



Handout

EMS FINANCIAL MANAGEMENT How to Start, How to Thrive

**Presented by:
Maggie Adams**

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EMS Financial Services
Practical ambulance reimbursement and compliance consulting

EMS Financial Management: How to Start, How to Thrive

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- Claims auditing of ground & air billing
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 - Live conferences & workshops to groups of all sizes
 - Webinars as a less expensive solution for training needs
 - Sessions available for field crews, billing personnel and management


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Today's Presenter

Maggie Adams has over 35 years' experience in healthcare and the ambulance industry. Maggie was the president of the only company in the country devoted exclusively to EMS patient account collections and insurance denial appeals. She was Page, Wolfberg & Wirth's senior consultant, a highly regarded presenter at their national ambulance billing conferences, and a key contributor in developing and delivering educational training sessions for the National Academy of Ambulance Compliance. Recently, Maggie became a member of the Compliance & Regulatory Compliance Advisory Board of NEMTAC (Non-Emergency Medical Transportation Accreditation Commission). Throughout her career, Maggie has been a sought-after speaker and has presented at conferences nationwide. Known for her upbeat and positive personality, Maggie draws the attention of the entire audience as she provides practical solutions to problems faced by all ambulance providers and billing companies. She is a Cum Laude graduate of the Wharton School of the University of Pennsylvania. Maggie can be reached by email at maggie@ems-financial.com or by phone at (610) 494-5255.



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What We'll Discuss

- The responsibility we bear
- Need to bring company together
- It all starts with emergency 911 dispatch or the NEMT call center
- Education
- Work flows & process
- Revenue cycle management
- Financial goals and metrics to monitor them

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PROVIDER RESPONSIBILITY

- Patients served
- Community support
- Board of directors, owners, city council, or county board of supervisors
- Taxpayers
- Fiduciary responsibility
- Compliance responsibility
- Whether billing performed in-house or outsourced to third-party

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When our departments operate as silos, the organization will not thrive




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Revenue cycle management (RCM) relies on ALL parts of the organization

- Call intake / dispatch process
- Operations / field providers
- Billing



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Financial management is about operational management

No more silos – ONE company – working together – as a team – teamwork is successful in the field – it can work throughout the organization

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Better Process

- Organizations will not grow by volume of transports, but by the quality of those transports
 - Transports that meet compliance standards
 - For which the provider can get paid
- To serve our facility customers better, care for our patients AND to meet our own needs, we need to rethink our processes
- Poor process is where costs can be driven up and money gets lost
 - Lost opportunities for appropriate billing

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The Beginning: Request for Service

This is an emergency and a non-emergency issue

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We Begin with Definition Emergency

Emergency response means responding immediately at the BLS or ALS/1 level of service to a 911 call or the equivalent in areas without a 911 call system. An immediate response is one in which the ambulance supplier begins as quickly as possible to take the steps necessary to respond to the call.

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ALS-1
Emergency

Transportation by ground ambulance vehicle, medically necessary supplies and services and either an ALS assessment by ALS personnel or the provision of at least one ALS intervention

From 42 CFR Ch. IV, § 414.605

All aspects of definition must be met to bill at ALS-1 Emergency level

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ALS Assessment Definition

An advanced life support (ALS) assessment is an assessment performed by an ALS crew as part of an emergency response that was necessary because the patient's reported condition at the time of dispatch was such that only an ALS crew was qualified to perform the assessment. An ALS assessment does not necessarily result in a determination that the patient requires an ALS level of service.

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Patient's Reported Condition & Dispatch Protocols

Level	Response	Mode
ECHO	Closest Apparatus—Any (includes Truck Companies, HAZMAT, or on-site staff)	HOT
DELTA	Closest BLS Engine/Paramedic Ambulance	HOT
CHARLIE	Paramedic Ambulance	COLD
BRAVO	Closest BLS Engine/BLS Ambulance (above not "I" listed)	HOT COLD
ALPHA	BLS Ambulance	COLD
OMEGA	Referral or Alternate Care	

Note: This example is considered the Academy's official recommendation for baseline response.

