AMS Solutions
A SUPERIOR MEDICAL BILLING SERVICE

WHY DOES MY MEDICAL PRACTICE A/R KEEP CLIMBING?

A/R DIAGNOSTIC GUIDE

A practical guide to finding where your revenue cycle is breaking down

Brad Becker, CRCR | Regional Billing Manager, AMS Solutions

THE REPORT IS NOT THE DIAGNOSIS. IT IS THE SYMPTOM.

When A/R keeps rising, work backward from the trend until you find the process creating the balance.

You open the monthly aging report. Last month: **$425,000**. This month: **$468,000**. The month before that: **$397,000**. Collections are still coming in. Claims are being submitted. The billing team says accounts are being worked. Yet the number keeps getting bigger.

MORE MONEY IS ENTERING A/R THAN YOUR REVENUE CYCLE IS SUCCESSFULLY REMOVING FROM IT.

THIS GUIDE WILL HELP YOU FIND	THE DIAGNOSTIC PATH
Volume growth, charge lag, rejections, denials, credentialing, payer issues, posting problems, patient balances, underpayments and follow-up failures.	**Trend** → **Payer** → **Aging** → **Cause** → **Owner** → **Recovery** → **Prevention**

FIRST: A/R GROWTH IS NOT AUTOMATICALLY BAD

Suppose your practice adds two providers. Monthly charges rise 40%. Patient volume rises. Collections rise. Your total A/R will probably rise too. A larger practice generally carries more receivables than a smaller practice. That does not automatically mean billing performance deteriorated.

TOTAL A/R DOLLARS ALONE ARE NOT ENOUGH TO DIAGNOSE PERFORMANCE.

	Practice A	Practice B
Total A/R - 6 months ago	$300,000	$300,000
Total A/R - today	$410,000	$410,000
Days in A/R - 6 months ago	34	34
Days in A/R - today	35	51
A/R over 90 - 6 months ago	7%	7%
A/R over 90 - today	7.5%	16%
Production	Increased significantly	Relatively flat

PRACTICE A	PRACTICE B
A/R is larger, but production is also larger and the aging profile is relatively stable. The practice may simply be carrying a proportionately larger receivable balance.	A/R is larger while days in A/R and aged A/R deteriorated despite flat production. **The money is getting older.**

GROWTH CAN MAKE A/R BIGGER. POOR PERFORMANCE MAKES A/R OLDER.

START WITH THREE NUMBERS

TOTAL A/R	DAYS IN A/R	A/R OVER 90 DAYS
How many dollars remain unresolved?	How long, relative to revenue, are receivables staying open?	How much of the receivable inventory has moved into older buckets?

HFMA MAP Keys treat aged A/R and net days in A/R as standard revenue-cycle trending indicators. For ambulatory and physician organizations, HFMA ages billed A/R from the date of service using 0-30, 31-60, 61-90, 91-120 and over-120-day buckets. MGMA guidance cites approximately **30-40 days in A/R** and **less than 10% of A/R over 90 days** as practical physician-practice benchmarks.

THINK OF A/R AS AN INVENTORY OF UNRESOLVED MONEY

Every open balance represents money that has not completed the revenue cycle. The payer may not have paid. The patient may not have paid. The claim may be denied or rejected. An appeal may be pending. A payment may be unposted. A balance may need an adjustment. Or nobody may have followed up.

THE BASIC A/R EQUATION

BEGINNING A/R + NEW RECEIVABLES - PAYMENTS - RESOLUTIONS = ENDING A/R

If ending A/R keeps growing, either **more is entering** or **less is leaving**. That narrows the investigation immediately.

QUESTIONS 1-2: PRODUCTION AND CHARGE LAG

QUESTION 1: ARE WE SIMPLY PRODUCING MORE?

Before blaming billing, compare visits, charges, providers, locations, procedures, monthly collections and A/R. If charges increased 35% while A/R increased 20%, that is very different from charges staying flat while A/R increased 35%.

