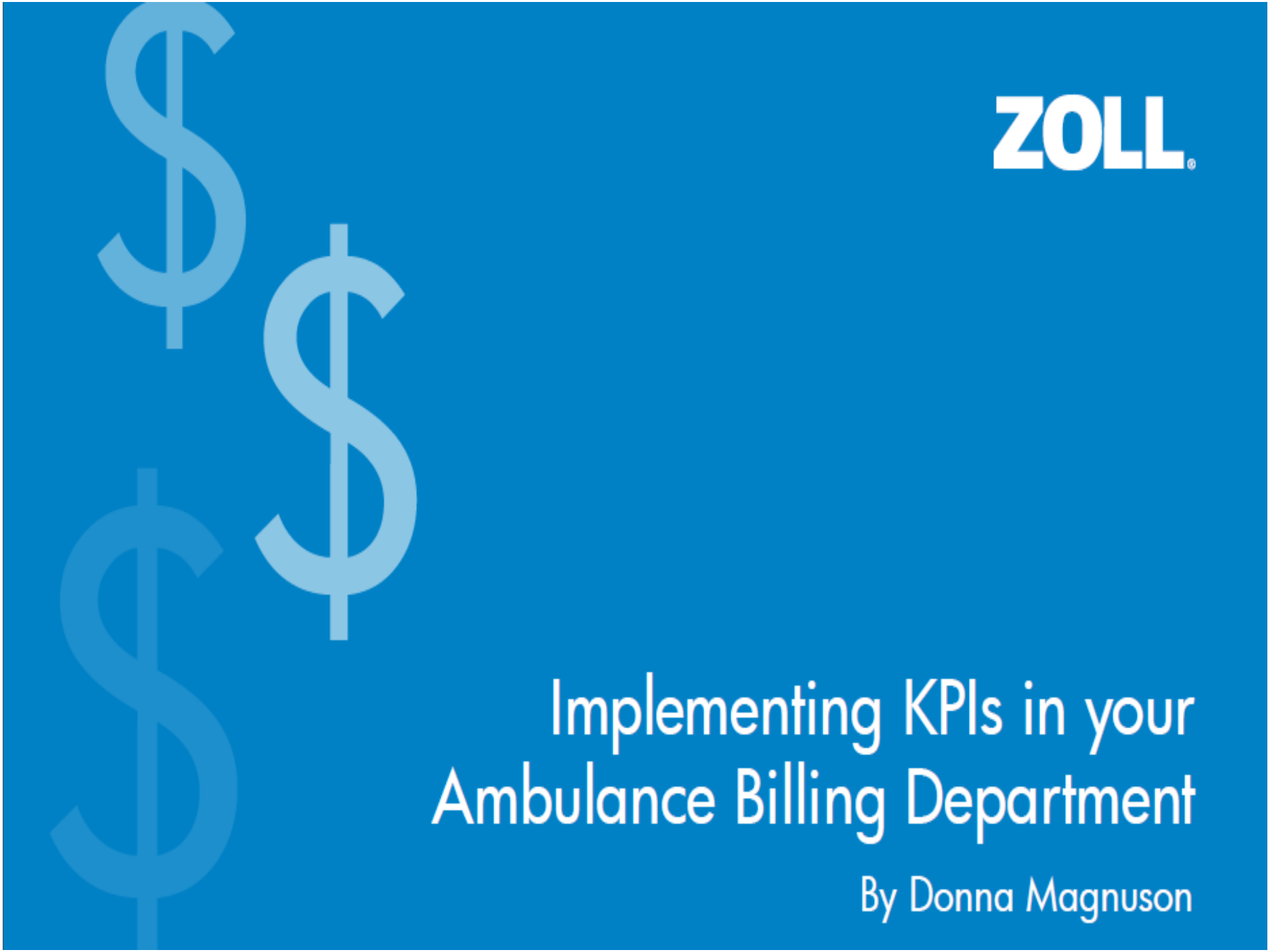
ZOLL
Implementing KPIs in your Ambulance Billing Department
By Donna Magnuson

What are KPIs?

- Quantifiable measurements to evaluate performance and efficiency
- Help managers understand how well the revenue cycle is being managed
- Tell you what to improve within the revenue cycle

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Agenda

- Billing Lag
- Trip Volume and Staffing
- Pre-bill/Coder Productivity
- Payor Mix
- AR > 90 Days
- Collection Productivity
- Denials

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KPIs

The following KPI recommendations will help you to get started.