- Whether using an EMS system like this, or,
- Using Priority I, II or III
- Dispatch usually has a level of priority

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BUT WE USE
A PSAP!
POLICE, FIRE
& EMS IN ONE
CENTER

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DISPATCH
STILL
IMPORTANT

Even when dispatch done jointly with police and fire

Important to note how dispatched

Document dispatch priority

Document patient condition

- "Dispatched ALS for chest pain"
- "Dispatched for seizures"

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Dispatch Priority or Scheduling Info Critical

Always note! Why or how dispatched

- Dispatch priority
- Or, note dispatch ALS or BLS
- Or note if inter-facility transport

Dispatch for what condition or purpose?

- Chest pain
- Man down, etc.
- Hospital discharge
- Dialysis transport

Document

- Bystanders report
- Police stated
- Facility personnel reported info

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Dispatch Protocols

What to do if there are no dispatch protocols currently in use

Work with your medical director

Assure your dispatch protocols are in good shape in accordance with Medicare's guidance

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This is especially important if calls come directly to the ambulance organization

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Medicare Benefits Policy Manual
Section 30.1.1

"The determination to respond emergently ... must be in accord with the local 911 or equivalent service dispatch protocol. If the call came in directly to the ambulance provider/supplier, then the provider's/supplier's dispatch protocol must meet, at a minimum, the standards of the dispatch protocol of the local 911 or equivalent service. In areas that do not have a local 911 or equivalent service, then the protocol must meet, at a minimum, the standards of a dispatch protocol in another similar jurisdiction within the State or, if there is no similar jurisdiction within the State, then the standards of any other dispatch protocol within the State."

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Emergency Calls May Come Directly to the Provider

```
graph TD
    Start([Receive Call]) --> IsEmergency{Is this an emergency call?}
    IsEmergency -- Yes --> DispatchAmbulance[Dispatch to Ambulance]
    IsEmergency -- No --> DispatchFacility[Dispatch to Facility]
    DispatchAmbulance --> RespondCall[Respond to Call]
    DispatchFacility --> RespondCall
    RespondCall --> ProvideCare[Provide Care]
    ProvideCare --> TransportFacility[Transport to Facility]
```

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Example Local 911 Dispatch

EVENT	SUB EVENT	PRIORITY	ALARM	UNIT TYPE	# OF UNITS	AGENCY
Abdominal pain	Abdominal pain, w/o signs or symptoms	2	1	Medic	1	Fire Response
Abdominal pain	Severe pain, nausea, vomiting, fainting	1	1	Medic	1	Fire Response
Allergic reaction	Difficulty breathing	1	1	Medic	1	Fire Response
Allergic reaction	No difficulty breathing	2	1	Medic	1	Fire Response

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Non-Emergency Transport Process

Need for quality facility interactions

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Facility/Provider Partnership



- Facilities need patients transported in a timely manner that assures highest quality care for patients
- NEMT providers are partners in that effort
- Compliance of BOTH organizations on the line
- Financial status of BOTH organizations involved
- Patient and facility needs must be met

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ANOTHER CRITICAL RELATIONSHIP

Provider and payer




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Goal:

Move the patient in the most appropriate mode of transport to meet their needs and provide good service to facility and the patient



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To meet the goals


- Need to understand what non-emergency transport encompasses:
 - Discharges from ER to home or skilled nursing facility
 - Many hospital to hospital transports
 - Dialysis, chemotherapy, radiation trips
 - Trips to medical appointments
 - And some other trips that are not emergency
- Important to understand the information required
- Must maintain compliance with forms and authorization requirements

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First step: decide Best Mode of Transport

- For many patients, wheelchair van is safe, appropriate transport
 - These patients don't need trained personnel at their side
 - They are unattended in back of van
- Other patients can only safely travel by ambulance with trained personnel at their side



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Questions Facility may be asked

- What does the patient need help with or what do they need an EMT to do for them?
- Does the patient follow basic safety commands?
- Can patient self-transfer?
- Can the patient regulate their own oxygen?
- What medications taken prior to transport or need to be monitored during transport?
- Is there any need for isolation precautions?

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Patient's need
Drives the
Questions

If the patient is in pain,

• Where is the pain?

If the patient reportedly has paralysis,

• Where is the paralysis?