LEADERSHIP RULE

Never review the A/R balance in isolation. **Growth can make A/R bigger. Poor performance makes A/R older.**

QUESTION 2: ARE CHARGES GETTING OUT THE DOOR?

Sometimes the revenue cycle slows before the payer ever sees a claim. Look for unsigned encounters, coding backlogs, missing charges, edit queues and claims held for information.

THE CHARGE-LAG TEST	DATE
Date of service	_____
Charge entered	_____
Claim created	_____
Clearinghouse accepted	_____
Payer received	_____

A CLAIM CANNOT BE PAID WHILE IT IS SITTING INSIDE YOUR OWN ORGANIZATION.

QUESTIONS 3-4: REJECTIONS AND DENIALS

QUESTION 3: ARE CLAIMS BEING REJECTED?

A rejection generally means the claim failed before normal payer adjudication. Common causes include invalid subscriber information, incorrect payer IDs, missing provider information, invalid NPI data, formatting problems, enrollment issues and other missing required data.

ASK TODAY	THEN ASK
How many rejected claims exist? What is the dollar value? How old are they? What are the top rejection reasons?	Who owns the queue? How quickly are rejections corrected? Is the same rejection being created repeatedly?

QUESTION 4: ARE DENIALS INCREASING?

If claims reach the payer but increasingly come back unpaid, A/R accumulates quickly. Break denial trends down by payer, provider, location, procedure, reason and dollar amount.

ONE DENIAL IS A CLAIM PROBLEM. FIFTY SIMILAR DENIALS ARE A PROCESS PROBLEM.

If forty claims suddenly deny for authorization, working forty individual claims may recover some money. But if nobody identifies why the authorization problem keeps happening, another forty claims may arrive next month. The team looks busy while the source keeps creating new balances.

QUESTIONS 5-6: PROGRESS AND PAYER CONCENTRATION

QUESTION 5: ARE WE FIXING DENIALS OR JUST TOUCHING THEM?

A denial can have many notes and still make very little progress. Repeated portal checks may be appropriate, but each follow-up should have a clear action, reference number, deadline, next step or escalation path.

TOUCHES ARE NOT PROGRESS

Reviewed claim. Appeal needed.

Appeal pending.

Checked payer portal. Still pending.

Four touches do not automatically mean the account has meaningfully advanced.

QUESTION 6: IS ONE PAYER CAUSING THE PROBLEM?

Do not look only at total A/R. HFMA specifically tracks aged A/R by payer group because an organization-wide number can hide payer-specific deterioration.

Example - A/R over 90	Amount
Blue Cross	$92,000
UnitedHealthcare	$28,000
Medicare	$21,000
Everything else	$39,000
TOTAL	$180,000

YOU MAY NOT HAVE AN ORGANIZATION-WIDE A/R PROBLEM. YOU MAY HAVE A BLUE CROSS PROBLEM.

QUESTIONS 7-8: CREDENTIALING AND PAYMENT POSTING

QUESTION 7: IS CREDENTIALING CREATING A/R?

Credentialing problems often introduce themselves as billing problems. Claims go out, claims deny, billing starts working them, but the underlying problem exists upstream.

- Provider not linked to group
- Provider not loaded at location
- Effective-date problem
- Enrollment terminated
- Revalidation missed
- New provider still pending
- Payer system not updated
- Group information incorrect

YOU CANNOT FOLLOW UP YOUR WAY OUT OF AN UNRESOLVED ENROLLMENT PROBLEM.

QUESTION 8: ARE PAYMENTS COMING IN BUT NOT BEING POSTED?

The payer may have already sent the money. If the payment is not posted correctly, the receivable may remain open and the aging report can overstate collection problems.

