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# Implementing KPIs in your Ambulance Billing Department

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Whitepaper

# Implementing KPIs in your Ambulance Billing Department

Key Performance Indicators (KPIs) are quantifiable measurements that a company uses to evaluate organization performance and efficiency. They are measurable, objective, and actionable. KPIs are powerful because they tell you what to improve within your processes. Measuring can positively impact billing processes and productivity. Additionally, KPIs initiate triggers for change in areas that an agency may not realize require re-evaluation. This document will offer recommendations for KPIs to implement within an Ambulance Billing Department. During the implementation of the KPIs you will develop tools to determine your own KPIs and make positive impact to the billing department.

One of the challenges to implementing KPIs is determining where to start and knowing which specific KPI measurements fit best within the billing department. If you don't know where to start, the best recommendation is to just start measuring. The details and the specific KPI measurements will begin to fit into place once you gain more knowledge.

Front-end, meaning prior to claim transmission, and back-end, defined as post claim transmission, measurements will be addressed within the article. As author, I have taken the liberty to include some industry metrics that I feel are relative during the course of my 20+ year career in medical billing. They are provided below in some of the examples. However, once initiating the measurement process for KPIs, I feel confident you will gain information to modify the KPI ranges specific to your organization.

## Front-End Measurements

KPI's for front-end processes are:

- Billing Lag
- Trip Volume
- Pre-biller and Coder Productivity
- Payor Mix

### Billing Lag

Billing Lag measures the average number of days it takes to bill a claim. This measurement takes into consideration the department's effectiveness in reconciling dispatched trips, tracking and resolving problem trips, staff productivity, and process efficiency. I often find reconciliation of unbilled and problem trips are not managed well within an organization resulting in lost revenue. The billing department may be two days behind in processing run-reports but the system may show a much larger number. A larger organization, with numerous stations, and not utilizing an electronic patient care record (ePCR) system, may take 1-2 days to actually receive the paper charts extending the lag time to 3-4 days. Regardless, establish a baseline that allows for the timeliest billing. The two key criteria needed are the average numbers of "billable trips per day" and the "total number of trips to be billed".

The following calculation assumes that Dispatch and Billing are either integrated or an interface exists between them. The reports listed in the document are found in the Professional Reporting package of RescueNet Reporting. If you don't have the Professional Reporting package, contact your local ZOLL sales representative.

## Data and Calculation

1. Determine the total number of trips to be billed. In ZOLL RescueNet Billing, the data includes trips at a "complete" status from the date of billing go-live date to current. The report, Reports>Billing>Trends>Trip Count/Amount by Schedule/Event can be used. Don't filter by date and only select the status of Complete.

2. Determine the average number of transports per day. Run a report that shows the total number of billable transports for the previous full month. The report, Reports>General>Trip related>Counts> Trip Count of Call Type by Month or Trip Count by Date/Call Type can be used. Be sure to include the billing statuses of; billed, closed, complete, and verified and only include the previous full month. Divide the total number of transports into the number of working days for the month.

3. Divide the average number of transports per day into the total number of outstanding trips to be billed.

EXAMPLE

### Calculating the average transports per day

Billable transports for Nov 2012 = 6,500
Working days* Nov 2012=22
Average (Avg) transports per day 6,500 / 22 = 295

*Working days are recommended instead of calendar because the billing staff has to fit 7 days of transports into a 5-day work week.

### Calculating the billing lag

Total number of transports to bill = 2,280
Previous months Avg transports per day = 22
Billing Lag = 11,280/22 = 7.7

KPI for Billing Lag =1 to 2 days

## Analyzing Your Data:

If the billing lag is greater than 1-2 days, determine the reason. Are the trips not billed due to staffing or productivity? Is there a lack of reconciliation processes leaving a large amount of unaccounted for trips? Is there a large amount of missing information which holds up the billing for several days? It could be logistical that it takes 3-4 days for the patient care reports to be received. However, determining the reason will improve process in billing and operations. Comparing the average daily trip volume (based on a 5-day work week) against the pre-billing and coding productivity will help to

determine if a lag is due to staffing. If the daily average volume is more than the total productivity expectation for either group, overtime or additional staff needs to be considered.

Keeping the lag to 1 to 2 days allows the billing office to quickly determine what may be missing and for operations to quickly respond. If a trip is found to be missing a run report 8 days after the transport, the likelihood of getting or recreating a report is less viable. Not meeting the signature requirements at the time of transport requires additional effort and increases the timeliness of billing.

## Trip Volume and Staffing

Using the trip volumes provides an objective approach to identifying the amount of billing staff required. Ongoing measurement of the trip volumes will provide a trigger when staffing needs to be modified. Additionally, reviewing the volumes by the "type" of call; i.e. wheelchair, emergency, etc. can determine the level of effort needed in the billing department. Use the KPIs given below as a guideline. Billing systems, processes and structures are different and the recommended staffing ratios may need to be adjusted.

### Data and Calculation

1. Determine the total number of transports per month by the type of transport, i.e. wheelchair, BLS, etc. Run the report, Reports>General>Trip related>Counts> Trip Count of Call Type by Month report for a rolling 12 months (a year from the most previous full month). Be sure to include the billing statuses of; billed, closed, complete, and verified.