You will develop specific and more sophisticated KPI measurements for your organization once more knowledge is gained.

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Billing Lag

- The average number of days to bill a claim
- Evaluates department's effectiveness
  - ✓ Reconciling dispatched trips
  - ✓ Tracking/Resolving problem trips
  - ✓ Staff productivity
  - ✓ Process efficiency

KPI – Billing Lag 1 to 2 days

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Billing Lag

Calculation (Trips to bill/Avg Trips/day)

- Total outstanding trips to bill
  - ✓ Reports>Billing>Trends>Trip Count/Amount by Schedule/Event
    - Don't filter the date
    - Status = Complete
    - Exclude Credit Balance/Refund schedule
    - Use the grand total

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Billing Lag

Calculation (Trips to bill/Avg Trips/day)

- Average Transport per day
  - ✓ Reports>General>Trip related>Counts>Trip Count of Call Type by Month
    - Use the most recent completed month (i.e. Feb -13)
    - Status = Billed, Closed, Complete, Verified
    - Divide by number work days for the month

Call Type	Jan-12	Feb-12	Mar-12	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12	Jan-13	Feb-13
BLS	2,545	2,552	2,829	2,769	2,731	2,654	2,705	2,813	2,537	2,526	2,500	2,479	2,618	2,458
Gurney	74	99	124	114	154	233	198	185	3	77	140	237	283	250
SCT	253	271	192	186	204	160	149	133	156	176	166	149	210	239
Total	2,872	2,922	3,145	3,069	3,089	3,047	3,052	3,131	2,696	2,779	2,806	2,865	3,111	2,947
Work Days	22	21	22	21	23	21	21	23	20	23	22	20	23	20
Avg/ Work Day	**131**	**139**	**143**	**146**	**134**	**145**	**145**	**136**	**135**	**121**	**128**	**143**	**135**	**147**

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Billing Lag

Example 1 (Trips to bill/Avg trips/day)

- Total trips to bill = 1,039
  - ✓ None = 114
  - ✓ Missing Information = 809
- Average trips/day = 147
- 1039 / 147 = 7 days billing lag

Trips at Sched Event Ex1.rtf - Shortcut.lnk (Command Line)

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Billing Lag

Example 2 (Trips to bill/Avg trips/day)

- Total trips to bill = 1,194
  - ✓ None = 1,179
- Average trips/day = 170
- 1194 / 170 = 7 days billing lag

Trips at Sched Event Ex2.rtf - Shortcut.lnk (Command Line)

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Billing Lag

Example 3 (Trips to bill/Avg trips/day)

- Total trips to bill = 596
  - ✓ None = 311
  - ✓ Missing = 102
- Average trips/day = 43
- 596 / 43 = 13 days billing lag

Trips at Sched Event Ex3.rtf - Shortcut.lnk

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Trip Volume and Staffing

- Objective approach to staffing a billing department
- Ongoing evaluation of trip volume provides trigger to increase staffing

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Trip Volume and Staffing

KPI – Recommended Staffing Ratio		
Type of Transport	Transports/FTE*/Year	
	Lower Range	Upper Range
Wheelchair	9,000	12,000
Emergency	4,500	5,500
Non-Emergency	4,000	5,000

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Trip Volume and Staffing

Calculation

- Total transports per rolling year
  - ✓ Reports>General>Trip Related>Counts>Trip Count of Call Type by Month
    - ❖ Date = year from last full month i.e. Apr2012-May2013
- Staffing Ratios
  - ✓ Use applicable ratio for type of business; non-emergency, emergency, etc.

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Trip Volume and Staffing

Example 1 - Volume is Consistent

- Total transports 1 year = 35,473
  - ✓ BLS Non-emergency 33,278 (Ratio 4,500)
  - ✓ Emergency 2,195 (Ratio 5,500)
- Staffing Non-emergency 35,473/4500= 8
- Staffing Emergency 2,195/5500= .5

Total Staff 8.5

Trip vol staffing example1.xls - Shortcut.lnk

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Trip Volume and Staffing

Example 2 - Volume is Inconsistent

- Total transports 1 year = 9,577 (last full mo) * 12 = 114,924 projected transports per year
  - ✓ BLS Non-emergency
  - ✓ Non-emergency ration 5,000/FTE
- Staffing Non-emergency 114,924/5000= 25.5