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Wheelchair Van First
Choice


• Go-to method of transport is
wheelchair van

• UNLESS, it is crystal clear why
the patient can only be
transported by ambulance



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Dementia patient

• Can this patient safely be transported
by wheelchair van without an attendant
at her side?

• Is she a flight risk?

• Fall risk? Safety risk?


• Danger to herself or others?

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Fall risk?

Can patient support himself
in a seated position for the
time it takes to transport?



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CMS National Payment Policy


Medicare covers ambulance services only if furnished to a beneficiary whose medical condition at the time of transport is such that transportation by other means would endanger the patient's health. A patient whose condition permits transport in any type of vehicle other than an ambulance does not qualify for Medicare payment.

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CMS Policy,
continued:

Medicare payment for
ambulance transportation
depends on the patient's
condition at the actual time of
the transport regardless of the
patient's diagnosis.




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Necessary
AND
Reasonable

ALL Medicare criteria must be met for ambulance trip to be paid

- Medically necessary
- Reasonable & necessary
- Transport to a covered destination
- Closest appropriate facility



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Need to know who the payer is BEFORE the transport – some payers want authorization or network provider only

Need to bill appropriately - do not want patient or facility billed for service that might be covered

Ambulance company NEEDs to Know the Payer

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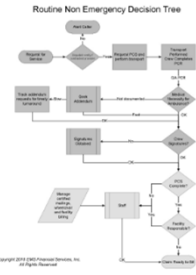
Fact of life: for many non-emergency transports

Providers have to be in network, have a contract, or prior authorization

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Routine Non Emergency Decision Tree



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Contract with an ambulance provider

Facility may have a contract with an ambulance service

Ambulance provider may be first choice for call for service


But not necessarily the provider who should transport the patient

Another provider might be contracted or in-network with the payer

Ambulance service needs to ask questions to assure they are right provider to transport the patient

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Managing and Responding to the Financial Picture

From Balance Sheet, to Income Statement to Billing Reports

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Basic Accounting Formula

Asset

Liability

Equity

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LIABILITIES INCLUDE:

Loans

Accounts payable

Mortgages


Deferred revenue

Accrued expenses

Liabilities are Expenses

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Assets are where ambulance billing topics are located

Current Assets

- Inventories
- Prepaid Expenses
- Accounts Receivables
- Cash in Hand
- Cash at Bank
- Cash Equivalents
- Marketable Securities

Liquid Assets

- Cash in Hand
- Cash at Bank
- Cash Equivalents
- Marketable Securities
- Accounts Receivables

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Money Gets Lost Without Metrics to Monitor What You are Doing




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It's All About You!

- What kind of reports do you typically look at and do the reports you now review give you the information you need?
- What's missing?
- What do you need to know to make good decisions about your financial and billing performance?



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What is a Performance Measure

- Performance measure is an indicator that helps an organization know how well it is achieving its goals
- Performance measures are
 - Specific and quantifiable
 - Measures both processes and results
 - Helps to spot trends in performance

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What is a Benchmark?

- Standard used as point of reference for evaluating performance
- Benchmark may be
 - Internal (based on your company's experience)
 - Based on industry standards
 - Legal requirement (e.g., providers under a C.I.A. need low error rate)

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How to Begin Benchmarking



- Establish your goals
- Goals are statements of what you want to achieve
- Goals can be high level
- What goals should you target?

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Benchmarking is the means to an end

If you can't measure it, you can't manage it




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Billing Reports Help Providers Diagnose the Health of the Organization

- Average patient charge
- Cash Receipts
 - Look also amount collected per transport
- Accounts Receivable Aging
- Denials Reports
- Credits
- Adjustments
- By Payor Mix
 - Medicare
 - Medicaid
 - Commercial
 - Facilities
 - Self Pay
 - Special (time pay, attorneys, etc.)
- Write-offs



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Track Clearinghouse Rejections

There are two doors – door INTO the clearinghouse & door OUT to payers

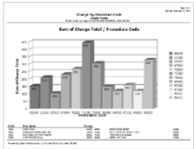


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In our world, we use HCPC Codes – track billing by code

- A0425 – Mileage
- A0426 – ALS NE
- A0427 – ALS 1 E
- A0428 – BLS NE
- A0429 – BLS E
- A0433 – ALS 2
- A0434 – SCT/CCT
- A0998 – Treat, No Transport



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Ongoing or One-Time Only?