- Unposted ERAs
- Unapplied cash
- Missing EFTs or paper checks
- Posting backlog
- Incorrect posting
- Patient payments not allocated
- Credit balances

HFMA identifies credit-balance performance as one indicator of payment-system and posting problems. If cash is in the bank while A/R remains open, that may be a posting problem rather than a collection problem. **Still a problem. Different problem.**

QUESTIONS 9-10: PATIENT A/R AND UNDERPAYMENTS

QUESTION 9: IS PATIENT A/R GROWING?

Insurance A/R and patient A/R behave differently. As deductibles, coinsurance and other patient responsibility accumulate, balances can migrate from insurance to the patient and become harder to collect as they age.

- Are copays collected at check-in?
- Are deductibles estimated?
- Are statements sent promptly?
- Are text or portal payments available?
- Are payment plans offered appropriately?
- Are small balances accumulating indefinitely?
- What percentage of old A/R is patient responsibility?

MGMA CONTEXT

MGMA benchmarking notes that stronger-performing groups tend to carry more A/R in younger aging categories and less in 120+ A/R, reinforcing the value of earlier patient-responsibility collection.

QUESTION 10: ARE WE BEING UNDERPAID?

A claim can be technically paid and still leave money behind. If an expected allowed amount is $800 and the payer reimburses $610, the residual balance may sit unless someone validates reimbursement.

- Unexpected residual insurance balances
- Frequent partial payments
- Contractual adjustment inconsistencies
- Payers paying below expected allowance
- Incorrect fee schedules
- Incorrect multiple-procedure reductions
- Missing modifiers

PAYMENT DOES NOT AUTOMATICALLY MEAN CORRECT PAYMENT.

QUESTIONS 11-13: FOLLOW-UP, OWNERSHIP AND STAFFING

QUESTION 11: IS OLD A/R ACTUALLY BEING WORKED?

Ask for the ten largest balances over 90 days, then ask what happened on each one. You should hear specific answers, not simply "the team is working the aging."

SPECIFIC BEATS VAGUE

$18,400 with Aetna. Records requested September 12. Submitted September 14. Receipt confirmed September 18. Medical review pending October 2. Next escalation October 16.

That tells you the account is being managed. "Aetna - pending" tells you almost nothing.

QUESTION 12: DOES EVERY BALANCE HAVE AN OWNER?

WHO OWNS THIS BALANCE? WHAT HAPPENS NEXT? WHEN DOES IT HAPPEN?

QUESTION 13: HAS STAFFING CHANGED?

A/R often reveals staffing problems months after they begin. A biller quits, a position stays vacant, one person covers two roles, an outsourced team turns over, or claim volume grows without enough capacity. At first, claims still go out and payments still arrive. Then 31-60 grows. Then 61-90. Then 90+.

A/R IS OFTEN A LAGGING INDICATOR

The operational failure may have started months before the aging report finally made it obvious.

READ THE SHAPE OF THE AGING REPORT

IF 0-30 DAYS IS GROWING	IF 31-60 DAYS IS GROWING
Possible causes include practice growth, new providers, increased volume, recent high-value procedures and normal collection timing. This is not automatically concerning if older buckets stay controlled.	Start paying attention. Possible causes include slower payer processing, rejection backlogs, claims needing corrections, early denial accumulation and follow-up delays.

THE SHAPE OF THE AGING REPORT TELLS YOU WHERE THE PIPELINE IS SLOWING.

A single total A/R number compresses a complicated workflow into one figure. Aging buckets restore some of the timeline. When newer A/R grows but old A/R stays stable, the issue may be volume or recent slowing. When older buckets grow, unresolved work is surviving multiple billing cycles.

DIAGNOSTIC MINDSET

Do not ask only: **How much A/R do we have?**

Ask: **Where in the aging curve is growth occurring, and what process should have resolved those balances before they got there?**

WHEN THE OLDER BUCKETS START GROWING

IF 61-90 DAYS IS GROWING

The problem is becoming harder to dismiss. Look for unresolved denials, inadequate payer follow-up, credentialing issues, appeals pending, patient balances aging and staffing limitations. Investigate before these balances cross 90 days.

