New York State Volunteer Ambulance & Rescue Assoc.
PULSE CHECK 2012

EMS Billing Pitfalls:
Recouping Your Fees

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Avoiding Common Pitfalls

- Many factors affecting your reimbursement are out of your control
- But what factors are under your control?
  - Consistency
  - Attention to detail
  - Industry Knowledge
  - Adequate Technology
  - Proper Motivation

Avoiding Common Pitfalls (cont.)

- When any one of these elements is missing there is a consequence
  - Volatile cash flow
  - Inordinately old A/R
  - Higher coding error rates
  - Unnecessary paperwork
  - Dwindling overall revenue

Avoiding Common Pitfalls (cont.)

- With this in mind, the purpose of today's seminar is to gain a high level understanding of two key things:
  - The components of a proper billing system
  - How to best evaluate its performance

It Starts with Documentation

- Everything starts with the chart
- Depending on agency protocol, any number of QA measures can be used
  - Consolidated to one person
  - Levels of peer review
  - Different e-PCR applications provide varying measures

It Starts with Documentation (cont.)

- Review for completeness, accuracy, logic, legal defensibility
- Did you obtain a legible patient signature?
  - Ensure familiarity with the signature rules
  - There are allowances for when you can't obtain a patient signature
- Did you obtain a copy of the insurance card or hospital face sheet?
  - What is the current method your Providers use for obtaining the insurance info?

It Starts with Documentation (cont.)

- Reinforce the direct connection between a PCR and its role in compliance and revenue creation for the agency
  - Schedule ongoing documentation refreshers
  - Look into classes offered from sources like VFIS, Cornerstone, and other consultants
  - Attach Con-Ed credits to the completion of these classes
  - Consider putting employees through a recognized curriculum like the NAAC Certified Ambulance Coder course

Data Transfer - Import/Export

- Import/export of data for billing
- But what does this mean?
  - Could be as simple as viewing a chart online
  - Could mean extracting data and synchronizing it with a billing application
  - Depends on the extent to which you want to automate the process

Data Transfer - Import/Export (cont.)

- So what gets imported/exported?
- Certain data is easier to import/export
  - Patient demographics
  - Pick-up & Drop-off locations
  - Times
  - Mileages
- Riskier areas include the import of things like Chief Complaint
  - Why? Because anything that typically needs verified by a trained/experienced person is inherently more risky to remove from human intervention

Data Transfer - Import/Export (cont.)

- Advantage/Disadvantage
  - The advantage of exporting data for billing is that you can strip out and upload the data which is least subject to human interpretation, and thereby realize increases in claims coding efficiency
  - To some, the disadvantage is the lessening of a more traditional mode of human intervention (i.e. someone sitting in an office reviewing paper charts)
- All of this attention on data export though means we are working toward a "paperless" environment
  - But what does paperless mean in practical daily application?

Document Management

- Before computers – everything handled manually
- Many things were misplaced or worse, lost
- This played a role in the creation of HIPAA
- With the move toward "paperless" the goal is three-fold:
  - Keep it safe
  - Prevent it from being lost
  - Make it quickly accessible

Document Management (cont.)

- This often requires an up-front solution for the digitization of hard copy
- Tied into a subsequent solution for routing/tracking of digital information
- A paperless billing solution then requires a superior document retrieval and management system
  - Some billing software applications allow for documents to be attached directly to a patient account, creating "one-touch" access
  - This can be helpful when speaking with a patient over the course of a phone call

Claims Coding and Submission

- Now that you have a streamlined field-to-office solution for your PCR data and have performed QA on your charts, it's time to create the claim
- Creating a claim is essentially turning one form of language into another
- Codes and Modifiers
  - Linked to the various reasons for transport
- Transitioning from ICD-9 to ICD-10

Claims Coding and Submission (cont.)