- What do you need to know?
- Need a snapshot of where you stand right now, or,
- Do you need ongoing monthly metrics

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Map Your Process

- Map your own processes into a detailed process model
- Collect metrics for each process
- Metrics are combined into numeric benchmarks that allow you to compare what you do, rank it and start improving

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First establish YOUR norm

Don't worry about the rest of billing world at the start; learn what YOU are doing and improve from there

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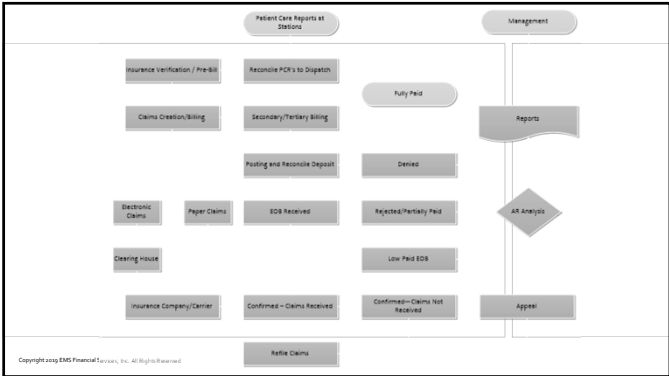
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Process Flow for Billing

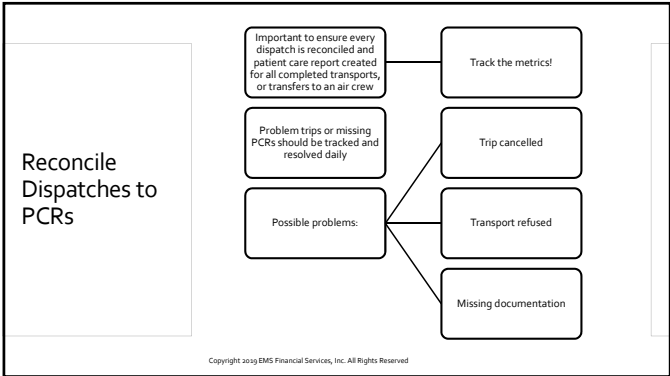
The things that need to be measured

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PCR Reconciliation Challenges

- Best practice: reconcile PCRs to dispatches daily
- BUT, it may not work for your organization
 - Outlying stations may take longer to send PCRs to billing
 - Organization's QA process may add time
- Establish a policy and follow it!
 - Set realistic time deadline for when documentation must be complete and sent to billing



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Billing Companies

- Reconciling incoming PCRs for billing depends upon your particular process and relationship with your clients
- Regardless of process, there should be a check and balance
 - Do you have expectation for number of trips being sent to you?
 - Reconcile what comes in to what actually gets billed or otherwise resolved
- Billing companies rely on quality of documentation sent to them by their clients
- Your ultimate goal should be the same
 - Quick turnaround and clean claims out the door

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Days to Bill

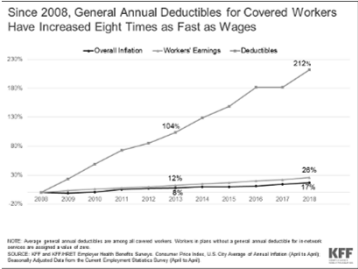
- Remember to track how long it takes to get trips billed and out the door
- Use most recent month
- Total number trips to bill divided by average transports per day
- BUT, focus on RIGHT DAY BILLING

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Right Day Billing

Since 2008, General Annual Deductibles for Covered Workers Have Increased Eight Times as Fast as Wages



Year	Overall Inflation	Workers' Earnings	Deductibles
2008	2.0%	2.0%	2.0%
2009	2.5%	2.5%	2.5%
2010	3.0%	3.0%	3.0%
2011	3.5%	3.5%	3.5%
2012	4.0%	4.0%	4.0%
2013	4.5%	4.5%	4.5%
2014	5.0%	5.0%	5.0%
2015	5.5%	5.5%	5.5%
2016	6.0%	6.0%	6.0%
2017	6.5%	6.5%	6.5%
2018	7.0%	7.0%	7.0%

Source: KFF. Average general annual deductibles are among all covered workers. Workers in plans without a general annual deductible for a network contract are excluded from this chart.