IF 90+ DAYS IS GROWING

You now have evidence of persistent unresolved work. Identify payer concentration, largest balances, denial causes, credentialing issues, patient responsibility and collectability. Do not simply tell the billing team to "focus on old A/R." Find out why it became old.

IF 120+ DAYS IS GROWING

Pay very close attention. These balances may face timely-filing risk, appeal deadlines, lower collectability, missing documentation, patient collection difficulty and more expensive research requirements.

YOUR GOAL SHOULD NOT BE TO BECOME EXCELLENT AT RECOVERING ANCIENT A/R.

YOUR GOAL SHOULD BE TO STOP CREATING SO MUCH OF IT.

RECOVERY VS. PREVENTION

When A/R is climbing, practices naturally focus on recovery. You have money sitting out there. Go collect it. But recovery alone is not enough.

THE TRAP

Suppose your team recovers **$200,000** of aged A/R while the same broken processes create **$250,000** of new aged A/R. The team worked extremely hard. The problem still got worse.

TRACK 1: RECOVERY	TRACK 2: PREVENTION
Work existing balances. Prioritize large balances, filing deadlines, appeal deadlines, high-value payers, correctable denials, credentialing issues, underpayments, 90+ and 120+ balances.	Fix charge lag, claim edits, rejections, authorization workflows, eligibility, credentialing, coding, documentation, denial root causes, posting problems and patient collections.

RECOVERY CLEANS UP YESTERDAY. PREVENTION PROTECTS TOMORROW.

Every serious A/R improvement project should have both tracks. If you only recover, the broken process keeps creating new inventory. If you only prevent, you leave money stranded in the existing aging.

THE A/R DIAGNOSTIC TREE

STEP	QUESTION	YES PATH	NO PATH
1	Did production increase significantly?	YES: Compare days in A/R and aging %. Stable metrics may indicate normal growth.	NO: Continue.
2	Are days in A/R increasing?	YES: Money is moving more slowly. Continue investigating.	NO: Compare A/R growth with revenue growth.
3	Is A/R over 90 increasing?	YES: Break old A/R down by payer and cause.	NO: Look at newer A/R and recent growth.
4	Is one payer responsible for a large share?	YES: Investigate that payer specifically.	NO: Look for a systemic workflow problem.
5	Are denials or rejections rising?	YES: Identify root causes and stop new inventory.	NO: Continue.
6	Is patient A/R rising?	YES: Review front-end collections and patient billing.	NO: Continue.
7	Are payments being posted correctly?	NO: Resolve posting and unapplied-cash issues.	YES: Continue.
8	Do we know why the largest aged balances remain open?	NO: Start with follow-up and accountability.	YES: Build recovery + prevention plans.

START BROAD. THEN KEEP NARROWING UNTIL A DOLLAR BALANCE HAS A CAUSE AND AN OWNER.

THE 15-MINUTE A/R DIAGNOSTIC

Pull your current aging report and fill this in before the next revenue-cycle meeting.

CURRENT SNAPSHOT	VALUE
TOTAL A/R	$_____
DAYS IN A/R	_____ days
A/R OVER 90 DAYS	$_____ _____ %
A/R OVER 120 DAYS	$_____ _____ %
PATIENT A/R	$_____ _____ %
INSURANCE A/R	$_____ _____ %

COMPARE WITH SIX MONTHS AGO

Metric	Six months ago	Today	Direction
Total A/R	$_____	$_____	↑ / ↓ / =
Days in A/R	_____	_____	↑ / ↓ / =
Over 90 %	_____%	_____%	↑ / ↓ / =
Over 120 %	_____%	_____%	↑ / ↓ / =

THE FIRST ANSWER YOU NEED

Is the trend improving or deteriorating?

One month is a photograph. Six months is a movie.