- It is critical to understand the law as it applies to things like
  - Nature of Dispatch
  - Medical Necessity
  - Reasonableness
  - ALS Assessments
- Some organizations have misinterpreted the rules, resulting in overpayments and retroactive Medicare audits
  - Consequences are well documented (see the growing number of mandatory refunds from agencies across the nation)

Claims Coding and Submission (cont.)

- Many carriers are able to accept claims electronically
  - Helps to speed the reimbursement process
  - Batch submissions and verifications
  - Online claims updates
- Most billing software applications are designed to make this simple
  - Common suppliers include ZOLL, TriTech, etc.
- Some claims must be submitted on paper, including those where a copy of the PCR is required as well

Recovering Revenue (RR)

- Not every claim is paid within the expected time frame
- As we know, some insurances pay the patient
- Recovering potentially lost revenue requires four things:
  - Understanding the reimbursement cycle
  - Understanding billing guidelines/federal law
  - Deploying an intelligent approach to scheduled workflow management
  - Keeping a trained and motivated staff

RR: The Reimbursement Cycle

- Medicare
  - Submit electronically and get paid electronically
  - Usually paid within 2 weeks of claims receipt
- Medicaid
  - Option of paper or electronic deposit
  - Usually paid within 30-45 days of claims receipt
- Commercial Insurance
  - Must pay on clean claims within 45 days
  - If non-par some carriers will pay the patient
- Private Pay
  - Varying levels of ability to pay
  - Managing hardships (objective criteria)

RR: Guidelines and Federal Law

- What is a fee schedule?
  - In lay terms, the amount a carrier agrees to pay
  - For instance, Medicare establishes a fee schedule (what it deems reasonable), and then pays 80% of that
    - The 20% balance would be the responsibility of a secondary carrier, the patient, or a membership program if applicable
    - An exception would be for municipally-affiliated agencies who are allowed to waive co-pays for their tax-paying residents
- Current Medicare Fee Schedule
  - Determined by *locality* and *rural* vs. *urban* designations

RR: Guidelines and Federal Law (cont.)

- **2011 Medicare Fee Schedule**

Locality 99		Urban	Rural
AO425	BLS Ground Mileage	6.86	*10.40
AO428	BLS Non-Emergency	207.35	209.38
AO429	BLS Emergency	331.76	335.01
AO426	ALS Non-Emergency	248.82	251.26
AO427	ALS Emergency Level I	393.96	397.82
AO433	ALS Emergency level II	570.21	575.80
AO434	Specialty Care Transport	673.88	680.49
*Miles 0-17; All miles over 17 are @ 6.93/mile			

RR: Guidelines and Federal Law (cont.)

- The Medicare Fee Schedule may go up or down each year, depending on multiple economic indicators
  - Projection for 2012 is a 2.4% increase
- Legislation is under consideration now that would provide permanent increases in the range of 3-6%
- The future of ambulance transport reimbursement is cloudy
- Consequently, this makes the billing solution that much more important

RR: Guidelines and Federal Law (cont.)

- Some EMS agencies consider being “par” with carriers
  - Advantage:
    - Have payments sent to you and not the patient
  - Disadvantage:
    - Often only makes sense for BLS agencies running a high volume of non-emergency transports
    - ALS agencies will ultimately lose money
- Other carriers may follow Medicare’s lead in setting their own reimbursement rates
  - Workers Comp & Auto
    - Pay a small percentage above the Medicare Fee Schedule

RR: Workflow Management

- Finding the optimal solution
  - Utilize software which provides scheduled workflow options
  - Some applications interface dispatch, PCR, billing, A/R, creating a total solution (ideal for in-house systems)
  - With the best applications, oversight measures are built in
  - Automated features allow for customization of invoices, the timing of your follow-up, and tracking

RR: A Trained and Motivated Staff

- Training and Human Resource Management
  - Consider the CAC program through NAAC
  - Recognize employee achievement
  - Foster a nurturing environment, with clear expectations
  - Incentive-based
    - Could be based on accuracy, attendance, volume (provided nothing conflicts with the 100% Compliance standard)

Evaluating Billing Performance

- Many ways to evaluate performance
- The first thing to ensure is also the most important
- 100% Compliance is the standard
  - Scheduled and unscheduled audits
  - Spot checking for accuracy
  - Commit to limiting your staff/billing company to a 1-3% error ceiling

Evaluating Billing Performance (cont.)