Total Staff 25.5

Trip vol staffing example2.xls - Shortcut.lnk

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Pre-biller / Coder Productivity

- Drives consistent billing
- Establishes staffing ratios
- Drives efficient staffing
- Great feedback to staff

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Pre-biller / Coder Productivity

Productivity Guidelines

Role	Prod / Day	Comment
Pre-Biller	50-70 / Day 6-9 / Hour	A pre-biller is typically responsible for verifying demographic and insurance information. Assuring that complete information is received
Coder	80-120 Day 10-15 / Hour	The coder is typically responsible for applying the ICD-0 code, completing the billing narrative, completing the ambulance certification requirements, verifying the level of service and modifiers, and verifying patient signatures requirements are met.
Biller	30-65 / Day 4-8 / Hour	This role fulfills both pre-billing and coding functions. There is a lot of information this role needs to check and confirm therefore, the productivity is typically lower to allow for accuracy and thoroughness

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Pre-biller / Coder Productivity

Reports

- Reports>Billing>Trends>Trips Verified by Biller by Day
- Reports>Billing>Collection>Notes Activity Report
- Custom
  - ✓ Verified by day
  - ✓ Pre-Billed by Day
    - Requires Pre-billed indicator to be turned on. Administration>Advanced>System Information> Billing>Use Pre-bill confirmation

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Trip Volume and Staffing

Example 1 – Pre-bill

- Look for consistency
- Is staff meeting goal?
- Does the total Pre-billed each day meet or exceed average daily trip volume?

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Pre-bill Productivity

170 transports per day
Pre-bill goal 50/day
Pre-bill staffing 170/50 = 3.5

50	6/1 Wed	6/2 Thu	6/3 Fri	6/6 Mon	6/7 Tue	6/8 Wed	6/9 Thu	6/10 Fri	6/13 Mon	6/14 Tue	6/15 Wed	6/16 Thu	6/17 Fri
A	60	39	51	0	18	49	33	34	1	33	37	42	10
B	74	51	2	0	74	79	30	56	0	62	36	65	33
C	37	1	2	0	0	0	0	8	8	28	52	11	58
D	69	84	71	1	60	49	52	47	20	57	29	79	26
Total	**246**	**182**	**147**	**1**	**152**	**177**	**115**	**145**	**29**	**180**	**154**	**197**	**127**

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Coder Productivity

170 transports per day
Coder goal 80/day
Pre-bill staffing 170/80 = 2.1

80	6/1 Wed	6/2 Thu	6/3 Fri	6/6 Mon	6/7 Tue	6/8 Wed	6/9 Thu	6/10 Fri	6/13 Mon	6/14 Tue	6/15 Wed	6/16 Thu	6/17 Fri
A	86	77	75	73	82	86	77	0	67	80	85	81	78
B	23	15	0	0	25	15	22	67	0	15	18	22	0
C	77	81	82	82	75	73	82	80	78	81	82	69	75
Total	**186**	**173**	**157**	**155**	**182**	**174**	**181**	**147**	**145**	**176**	**185**	**172**	**153**

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Payor Mix

- Distribution of trips across payor classes
- Can be impacted by front-end processes
- If consistent, is a good tool for forecasting revenue

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Payor Mix

Reports

- Reports>Billing>Trends>Trip Count by Primary Payor Type
- Reports>Billing>Trends>Trip Count by Primary Payor Category
- Custom>Payor Mix
  - ✓ Status=Billed, Closed, Complete, Verified
  - ✓ Year from last full month

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Payor Mix

Example 1 – Initiated Insurance verification May 2012

Payer Type	1/2012	2/2012	3/2012	4/2012	5/2012	6/2012	7/2012	8/2012	9/2012	10/2012	11/2012	12/2012	1/2013	2/2013	Total
Medicare	1,131	940	992	1,185	1,399	1,459	1,565	1,678	1,443	1,442	1,301	1,295	1,370	1,396	18,596
Insurance	1,309	1,267	1,506	1,455	1,314	1,181	1,137	1,125	1,092	1,093	1,217	1,213	1,351	1,129	17,389
Medicaid	199	195	207	223	279	256	239	247	234	222	217	175	130	175	2,998
Bill Patient	156	424	388	178	26	22	34	23	35	53	35	42	40	42	1,498
None	2	2	1	2	1	1	4	2	4	5	1	6	3	24	58
Private Pay	1	0	0	3	1	3	3	2	1	1	0	0	2	2	19
Contract	0	0	0	0	0	0	0	1	0	0	0	0	2	0	3
Total	2,798	2,828	3,094	3,046	3,020	2,922	2,982	3,078	2,809	2,816	2,771	2,731	2,898	2,768	40,561

