

9 WAYS TO IMPROVE PROCESSES AND GENERATE MORE REVENUE

A Self-Assessment Guide

AIR MEDICAL
EMS
AMBULANCE



How to Use This Guide

Maximizing revenue is a big job for EMS services, whether air or ground, private or public, fire- or hospital-based. Often, the difference between an organization that's financially healthy and one that's in fiscal distress lies in how well it manages its processes and seeks continuous improvement.

This guide will help you assess how well your EMS organization manages the details necessary for maximum revenue recover. As you read each section, take a moment to assess how well your service measures up in each area. Your answers will form a profile showing areas where your service is doing well, as well as areas that need improvement most.



1. Culture

Optimal revenue recovery requires an organization-wide commitment to doing things right in order to optimize revenue recovery. Optimal revenue recovery depends upon the commitment of the entire organization from the caregivers to the CEO or chief. The entire team should recognize the value of the services that they provide and there should be an expectation of compensation for these valued services.

Key Questions:

Do all of your organization's members recognize how their actions, attitudes and performance impact revenue? Is billing something that all personnel feel responsible for, or is it something that's left solely to the billing department?

Needs Improvement	Average	Excellent
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

2. Documentation

Documentation training for caregivers is essential for maximum revenue recovery because without clear, precise and accurate clinical documentation and supporting information, reimbursement may be denied or delayed. The paramedics, EMTs and nurses who provide direct care to patients are the only ones who can effectively answer and document specific questions essential for reimbursement. But documentation from caregivers isn't the only information that needs to be supplied for proper claims processing: Information from the dispatch center is required to support ALS reimbursement when an ALS assessment is the only higher level care provided. Also, documentation of the source of the call (e.g., 9-1-1) and the immediate response of the unit are required to support filing of claims at the emergency level.

Key Questions:

How effective is your documentation training for caregivers? Does your service's clinical documentation routinely answer questions (Continued)

Needs Improvement	Average	Excellent
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>



(Continued from previous page) such as what specifically about the patient's medical condition required transport by ambulance, why the patient could not be transported by ground rather than air, or why a closer facility was unable to treat or accept the patient? When documentation is lacking, what processes does your service follow for improving documentation quality and completeness?

3. Reconciliation

Ensuring that documentation is present for all transports seems straightforward, but many services skip the critical step of matching dispatch records with call documentation. Every call that slips through the cracks can represent missed revenue. Even after claims and invoices are prepared, a prudent EMS organization will conduct a second reconciliation to be confident that no revenue opportunities are missed.

Key Questions:

How soon does your service reconcile dispatch records with call documentation?

Do you conduct a second reconciliation? When?

Needs Improvement	Average	Excellent
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

4. Compliance/Audit Avoidance

Everyone in your organization has a stake in being compliant with the myriad of rules and regulations that govern medical transportation reimbursement. It's just as important to recognize and identify patients who do not meet medical necessity requirements as it is to document patient conditions that do justify transport. Reimbursement should not be sought from payers when the patients do not meet medical necessity requirements. (Continued on next page)



(Continued from previous page) Likewise, reimbursement for mileage beyond the closest appropriate facility should not be requested.

Government and commercial payers also have coverage requirements. For example, Medicare does not cover a patient transport to a physician's office, but many Medicaid programs do. On the other hand, government payers and most commercial insurance companies do not cover air medical transport to move a patient closer to home or to their primary physicians.

Key Questions:

What kind of compliance training does your organization conduct? How confident are you in your knowledge of Medicare, Medicaid and commercial payer coverage requirements?

Needs Improvement	Average	Excellent
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

5. Proper Coding

For ground ambulance services, proper use of codes determines reimbursement amounts. When the criteria are met for emergency classifications and ALS, reimbursement amounts are higher. Because patient conditions or diagnoses are also coded, it's essential to select the specific patient condition/diagnosis that justifies the use of an ambulance on the date and time of service. For example, a patient is being dismissed from a hospital after being treated an acute myocardial infarction. Using the code for a M.I. is not appropriate. Most patients being dismissed from hospitals after a heart attack do not require an ambulance. Again, the coder must identify the patient's specific conditions that support the use of an ambulance. If the documentation does not support ambulance use, the transport should not be submitted for reimbursement.