- Key Performance Indicators (KPI)
  - Can use any number and variety of KPI
  - The following two provide a quick and useful snapshot
    - Average Payment
      - By Overall Trip
      - By Payer
      - By Call Type
      - By Age of Claim
    - Collection Percentage
      - Varying methods
      - Recommended to use 6 Month Collection Cycle on set blocks of claims

Evaluating Billing Performance (cont.)

- Average Payment
  - To establish an overall number, take your payments (less refunds) and divide that into your billable trips
  - To obtain more specific figures, drill down
- Collection Percentage
  - Best to isolate a block of trips by DOS and track the residual performance
    - Many agencies use month to month
  - Based on "net collectible," or the maximum collectible amount once contractual allowances are applied

Evaluating Billing Performance (cont.)

- How do I know what is good or not good?
  - Much depends on each agency's demographics and payer mix
    - Two agencies may run 1,000 calls each but may not bring in the same revenue
      - One may have 5% Medicaid and another has 15% Medicaid
      - One may have a higher percentage of a commercial insurance which pays 100% of the billed amount
  - As far as payments, if you know who you are billing, then you know what they should pay *and when*
    - If your payment per trip does not measure up, or if your Aging seems high or inordinately old, reference it against this expected standard

Evaluating Billing Performance (cont.)

- Example 1
  - Your average payment is under $300.00.
  - You think that's low considering your average charge is $500 and 70% of your payer mix is Medicare and Commercial.
  - More research reveals 20% of your payer mix is Private Pay.
  - You drill down and find that your average Private Pay reimbursement is only $100.00.
  - At your current call volume of 2,000 trips, that means you have 400 trips creating a negative drain on the overall revenue picture.
  - What can you do to improve performance in this area?

Evaluating Billing Performance (cont.)

- Example 1
  - It's all about finding a root cause
    - How are payment plans being presented?
    - What payment options are offered to a patient?
    - What is the frequency with which patients are contacted?
    - What times of day are patients contacted?
    - Do you have a built-in report which details all activity performed on the account?
    - Can you drill it down to a certain employee who may be struggling to effectively work with these patients?

Evaluating Billing Performance (cont.)

- Example 2
  - It's taking you over 100 days to get paid on Highmark Blue Shield claims.
  - You don't "participate" with Highmark and know that as a result they will pay the patient.
  - But you also know that due to Act 68 carriers are required to pay "clean claims" within 45 days of receiving the claim.
  - When reviewing your existing Highmark claims, you determine they are not being denied or rejected. It must mean that the patients aren't forwarding these checks.
  - You then review the activity on every such account and see that no phone calls were made on nearly half of them. Of that half, payment wasn't made until two weeks after the third invoice was mailed.

Evaluating Billing Performance (cont.)

- Example 2
  - It's all about finding the root cause
    - What happens when phone calls are made on all of the claims?
      - Does this solve the problem?
    - What happens if you send a courtesy notice to the patient at the same time you bill their insurance?
      - Does this show an improvement?
    - Have you isolated the payment processing time for Highmark Blue Shield? If so, you may find it is generally 32 days.
      - What happens if you place a call to the patient on Day 32 alerting them to the impending check they will receive in the mail?
      - Are they more responsive?
      - Are you able to identify earlier a potential candidate for collections?

Fire/Rescue Billing

- Some states are more regulated than others
- In PA, it is less regulated and therefore the reimbursement cycle is often longer
  - There is much less predictability
  - Typically you are billing auto and homeowners insurance
- Bottom Line:
  - Can be done in-house but can also be outsourced
  - Be mindful of lofty expectations
  - Not uncommon to bill $100K and only receive $10-15K

Thank you for attending!

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