FOLLOW THE AGED A/R DOLLARS

List the five payers responsible for the most A/R over 90 days. Do not guess. Pull the dollars.

#	PAYER	A/R OVER 90	PRIMARY CAUSE
1	_____	$_____	_____
2	_____	$_____	_____
3	_____	$_____	_____
4	_____	$_____	_____
5	_____	$_____	_____

THREE BIGGEST ROOT CAUSES

#	ROOT CAUSE	EST. A/R AFFECTED
1	_____	$_____
2	_____	$_____
3	_____	$_____

IF YOUR TEAM CANNOT IDENTIFY THE THREE BIGGEST CAUSES OF AGED A/R, THAT ITSELF IS USEFUL INFORMATION.

Follow the dollars, not the anecdotes. "UnitedHealthcare has been terrible" is not yet a diagnosis. How many dollars? "It is credentialing" is not yet a diagnosis. Which providers, which payers and which balances? The loudest issue is not always the largest issue.

BUILD A 30-DAY A/R ACTION PLAN

Do not try to fix everything at once. Attack the few problems producing most of the financial damage.

Problem	_____
Dollars at risk	$_____
Root cause	_____
Owner	_____
Immediate recovery action	_____ _____
Prevention action	_____ _____
Deadline	_____
Success measure	_____ _____

EXAMPLE

Problem: Blue Cross authorization denials
Dollars at risk: $78,000
Root cause: Authorizations are not consistently updated when procedures change.
Recovery: Review denied claims, pursue retrospective authorization where permitted, appeal eligible claims and escalate high-dollar cases.
Prevention: Add authorization verification before procedure scheduling and again before claim submission.
Success measure: Reduce Blue Cross authorization-denial dollars by 75% within 60 days.

RED FLAGS

WHAT YOU HEAR	WHAT TO ASK NEXT
"A/R is up because we are busy."	Maybe. Show me days in A/R and aging percentages.
"The team is working it."	Show me the largest balances and next actions.
"It is mostly payer delays."	Which payers? How much?
"Everything over 90 is being worked."	Why did it become over 90?
"We just need more A/R staff."	Maybe. First determine why the A/R is being created.
"We cleaned up $100,000 last month."	Excellent. How much new 90+ A/R entered the report?
"That is just patient responsibility."	How much?
"It is credentialing."	Which providers, payers and balances?
"The payer says it is pending."	Since when? What happens next?

VAGUE EXPLANATIONS SHOULD BECOME SPECIFIC DOLLARS, CAUSES, OWNERS AND NEXT ACTIONS.

A/R MANAGEMENT SHOULD NOT BE AN ARCHAEOLOGICAL PROJECT

A healthy revenue cycle should not spend all of its energy excavating problems created six months ago. Old balances will always exist. Complex claims happen. Payers make mistakes. Patients do not always pay immediately.

GREAT A/R MANAGEMENT IS NOT JUST EXCELLENT RECOVERY. IT IS MAKING SURE FEWER BALANCES NEED RESCUING IN THE FIRST PLACE.

WHAT SHOULD LEADERSHIP REVIEW EVERY MONTH?

MONTHLY SCORECARD	MONTHLY SCORECARD
• Total A/R • Days in A/R • A/R over 90 days • A/R over 120 days • A/R by payer • Patient vs. insurance A/R	• Top aged balances • Denial trends • Rejection trends • Major credentialing issues • Unapplied / unposted payments • Trend vs. prior months

ONE MONTH IS A PHOTOGRAPH. SIX MONTHS IS A MOVIE. WATCH THE MOVIE.

FIVE QUESTIONS YOUR BILLING TEAM SHOULD ANSWER

1. WHY?

Not generally. Specifically.

2. WHICH PAYERS ARE DRIVING IT?

Follow the dollars.

3. WHAT ARE THE THREE LARGEST ROOT CAUSES?

Patterns, not isolated claims.

4. WHAT ARE WE DOING ABOUT THE EXISTING A/R?

That is recovery.