Payer Type	1/2012	2/2012	3/2012	4/2012	5/2012	6/2012	7/2012	8/2012	9/2012	10/2012	11/2012	12/2012	1/2013	2/2013	Total
Medicare	40%	33%	32%	39%	46%	50%	52%	55%	51%	51%	47%	47%	47%	50%	46%
Insurance	47%	45%	49%	48%	44%	40%	38%	37%	39%	39%	44%	44%	47%	41%	43%
Medicaid	7%	7%	7%	7%	9%	9%	8%	8%	8%	8%	8%	6%	4%	6%	7%
Bill Patient	6%	15%	13%	6%	1%	1%	1%	1%	1%	2%	1%	2%	1%	2%	4%
None	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	1%	0%
Private Pay	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
Contract	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%

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Payor Mix

Example 2 –Payer Mix

Payer Type	1/2012	2/2012	3/2012	4/2012	5/2012	6/2012	7/2012	8/2012	9/2012	10/2012	11/2012	12/2012	Total
None	7	9	7	14	8	4	5	3	6	7	26	139	235
Bill Patient	44	34	35	23	24	25	37	71	42	104	63	48	550
Contract	828	777	795	649	748	719	644	709	642	724	684	525	8,444
Insurance	1,344	1,132	1,294	1,155	1,251	1,021	992	1,089	1,026	1,196	1,137	1,159	13,796
Medicaid	111	144	114	126	115	132	141	145	159	132	103	95	1,517
Medicare	1,842	1,732	1,655	1,678	1,573	1,391	1,429	1,587	1,397	1,622	1,573	1,604	19,083
Total	4,176	3,828	3,900	3,645	3,719	3,292	3,248	3,604	3,272	3,785	3,586	3,570	43,625

Payer Type	1/2012	2/2012	3/2012	4/2012	5/2012	6/2012	7/2012	8/2012	9/2012	10/2012	11/2012	12/2012	Total
None	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	1%	4%	1%
Bill Patient	1%	1%	1%	1%	1%	1%	1%	2%	1%	3%	2%	1%	1%
Contract	20%	20%	20%	18%	20%	22%	20%	20%	20%	19%	19%	15%	19%
Insurance	32%	30%	33%	32%	34%	31%	31%	30%	31%	32%	32%	32%	32%
Medicaid	3%	4%	3%	3%	3%	4%	4%	4%	5%	3%	3%	3%	3%
Medicare	44%	45%	42%	46%	42%	42%	44%	44%	43%	43%	44%	45%	44%

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AR > 90 Days

- Majority of accounts receivable should be resolved in 90 days
- Impacted by;
  - ✓ High billing lag days
  - ✓ Poor front-end processes
  - ✓ Untimely follow-up of denied or un-adjudicated claims
  - ✓ Lack of productivity guidelines

KPI – AR > 90 days is 18%-25%

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AR Days > 90

Example 1

Aging by Payer Type	Current	31-60	61-90	91-120	121-180	181+	Total	> 90 days	%>90
Bill Patient	53,730	74,350	130,526	83,545	160,993	112,365	616,933	356,903	58%
Facility Contract	0	4,345	0	0	0	446	4,791	446	9%
Insurance	1,310,411	1,335,677	826,833	551,166	714,810	1,525,355	6,202,467	2,791,331	45%
Medicaid	40,839	114,599	35,549	18,257	38,054	22,027	262,523	78,338	30%
Medicare	530,482	142,809	32,543	5,456	22,193	5,826	732,415	33,475	5%
Private Pay	100	2,558	225	0	0	9,254	12,137	9,254	76%
Grand Total Count of I	1,935,562	1,674,340	1,025,677	658,425	936,050	1,675,222	7,831,216	3,269,697	42%