Key Questions:

Do your coders use optimal and appropriate (Continued on next page)

Needs Improvement	Average	Excellent
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>



(Continued from previous page) codes on every claim for reimbursement?
How fully do your coders understand the definitions of different levels of transport to ensure that the right codes are used?

6. Timeliness & Follow-up

Prompt processing of accounts improves the organization's collection performance and cash flow, so every step of your billing and collection process should be as efficient and timely as possible. That means closely tracking and monitoring the length of each step in the process and seeking improvement at every opportunity. Timelines differ from one organization to the next, but as a rule of thumb, claims and invoices should be out the door within three business days of the date of service. The most efficient organizations have same-day or next-day claims filing and invoice generation.

Each payer pays claims within different timeframes, and your service's follow-up activities should be scheduled to coincide with them. For example, if a specific transport has not been paid within 5 days of its expected payment date, a follow-up call should be made to the payer.

Key Questions:

How do you measure your service's performance at each step of your billing and collection process? How effectively do you schedule follow-up activities with individual payers? How does your organization track inactive accounts to ensure positive collection performance?

Needs Improvement	Average	Excellent
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>



7. Technology

EMS services today have access to a wide array of tools to help them be more productive and efficient, allowing them to focus on follow-up activities. Used properly, technology can greatly enhance a service's billing and collection performance. Some examples include:

- Electronic patient care reports. Caregivers enter information into handhelds, laptops or on forms that are electronically scanned. This information is then electronically downloaded into the billing system eliminating much of the data entry requirements.
- Web-based search programs, which allow account representatives to search for people, missing addresses, phone numbers, and insurance coverage.
- Sophisticated billing software to receive data, manage accounts, and transmit files.
- Electronic claims submission. Most payers allow or even require claims to be submitted electronically. This process facilitates a quick turnaround and payment.
- Address verification. Access to address verification services allows patient addresses to be confirmed prior to sending invoices, providing early recognition of bad addresses and reducing the amount of returned mail.
- Electronic remittance and payment posting. Medicare carriers can return payments electronically to the bank and provide for automatic payment posting to accounts in many of the billing software programs.

Needs Improvement Average Excellent

Key Question:

How effectively does your service employ technology to increase billing and collection efficiency and effectiveness?



8. Competence

Tools, technology, systems, and procedures are useless without competent personnel. Everyone on your team must understand the rules, regulations, and requirements of the various payers. To function as strong and competent team members, they must be able to effectively use the system and tools you provide for them. Many organizations find that competence goes hand-in-hand with high levels of energy, loyalty, and compassion, and they seek to build teams of people who exude these qualities. The results can often be measured in improved performance, fewer patient complaints and a healthier organizational bottom line.

Key Questions:

How does your organization achieve high performance in its billing department? How do you select and retain highly competent staff members? How is the value that your billing team members bring to the organization communicated to top management, and back to the employees?

Needs Improvement	Average	Excellent
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

9. Customer Service

Every aspect of the organization must focus on customer service. This is critical to achieve the best possible collection results. As most people know from personal experience, satisfied customers are more willing to pay for the services that they received than dissatisfied clients.

There are multiple opportunities for a medical transportation organization to create negative or positive relationships with customers. Call-taking, dispatch, caregivers, complaint receivers, and patient account personnel all present the opportunity to provide the customer with a positive experience with the organization, thereby enhancing customer willingness to pay for the services.

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(Continued from previous page) Customers are not confined to the patients being transported, but include family members, facility personnel, and payer representatives.

Key Questions:

Do your patient account representatives continually strive to build positive relationships with patients, caregivers, and payers? What does your service do to create an across-the-board attitude toward creating excellent customer service at every opportunity? Does top management recognize the impact of customer service on the bottom line?

Needs Improvement	Average	Excellent
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Analyzing Your Results

Look back at the answers you provided. What patterns emerge? As a suggested next step, try choosing key statistical indicators to monitor, if you aren't already, and adjust actions or procedures to improve results. Comparing your organization's practices with those of similar services can also provide a wealth of information and ideas. And remember, as with any EMS activity, high performance in billing and collections is not a given: Your organization must define it, strive for it, monitor it, and use the results to make continuous performance improvements.

Want to Know More?

MedServ is here to help — we know medical transportation billing like nobody else. Call us at 816-431-5791 for a free 10-minute analysis.

