any state or county subsidy, ambulance

Net Days in Accounts Receivable (A/R) (continued)

services, tax and match type assessments, retail pharmacy, post acute services and ambulatory, including physician practices/clinics, unless Medicare recognized provider-based status clinics

- If reporting ambulatory data, any state or county subsidy, tax and match type assessments, post acute care services and hospital services, and physician practices/clinics which are Medicare recognized provider-based clinics already included in the hospital data reported. If not reporting hospital data, or not including Medicare recognized provider-based clinics in hospital data reported, the exclusion of these clinics does not apply
- If reporting post acute care data, patient cash collected for ambulance, hospital and all ambulatory services
- **NOTE: For MAP App reporting, reporting at least two or more types of data (hospital, ambulatory or post acute care) at the parent level is required for health system level reporting.**
- Capitation and/or premium revenue related to value- or risk-based payer contracts

Illustration of Revenue Recognition under ASC 606:

For illustration, assume a patient with commercial insurance is discharged from a hospital with incurred charges of $24,000. The hospital records an explicit price concession (as defined by the agreement with the insurance company) of $13,000, collects $10,000 from the insurance company and finally sends a $1,000 bill to the patient. The hospital historically has collected 30% of the amount billed to patients in this portfolio, and thus records an estimated $700 implicit price concession when revenue is recorded. If the actual amount collected from this patient varies from the estimated amount to be received of $300, that difference would typically be recorded as an adjustment to the implicit price concession. Hospital financial records will reflect the following:

Charges for service	$24,000
Explicit price concession	(13,000)
Billed to and paid by insurance	(10,000)
Billed to patient	1,000
Implicit price concession	(700)
Estimated amount to be collected from patient	$300

This activity would be re flected in the financial statements of the hospital as follows:

Prior to Topic 606

Net patient service revenue	$11,000
Less provision for doubtful accounts	700
Net patient service revenue, less provision for doubtful accounts	$10,300

Under Topic 606

Net patient service revenue	$10,300

Cash Collection as a Percentage of Net Patient Service Revenue

PURPOSE

Trending indicator of revenue cycle ability to convert net patient services revenue to cash.

VALUE

Indicates fiscal integrity/financial health of the organization.

EQUATION

$$\frac{\text{Total patient service cash collected}}{\text{Average monthly net patient service revenue}} = \frac{\text{General Ledger}}{\text{Income Statement}}$$

POINTS OF CLARIFICATION

Total Patient Service Cash Collected

Total patient service cash collected for the reporting month, net of refunds.

INCLUDES

- All patient service payments posted to patient accounts, including undistributed payments
- Bad debt recoveries
- Medicare Disproportionate Share Hospital (DSH) payments
- Medicare Indirect Medical Education (IME) payments

EXCLUDES

- Remittances received but the cash has not been deposited in the bank
- Non-patient-related settlements/payments; examples: capitation, Safety Net, Direct Graduate Medical Education (DGME), Medicare Pass through, Medicaid DSH
- Non-patient cash; examples: retail pharmacy, gift store, cafeteria
- If reporting hospital data, any state or county subsidy, ambulance services, tax and match type assessments, retail pharmacy, post acute services and ambulatory, including physician practices/clinics, unless Medicare recognized provider-based status clinics
- If reporting ambulatory data, any state or county subsidy, tax and match type assessments, post acute care services and hospital services, and physician practices/clinics which are Medicare recognized provider-based clinics already included in the hospital data reported. If not reporting hospital data, or not including Medicare recognized provider-based clinics in hospital data reported, the exclusion of these clinics does not apply
- If reporting post acute care data, patient cash collected for ambulance, hospital and all ambulatory services
- **NOTE: For MAP App reporting, reporting at least two or more types of data (hospital, ambulatory or post acute care) at the parent level is required for health system level reporting.**

Average Monthly Net Patient Service Revenue

Most recent three-month average of total net patient service revenue.[1] Net patient service revenue is defined as gross patient service revenue minus contractual allowances, minus charity care provision, then minus the provision for doubtful accounts. **Note: Gross patient service revenue does not appear on the audited income statement.**

INCLUDES

- Medicare Disproportionate Share Hospital (DSH) payments
- Medicare Indirect Medical Education (IME) paid on a MS-DRG basis

EXCLUDES

- Medicaid Disproportionate Share Hospital (DSH)
- 340B drug purchasing program revenue if NOT recognized as a patient receivable in the patient accounting system
- If reporting hospital data, any state or county subsidy, ambulance services, tax and match type assessments, retail pharmacy, post acute services and ambulatory, including physician practices/clinics, unless Medicare recognized provider-based status clinics
- If reporting ambulatory data, any state or county subsidy, tax and match type assessments, post acute care services and hospital services, and physician practices/clinics which are Medicare recognized provider-based clinics already included in the hospital data reported. If not reporting hospital data, or not including Medicare recognized provider-based clinics in hospital data reported, the exclusion of these clinics does not apply
- If reporting post acute care data, patient cash collected for

1 Most recent three months is defined as the month most recently ended plus the two months immediately before the most recently ended month.