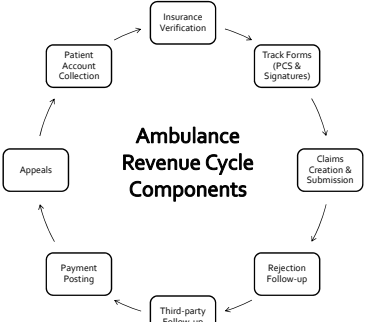
Source: KFF. KFF uses the 2018 Employee Health Benefits Survey. Consumer Price Index, U.S. City Average of Annual Inflation (April to April). Researcher: KFF. Data from the United States Employment Statistics Survey (April to April).

- Getting claim out when it is mostly likely to get paid – and not require provider to chase deductible
- Need mechanism to check deductible status

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Steps to successful billing and follow-up



Ambulance Revenue Cycle Components

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Track, Track, Track!

How many trips get verified?

How many of the verified trips need to be touched again?

Are there trends?

People problems? Problem payers?

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Track Signature Compliance

- Track signature compliance among crew members and provide re-education or corrective action as necessary
- Educate your facilities, especially that signature of facility rep does NOT create a financial obligation
- Provide facilities with lifetime signature form for inclusion in every new patient's packet of information

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PCS Form Compliance

- Total Non-emergency Trips / Total PCS Forms Received Timely
- Target facilities that do not comply
- In case of repetitive transports, outreach to physicians to educate
- Put repetitive PCS requests on a timeline
 - Don't wait until last day
 - Request updated PCS two weeks prior to expiration

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Days in Accounts Receivable

Total Accounts Receivable + Credit Balances

Gross Charges – Writeoffs & Adjustments

X 30

Measures how quickly claims are paid

Good range ≤ 40 to 45 days

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A/R Greater than 90 Days

Total Accounts Receivable > 90 Days Old

Total Accounts Receivable

TARGET GOAL: <12%

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Receivables Monitoring

- Monitor aged receivables to determine if your efforts are paying off
- Shoot for less than 12% of commercial accounts being over 90 days
 - Critical as some payers have very short filing limits
 - If your claim with wrong payer, you may lose filing time to get claim to correct payer
- Exclude credits when analyzing the amount of accounts receivables over 90 days

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What Impacts Days in A/R

- Should be in the range of 40 to 45 days
- Factors may cause it to fall outside this target
 - Difficult payers
 - Many claims which are tied up in lawsuit (MVA, worker's comp, etc.)
 - High volume of patients on payment plans
- Improve results through:
 - Robust time-of-service collections (air transports, non-emergency transports, wheelchair vans)
 - Insurance verification when service arranged (non-emergencies)
 - Get the bill to correct payer from the get-go

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Remember Impact of Payer

Consider insurance mix when looking at Days Receivable Outstanding

~30 days for Medicare is not optimal

Know your average Medicaid turnaround and monitor those accounts as well

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Good overall indicator of billing performance

Must be measured consistently in order to be meaningful

Working with Days in A/R

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What Impacts Days in A/R


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Credit Balance Mask

- Carrying credits masks true performance
 - May make things look better than they really are
- Tightly monitor credits
 - Compliance issue as well as financial issue
 - Medicare overpayments need to be reported promptly
 - Proposed rule could make the lack of reporting to Medicare an expensive issue for providers
- No matter who the payer, use the 60-day mark for getting credits processed back to the correct party



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Overall Claims Denial Rate

Total Claims Filed to a Payer

Total Denied Line Items

Track line items to ensure both mileage and level of service receive reimbursement

You may find one or the other get denied

Target <2%

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Claims Denial Rates

- Claims denials are not as well tracked in the ambulance industry as they are in other parts of healthcare
- It's useful to track three issues
 - Overall claims denial rate
 - Top denial reasons
 - Denials by payer

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Task Force Recommendations

- Patient friendly billing – clear, concise, correct
- Patient financial communications
 - Most communication about financial matters occurs post discharge or after service
 - But, policies that address financial matters PRIOR to service lead to less problems post service and improve collections – how to do?
- Patient education
- Shared responsibilities

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According to Task Force, “it is important for healthcare providers to assume responsibility for educating consumers early (prior to service and/or at the time of service where possible) in the account resolution process”

PATIENT EDUCATION???