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AR Days > 90

Example 2

Payer Type	0 - 30	31 - 60	61 - 90	91 - 120	121 - 180	Over 180	Tot Bal	Amt >90	%>90
None	0.00	329.25	0.00	72.03	0.00	1,082.10	1,483.38	1,154.13	78%
Bill Patient	83,241.07	222,549.65	309,253.05	458,294.45	625,678.05	1,105,114.13	2,804,130.40	2,189,086.63	78%
Contract	23,291.00	190,365.78	203,007.19	182,092.70	311,485.53	322,484.33	1,232,726.53	816,062.56	66%
Insurance	511,691.76	668,951.25	396,495.80	254,143.51	313,014.01	392,006.66	2,536,302.99	959,164.18	38%
Medicaid	143,429.09	370,996.04	327,180.20	230,939.88	259,252.22	733,910.67	2,065,708.10	1,224,102.77	59%
Medicare	640,969.50	871,362.00	330,331.53	98,267.78	197,205.14	188,675.60	2,326,811.55	484,148.52	21%
Grand Total	$1,402,622.42	$2,324,553.97	$1,566,267.77	$1,223,810.35	$1,706,634.95	$2,743,273.49	$10,967,162.95	$5,673,718.79	52%

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AR Days > 90

Example 3

Payor Type	0 - 30	31 - 60	61 - 90	91 - 120	121 - 180	Over 180	Tot Bal	Amt >90	%>90
Bill Patient	252,897.43	322,491.65	233,177.11	93,272.77	68,849.97	58,705.56	1,029,394.49	220,828.30	**21.5%**
Medicaid	18,195.61	9,188.93	5,126.32	1,799.10	3,718.47	3,130.53	41,158.96	8,648.10	**21.0%**
Insurance	417,094.57	157,772.17	53,511.73	21,163.16	9,658.12	8,385.64	667,585.39	39,206.92	**5.9%**
Contract	9,768.42	1,138.88	0.00	0.00	0.00	422.91	11,330.21	422.91	**3.7%**
Medicare	517,274.38	142,404.37	8,478.25	10,371.80	7,280.97	7,764.63	693,574.40	25,417.40	**3.7%**
Grand Total	**$1,215,230.41**	**$632,996.00**	**$300,293.41**	**$126,606.83**	**$89,507.53**	**$78,409.27**	**$2,443,043.45**	**$294,523.63**	**12.1%**

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Follow-up/Collection Productivity

- Difficult to measure effectiveness
- Recommendations are just a starting point
- Look for consistency
  - ✓ Meeting productivity standard
  - ✓ Follow-up bandwidth with incoming phone calls
  - ✓ Do you have more calls that require follow-up than staff?
  - ✓ Are there front-end processes that is creating back-end work?

KPI – Productivity 50-65 trips / day

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Follow-up/Collection Productivity

- Reports>Billing>Collections>Note Activity Report
  - ✓ Specify Note Date
  - ✓ Shows detail so limit date range
- Custom>Notes by User and Type
  - ✓ Specify Note Date
  - ✓ Trends by day
- Custom>Credits by Payor Type
  - ✓ Specify Deposit Date Range
  - ✓ Select only payment credits

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Follow-up/Collection Productivity

Example – Note Productivity

Are incoming phone calls impacting the ability to do effective follow-up?

User 1	10/11	10/12	10/13	10/14	10/15	10/16	10/17	10/18	10/19	10/20	10/21	10/22
Incoming Phone	13	7	15	4	5	5	38	6	4	8	32	27
Follow-up	15	11	18	12	11	8	2	11	9	14	8	11
Denial	0	0	0	0	0	0	0	0	0	0	0	0
Total	**28**	**18**	**33**	**16**	**16**	**13**	**40**	**17**	**13**	**22**	**40**	**38**

Note types can help to define where effort is spent

Is the staff consistent?

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Follow-up/Collection Productivity