Cash Collection as a Percentage of Net Patient Service Revenue (continued)

ambulance, hospital and all ambulatory services

- **NOTE: For MAP App reporting, reporting at least two or more types of data (hospital, ambulatory or post acute care) at the parent level is required for health system level reporting.**
- Capitation and/or premium revenue related to value or risk based payer contracts

Uninsured Discounts

PURPOSE

Trending indicator of amounts not expected to be paid by uninsured patients.

VALUE

Indicates the portion of the self-pay gross revenue not included in cash, charity, or bad debt metrics.

EQUATION

$$\frac{\text{Uninsured discounts (prior to charity care and bad debt)}}{\text{Gross patient service revenue}} = \frac{\text{Accounts Receivable}}{\text{Income Statement}}$$

POINTS OF CLARIFICATION

Uninsured Discounts

Total patient revenue reported at month-end as "Uninsured Discounts" prior to transfer to bad debt, as shown on income statement for the reporting month. If patient later qualifies for Charity Care, this discount is reversed and the Charity Care discount is applied, which should reflect a reduction in this amount in the month reversed.

INCLUDES

- Any account registered without insurance, except where exclusions apply

EXCLUDES

- Charity Care
- Bad Debt
- Discounts to self-pay balance after insurance payment
- Prompt-pay discounts

Gross Patient Service Revenue

Total gross patient service revenue for the reporting month.

Uncompensated Care

PURPOSE

Trending indicator of total amounts not collected from patients related to self-pay discounts, charity care, and bad debt combined.

VALUE

Indicates the portion of the self-pay gross revenue not included in cash, charity, or bad debt metrics.

EQUATION

$$\frac{\text{Uncompensated care}}{\text{Gross patient service revenue}} = \frac{\text{KPI AR7 + AR8 + FM3}}{\text{Income Statement}}$$

POINTS OF CLARIFICATION

Uncompensated Care

Sum of uninsured discounts, charity care and bad debt for the reporting month.

Gross Patient Service Revenue

Total gross patient service revenue for the reporting month.

Case Mix Index

PURPOSE

Trending indicator of patient acuity, clinical documentation and coding.

VALUE

Supports appropriate reimbursement for services performed and accurate clinical reporting.

EQUATION

$$\frac{\text{Sum of relative weights for inpatients}}{\text{Number of discharged inpatients in the month}} = \frac{\text{Encoder-Decision Support}}{\text{Encoder-Decision Support}}$$

POINTS OF CLARIFICATION

Sum of Relative Weights for Inpatients

Sum of Medicare MS-DRG weights universally applied to all discharged inpatients for the reporting month[1]. Only applicable to hospitals and hospital systems, including hospitals and hospital systems within an integrated delivery system.

EXCLUDES

- Normal newborns; for hospitals with a NICU, normal newborns will have a revenue code of UB 0170 or UB 0171 – only these should be excluded.
- Medicare exempt units; a "Medicare exempt unit" is a unit that does not qualify for Medicare reimbursement, under IPPS, for example, Medicare IPPS exempt psychiatric specialty units. **Note: this exclusion does NOT apply to Integrated Delivery Systems unless no MS-DRG assignment is processed.**

Number of Discharged Inpatients In The Month

Discharged inpatient count for the reporting month, excluding normal newborns. Only applicable to hospitals and hospital systems, including hospitals and hospital systems within an integrated delivery system.

EXCLUDES

- Normal newborns; for hospitals with a NICU, normal newborns will have a revenue code of UB 0170 or UB 0171 – only these should be excluded.
- Medicare exempt units; a "Medicare exempt unit" is a unit that does not qualify for Medicare reimbursement, under IPPS, for example, Medicare IPPS exempt psychiatric specialty units. **Note: this exclusion does NOT apply to Integrated Delivery Systems unless no MS-DRG assignment is processed.**

1 Data for the reporting month may be updated until all included cases have been coded and assigned to a MS-DRG.

Cost to Collect

PURPOSE

Trending indicator of operational performance.

VALUE

Indicates the efficiency and productivity of revenue cycle process.

EQUATION

$$\frac{\text{Total revenue cycle cost}}{\text{Total patient service cash collected}} = \frac{\text{Income Statement}}{\text{Balance Sheet}}$$

POINTS OF CLARIFICATION

Revenue Cycle Cost

The following Revenue Cycle Costs should be reported with their respective functional area's costs as applicable: salaries and fringe benefits, subscription fees, outsourced arrangements, purchased services, software maintenance fees, bolt-on application costs and their associated support staff, IT operational expenses related to the revenue cycle, record storage, contingency fees, and transaction fees.