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Accessible Payment Info

- Publish fees on your website
- Define a collections policy for patients
 - Website access to this information
 - Easy-to-understand handout for patients
 - Expectations
 - When an account becomes delinquent
 - Payment options
 - Clear and simple
- Electronic means of payment
 - Website payment
 - Paypal options
 - Available when the patient-payer is available

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Measure the Cash

- Measure collections on a weekly, if not daily, basis
- Although cash can't be benchmarked, you can ensure that its flow is the same as – or better than – the previous time period
- Cash may vary week to week (or day to day)
- Will increase or decrease as volume moves or seasonal issues impact your service



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Gross collection is misleading

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Net Collection Rate – Better Info

- Net collection looks at the cash that a provider is most likely to receive
- Net collection takes contractual allowance and credits into account
- Take payments less credits and divide by charges less contractual allowance and do this for the time period you want to monitor (best to tie payments to date of service and not to date of posting)
- Track this information for a year by using a rolling 12-month schedule.

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Net Collections Rate

Total Payments - Credits

Gross Charges – Writeoffs & Adjustments

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Enable yourself to be responsive - look at net collection for individual payers and look at it from an overall perspective

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Billing Metrics

Metric Name	Calculation	Best Practice	Potential Problem
Net Collections Rate	Total payments less Credits / (Gross charges – Writeoffs & Adjustments)	85% (E) 90% Plus (NE)	75-80%
Days in A/R Ratio	Total Accts Receivable / (Gross Charges – Writeoffs & Adjustments) times 30	40-45 days	65 days
A/R > 90+ Days	Total A/R > 90 Days / Total Accts Receivable	<12%	>20%
Claim Denial Rate	Total Claims Filed to a Payer / Total Denial Line Items	<2%	Depends on payer
Credits Processing		50-60 days	>60 days for Medicare 60-75 days other payers

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When to Panic




- Panic when you notice a significant drop in any of your baseline numbers or a dramatic change in cash flow
- Start investigating the various standards we've outlined
- Identify the problem
- Take corrective action
- Turn off the panic button

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Remember to measure the whole process and share performance and expectations with your teams



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Think About What You Will Need for the Future

- Communicate with your patient care reporting software vendor
 - What kind of documentation will be needed for upcoming services
 - Treat, no transport
 - Telehealth coordination
 - Transport to alternate destinations
- Billing systems and billing reports will be needed as well
- Keep your vendors informed and involved for what you will need

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We don't operate in a perfect world. Your "norm" may not be same as other services or billing companies.

Establish a baseline so you know where you want to go – and follow your process

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Based on what you do (all emergencies, high Medicaid population, etc.), you may underperform on these indicators. You can't change demographics or service you render.

But, having a "line in the sand" signals that you may need to dig deeper for opportunities to improve performance. This is information that could pay off.

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Keep the Goal in Mind

The goal of monitoring your key performance indicators – not to judge, but to improve...you have to start some place....start now so improvement can begin!

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Reimbursement tightens while fraud and abuse oversight continues

With oversight comes stronger enforcement

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Billing staff trying to navigate regulations



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Billers are NOT the red-headed step children of the company



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Needs of Billers


When met, performance improves

- Training
 - Alternate attendance at national conference, if possible
 - AAA
 - ABC
 - Routine attendance at state association events (understands local issues)
 - Online webinars
- Management support
 - Lighting
 - Office tools
 - Software
- Appropriate compensation

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The Cost of Compliance (without it, companies can be ruined) Billers help maintain compliance