Note Activity Report

AAA AMB CO

Notes Entered By BTERRILL

Run #	Customer Name	Trip Date	Schedule	Event	Payor	Balance
0	HALEMAN, JOHN	01/08/13	Bill Patient	No Bill Sent	Bill Patient	700.00
01/08/13 16:31 Billing	check with dispatch on this trip					
3	NOVATO, PATIENT	01/01/10	1 new	missing ins info	Novato Payor	700.00
05/17/13 07:58 Billing	no sigs -					
06/25/13 16:16 Billing	send missing sig letter now					
06/25/13 16:11 Billing	Called Medicare, they said this would need to be appealed.					
11	GERLAND, MIKE	02/02/13	Bill Patient	No Bill Sent	Bill Patient	700.00
06/25/13 16:09 Billing	Called Ins - they did not receive claim - set to resubmit					
16	TESLEY, GUY	03/01/13	Missing Paperwork	missing PCR	Bill Patient	690.00
03/14/13 14:58 Billing	CAlled insurance, no coverage for this time period - bill patient					
17	SAMSON, SAM	03/06/13	Zirmed electronic	No Bill Sent	Sentry Insurance	970.20
06/25/13 16:13 Billing	Patient does not have ambulance coverage on his medical ins					
19	JACKSON, ADOLPH	03/01/13	Zirmed 5010	No Bill Sent	Westminster Blue Cr	355.50
06/25/13 16:10 Billing	Called patient - he will call with updated information by 6/28/2013					
61	SMITH, VIRGINIA	02/02/09	Bill Patient	No Bill Sent	Bill Patient	672.25
01/23/13 16:24 Billing	Check on secondary insurance					
100	WATSON, SARAH	06/01/12	999 Schedule	missing signature	AAA Nursing Home	700.00
06/24/13 15:54 Billing	Call NH to see if they are covering charges on this transport.					
143	SMITH, VIRGINIA	02/12/12	Missing Paperwork	missing PCR	Bill Patient	700.00
01/22/13 15:23 Billing	Call daughter to see if she is paying - this is not a Medicare covered trip.					

Totals Notes for BTERRILL: 11 **Dollars** **$6,187.95**

Total Notes for AAA AMB CO: 11 **Total Dollars** **6,187.95**

Follow-up/Collection Productivity

Example – Payments by Payer Type

Payor Type	6/2012	7/2012	8/2012	9/2012	10/2012	11/2012	12/2012	1/2013	2/2013	3/2013	4/2013	5/2013	% 6/2012	% 5/2013
Medicare	1,031,572	4,111,330	1,916,083	1,105,770	1,790,700	1,933,309	1,183,006	1,245,105	934,795	1,416,171	1,671,010	1,687,505	53%	52%
Insurance	498,470	974,776	939,194	700,883	1,053,095	826,859	636,461	732,572	689,252	743,158	710,165	803,693	26%	25%
Contract	197,530	420,500	317,941	126,238	274,993	221,989	187,776	327,068	221,954	310,709	184,665	375,824	10%	12%
Medicaid	108,171	304,722	294,734	201,186	258,934	295,918	222,819	300,852	207,469	221,594	256,912	256,654	6%	8%
Bill Patient	98,542	153,242	154,139	94,016	163,333	130,848	116,767	150,354	123,724	135,397	148,606	133,177	5%	4%
Total	**1,934,286**	**5,964,570**	**3,622,092**	**2,228,093**	**3,541,054**	**3,408,922**	**2,346,829**	**2,755,950**	**2,177,194**	**2,827,029**	**2,971,358**	**3,256,853**		

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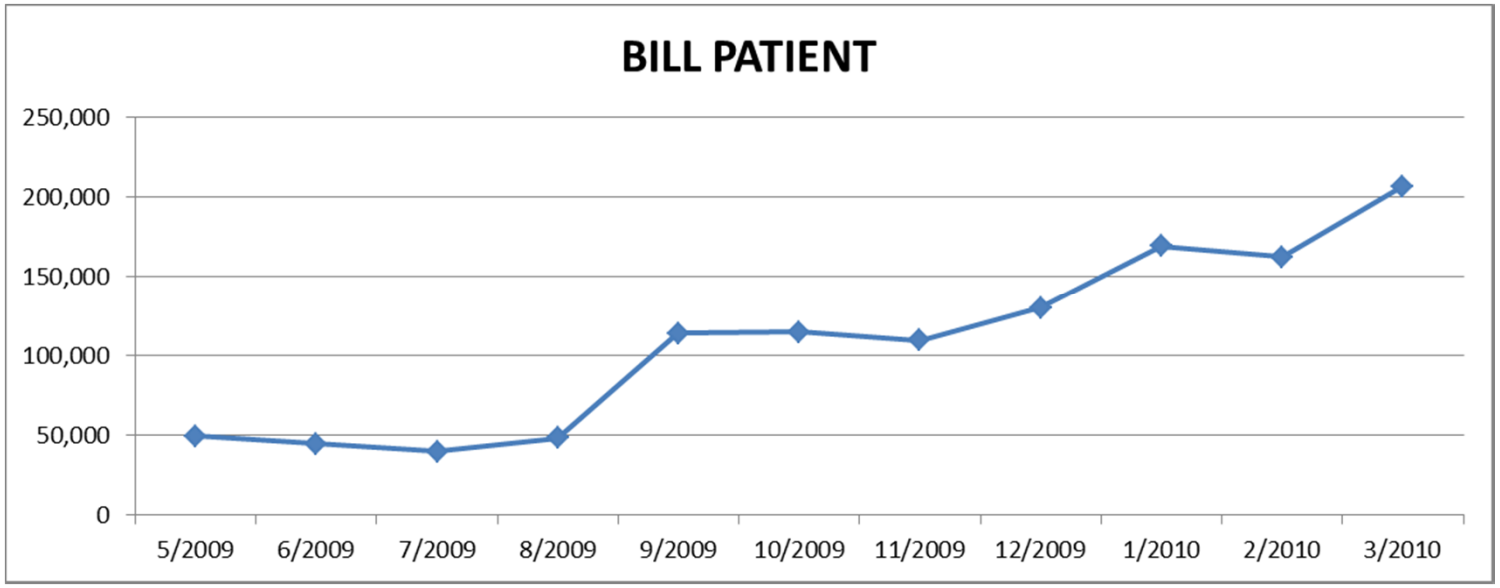
Follow-up/Collection Productivity