INCLUDES

- **Patient Access Expense:** eligibility and insurance verification, cashiers, centralized scheduling, pre-registration, admissions/registration, authorization/pre-certification, financial clearance, Medicaid eligibility, and financial counseling
- **Patient Accounting Expense:** billing, collections, denials, customer service, subscription fees, collection agency fees, Charge Description Master/revenue integrity, cash application, payment variances, and all related expenses associated with these functions
- **HIM Expense:** transcription, coding, Clinical Documentation Improvement (CDI), chart completion, imaging, and all related expenses associated with these functions regardless of reporting structure

EXCLUDES

- IT "hard" costs: capitalized costs such as hardware, licensing fees, core HIS and PAS, servers, and any FTE that supports these
- Lease/rent expenses
- Physical space costs: utilities, maintenance, depreciation
- Scheduling if performed in the service departments by service department personnel

Total Patient Service Cash Collected

Total patient service cash collected for the reporting month, net of refunds.

INCLUDES

- All patient service payments (insurance and patient pay) posted to patient accounts, including undistributed payments
- Bad debt recoveries
- Medicare Disproportionate Share Hospital (DSH) payments
- Medicare Indirect Medical Education (IME) payments

EXCLUDES

- Patient-related settlements/payments; examples: capitation, Safety Net, Direct Graduate Medical Education (DGME), Medicare Pass Through, Medicaid DSH
- Non-patient cash; examples: retail pharmacy, gift store, cafeteria
- If reporting hospital data, patient cash collected for ambulance, post acute care services, and ambulatory, including physician practices/clinics, unless Medicare recognized provider-based status clinics
- If reporting ambulatory data, patient cash collected for post acute care services, hospitals, and physician practices/clinics which are Medicare recognized provider-based clinics already included in the hospital data reported. If not reporting hospital data, or not including Medicare recognized provider-based clinics in hospital data reported, the exclusion of these clinics does not apply.
- If reporting post acute care data, patient cash collected for ambulance, hospital and all ambulatory services

Cost to Collect by Functional Area

PURPOSE

Trending indicator of operational performance by functional area as reported in KPI FM-6.

VALUE

Indicates the efficiency and productivity of revenue cycle process by functional area.

EQUATION

$$\frac{\text{Total x (x = each functional area) cost}}{\text{Total patient service cash collected}} = \frac{\text{Income Statement}}{\text{Balance Sheet}}$$

POINTS OF CLARIFICATION

Total x (x = each functional area) Cost

Breakdown of revenue cycle cost based on functional area. Functional areas include patient access, patient accounting, and HIM. The following Revenue Cycle Costs should be reported with their respective functional area's costs as applicable: salaries and fringe benefits, subscription fees, outsourced arrangements, purchased services, software maintenance fees, bolt-on application costs and their associated support staff, IT operational expenses related to the revenue cycle, record storage, contingency fees, and transaction fees.

INCLUDES

- Patient Access Expense: eligibility and insurance verification, cashiers, central scheduling, pre-registration, admissions/registration, authorization/pre-certification, financial clearance, Medicaid eligibility, and financial counseling
- Patient Accounting Expense: billing, collections, denials, customer service, subscription fees, collection agency fees, Charge Description Master/revenue integrity, cash application, payment variances, and all related expenses associated with these functions
- HIM Expense: transcription, coding, Clinical Documentation Improvement (CDI), chart completion, imaging, and all related expenses associated with these functions regardless of reporting structure

EXCLUDES

- IT "hard" costs: capitalized costs such as hardware, licensing fees, core HIS and PAS, servers, and any FTE that supports these
- Lease/rent expenses
- Physical space costs: utilities, maintenance, depreciation
- Scheduling if performed in the service departments by service department personnel

Total Patient Service Cash Collected

Total patient service cash collected for the reporting month, net of refunds.

INCLUDES

- All patient service payments (insurance and patient pay) posted to patient accounts, including undistributed payments
- Bad debt recoveries
- Medicare Disproportionate Share Hospital (DSH) payments
- Medicare Indirect Medical Education (IME) Payments

EXCLUDES

- Patient-related settlements/payments; examples: capitation, Safety Net, Direct Graduate Medical Education (DGME), Medicare Pass-Through, Medicaid DSH
- Non-patient cash; examples: retail pharmacy, gift store, cafeteria
- If reporting hospital data, patient cash collected for ambulance, post acute care services, and ambulatory, including physician practices/clinics, unless Medicare recognized provider-based status clinics
- If reporting ambulatory data, patient cash collected for post acute care services, hospitals, and physician practices/clinics which are Medicare recognized provider-based clinics already included in the hospital data reported. If not reporting hospital data, or not including Medicare recognized provider-based clinics in hospital data reported, the exclusion of these clinics does not apply.
- If reporting post acute care data, patient cash collected for ambulance, hospital and all ambulatory services