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Emergency transports

Receive increasingly close scrutiny



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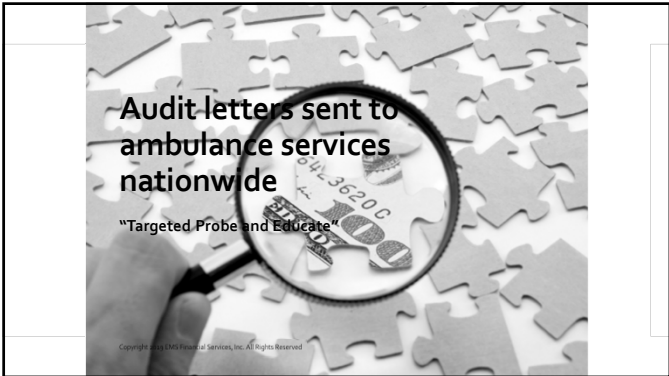
Medicare Improper Payments Report September 12, 2016

\$226 million in overpayments for ALS emergency services – CMS again repeated their concern November 2017. OIG Work Plans continue to note the issue

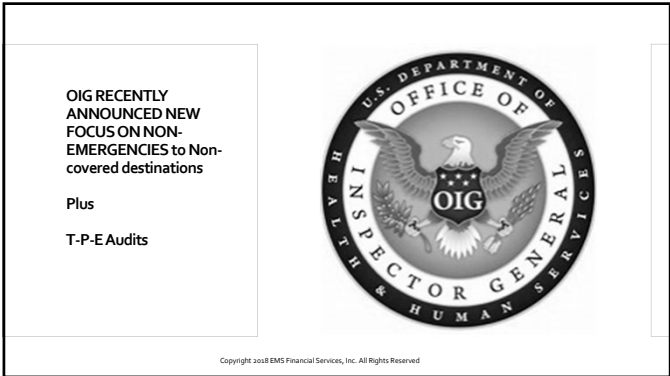


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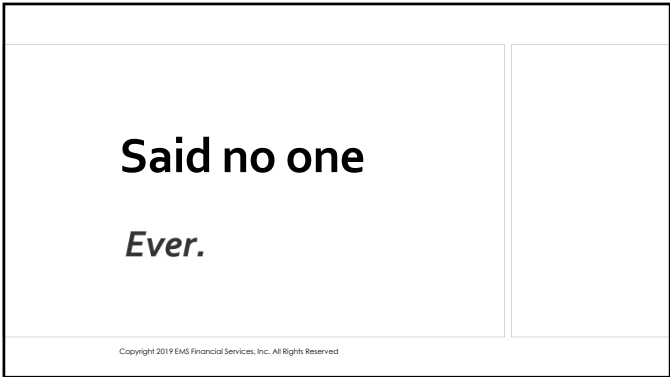
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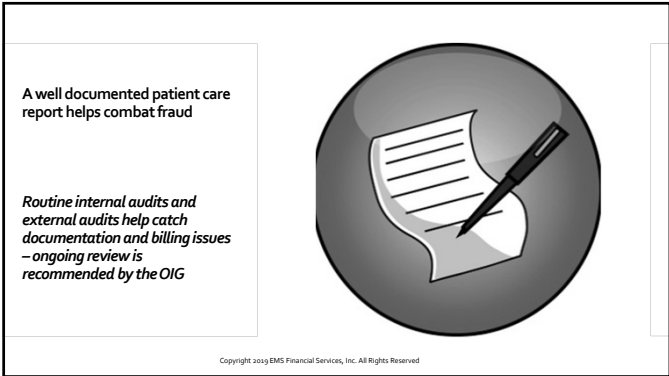
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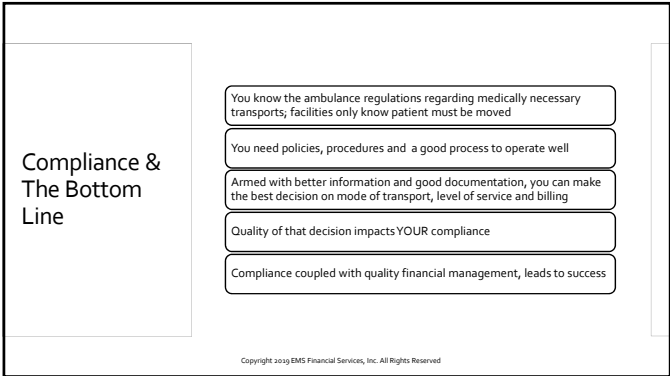
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Plan to address the cost of compliance along with overall financial management

Cost of field documentation training, billing training and routine audit review

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Thanks for listening!

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