5. WHAT ARE WE CHANGING SO IT STOPS HAPPENING?

That is prevention.

IF NOBODY CAN ANSWER THOSE FIVE QUESTIONS, THAT MAY BE THE BIGGER PROBLEM.

YOUR A/R REPORT IS TRYING TO TELL YOU SOMETHING

A/R is not simply a pile of unpaid claims. It is feedback from the revenue cycle.

WHAT YOU SEE	WHAT IT MAY BE TELLING YOU
Growing 0-30	Practice may be expanding or newer receivables may be building.
Growing rejection queue	Claim-submission process may be breaking.
Payer-specific 90+ spike	A contract, enrollment, payer or workflow problem may exist.
Growing patient A/R	Front-end collections or patient billing may need attention.
Growing 120+	Follow-up, deadlines or collectability may be deteriorating.

THE REPORT IS NOT THE DIAGNOSIS. IT IS THE SYMPTOM.

IF YOUR A/R KEEPS CLIMBING, DO NOT JUST WORK HARDER

Working more accounts can help. Adding staff may help. Running an A/R blitz may help. But first understand the problem. Otherwise you may simply become more efficient at cleaning up the same failure over and over again.

TREND → PAYER → AGING → CAUSE → OWNER → RECOVERY → PREVENTION

NOT SURE WHY YOUR A/R KEEPS GROWING?

This is exactly the kind of problem AMS Solutions evaluates when reviewing a medical practice's revenue cycle.

We can help analyze:

- A/R aging
- Payer concentration
- Denial patterns
- Rejections
- Credentialing-related balances
- Patient A/R
- Payment-posting issues
- Follow-up workflows
- Revenue-cycle trends

THE GOAL IS NOT SIMPLY TO TELL YOU THAT YOUR A/R IS HIGH.

WE WANT TO TELL YOU WHY - AND WHAT NEEDS TO CHANGE TO BRING IT BACK UNDER CONTROL.

NO-OBLIGATION A/R AND REVENUE-CYCLE REVIEW

Bring us your aging report, payer mix, denial data and current workflow. We will help you identify where the receivable inventory is being created and where the operation is losing momentum.

Brad Becker, CRCR
Regional Billing Manager
AMS Solutions

SOURCES & METHODOLOGY

Healthcare Financial Management Association (HFMA) - MAP Keys

HFMA identifies aged A/R as a percentage of billed A/R, payer-specific aged A/R, remittance denial rate and net days in A/R as standardized revenue-cycle performance measures. For ambulatory and physician organizations, billed A/R aging is measured from the date of service using 0-30, 31-60, 61-90, 91-120 and over-120-day categories.

View HFMA MAP Keys

Medical Group Management Association (MGMA) - Patient Revenue Cycle Management KPI

MGMA physician-practice revenue-cycle guidance cites approximately 30-40 days as an optimal days-in-A/R range and less than 10% of A/R over 90 days as a practical benchmark, while emphasizing timely correction, appeals and account resolution.

View MGMA Days in A/R guidance

MGMA - Patient Balance Collection

MGMA notes the importance of collecting patient responsibility earlier in the revenue cycle and reports that stronger-performing practices tend to carry a larger share of A/R in younger categories and less in 120+ A/R.

View MGMA patient balance collection guidance

METHODOLOGY NOTE

Benchmarks should be interpreted in the context of specialty, payer mix, practice growth, service mix and local market conditions. This guide is intended as an operational diagnostic resource rather than a universal performance standard.

THE BEST A/R REVIEW DOES NOT END WITH A NUMBER. IT ENDS WITH A CAUSE, AN OWNER AND A PLAN.

AMS SOLUTIONS

Ready to talk it through?

Every practice's numbers are different. Tell us what you are seeing in your billing and A/R, and our team will walk through where revenue is getting stuck and what it would take to fix it.

Free and no obligation. Complete a short form and a member of our team will follow up.

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