Example – Payments by Payer Type

Payments	5/2009	6/2009	7/2009	8/2009	9/2009	10/2009	11/2009	12/2009	1/2010	2/2010	3/2010
BILL PATIENT	49,706	44,646	40,046	48,286	114,285	114,898	109,703	130,068	169,212	162,605	206,700



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Denials

- Denials are valuable
- Tell you why you aren't getting paid
- Can alert of potential audits
- Can indicate front-end processes

Post all Denials into your System!

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Denials

- Reports>Billing>Trends>Denial Code and Reason Trended by month
  - ✓ Specify deposit date range
- Reports>Billing>Collections>Denial Reason Detail by Payor
- Reports>Billing>Collections>Trip Denials by Denial Reason and Biller
- Custom>Forms Activity by Month
  - ✓ Specify form processed date range

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Denials

Example – Denials trended by month

	Jan-13	Feb-13	Mar-13	Apr-13	May-13	Total
Non-covered charge(s). This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	106	110	148	133	135	987
Services not covered because the patient is enrolled in a Hospice.	13	42	60	62	72	432
Duplicate claim/service.	123	231	82	118	53	778
Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code).	25	35	35	48	40	390
This type of service, equipment, or supply is not covered under the plan.	24	20	28	69	36	316
Claim currently in process	132	110	130	144	132	816
Duplicate claim/service	0	13	1	8	23	164
Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided.	7	6	8	3	17	107
Payment adjusted because this care may be covered by another payer per coordination of benefits.	4	38	15	32	44	191

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Denials

Example – Denials trended by month

	Feb-13	Mar-13
Non-covered charge(s). This change to be effective 4/1/2007: At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	587	1,096
Payment adjusted because this care may be covered by another payer per coordination of benefits.	50	299
Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate. This change to be effective 4/1/2007: At least one Remark Code must be provided.	8	173
Duplicate claim/service.	36	129
Services not covered because the patient is enrolled in a Hospice.	53	105
Patient/Insured health identification number and name do not match.	94	102
Claim/service not covered/reduced because alternative services were available, and should have been utilized.	14	71
Payment adjusted due to the impact of prior payer(s) adjudication including payments and/or adjustments	3	57
Not covered unless the provider accepts assignment.	99	44
Payment for charges adjusted. Charges are covered under a capitation agreement/managed care plan.	16	33
Expenses incurred prior to coverage.	5	21
Expenses incurred after coverage terminated.	10	16

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Denials

Example – Denial Percentage

Total	1,058	2,225
Denials minus the PR96-Non Covered Charges	471	1,129
Total Insurance Forms	10,379	12,347
Denial percentage including PR96	10%	18%
Denial percentage excluding PR96	5%	9%

KPI – Denials 3%-5% of claim submission

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Conclusion

- Direct correlation of implementing KPIs and efficient and effective billing.
- Implementing these guidelines will allow you to be equipped to develop your own KPIs.
- If you don’t know where to start, just start. The pieces will start to fall into place.

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Conclusion

- Copy of presentation
- Copy of KPI Whitepaper
- Custom Reports – available to RescueNet Dispatch Billing customers

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