2. Divide the recommended staffing ratio into the total number of transports per year for that particular call type to get the total number of staff.

| 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 |

*Full Time Equivalent (FTE)
**The staffing recommendations above do not include management. To account for management staff, take the total number of transports per year and multiply by 10%.

EXAMPLE

| ABC Ambulance Company - Transports by call type and trip month | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Transport Type | Dec-11 | Jan-12 | Feb-12 | Mar-12 | Apr-12 | May-12 | Jun-12 | Jul-12 | Aug-12 | Sep-12 | Oct-12 | Nov-12 | Total |
| BLS Non-Emerg | 4,346 | 4,481 | 4,362 | 4,465 | 4,277 | 4,610 | 4,424 | 4,410 | 4,477 | 4,476 | 4,389 | 4,401 | 37,701 |
| ALS - Emerg | 1,299 | 1,352 | 1,184 | 1,327 | 1,196 | 1,285 | 1,202 | 1,279 | 1,184 | 1,212 | 1,197 | 1,243 | 10,621 |
| Wheelchair | 643 | 664 | 625 | 741 | 767 | 880 | 791 | 800 | 920 | 886 | 912 | 901 | 6,616 |
| TOTAL | 6,288 | 7,024 | 6,721 | 7,180 | 6,866 | 7,484 | 7,101 | 7,204 | 7,297 | 6,913 | 6,489 | 6,545 | 64,813 |

Staffing Recommendation for Basic Life Support (BLS) Non-emergency transports
37,701 total transports/ 5,000 transports/FTE = 7.5 FTE

Staffing Recommendation for Advanced Life Support (ALS) Emergency transports
10,621 total transports / 5,500 transports/FTE = 2.0 FTE

Staffing Recommendations for Wheelchair transports
6,616 total transports / 12,000 transports/FTE = .5 FTE

### Total billing staff recommendation – 10 FTE

Please note, using the lower-end range vs. the upper-end range is dependent upon a multitude of criteria but is ultimately affected by the quality and completeness of information received into the billing department, automations, and efficiency in the billing department.

### Analyzing your Data:

Review the trips volumes daily and monthly. Knowing the average daily and monthly trip volumes will help to keep the billing department staffed appropriately. If future growth is forecasted, use these new projections with the Billing Staff Ratios to prepare accordingly. Implementing productivity guidelines within the department will aide in determining the staffing for each function; pre-billing, billing, follow-up, etc. This will be explained further in the next section.

## Pre-biller and Coder Productivity

There are numerous benefits to establishing benchmarks for both the pre-billing and coding staff's productivity. These include:

- Consistent billing = consistent cash flow
- Efficient staffing
- Daily and/or weekly feedback provided to the staff

Productivity is typically higher when consistently measured. Use the KPI recommendations below as a guideline to start the process, however it is recommended that productivity be evaluated for a period of time to establish guidelines that are meaningful for your organization. An employee meeting a

quota is the ultimate goal. However, it can backfire if their quota becomes more important that producing quality results. The areas that potentially impact quality are; paper vs. electronic Patient Care Reports (ePCR), the quality and accuracy of the PCR, lack of training and feedback to EMT crew members regarding billing requirements, if billing department consistently receives face sheets from the facility or if they have system access into a facility, the tools available to the staff (i.e. eligibility, address search, etc.). The more the billing staff has to hunt for information or place a trip on hold and request information the less they will be productive and effective.

## Data and Calculation

1. Run a system report and compare the data with the KPI below. Depending upon the billing roles you have within your organization; Pre-biller, Coder, or a Biller that performs both pre-bill and coding functions determines what you need to track. Obviously these titles may be different in your organization. Consider the following ZOLL RescueNet Reporting reports:

    - Reports>Billing>Collections>Notes Activity Report. Select the User, note types, and note date.
    - Reports>Billing>Trends> Trips Verified by Biller by Day or Trips Verified by Biller by Week. Select the verified date.

## KPI - Pre-biller and Coder Productivity

| Role | Prod / Day | Comment |
|---|---|---|
| Pre-Biller | 50-70 / Day<br>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<br>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<br>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 |

Please note, using the lower-end range vs. the upper-end range is dependent upon a multitude of criteria but is ultimately affected by the quality and completeness of information received, automations, and efficiency in the billing department.

You can also use this information to determine the staffing for each of the areas. Once having calculated the productivity KPI, you can divide this KPI into your total trip volume.

See the "Calculating Staffing for each Department" example below. Remember to take into consideration vacations, holidays, sickness, etc. It is most effective to see the daily productivity report trended for the month-to-date.

## EXAMPLE

| Coding Productivity Example | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Coder | Oct-1 | Oct-2 | Oct-3 | Oct-4 | Oct-5 | Oct-8 | Oct-9 | Oct-10 | Oct-11 | Oct-12 | Oct-15 | Oct-16 |
| JDoe | 91 | 83 | 93 | 95 | 82 | 85 | 91 | 86 | 88 | 90 | 85 | 100 |
| JDoe 2 | 82 | 66 | 0 | 64 | 80 | 99 | 122 | 63 | 78 | 89 | 91 | 45 |
| JDoe 3 | 25 | 98 | 38 | 56 | 91 | 42 | 65 | 0 | 82 | 70 | 0 | 105 |
| Dly Total | 198 | 247 | 131 | 215 | 253 | 226 | 278 | 149 | 248 | 249 | 176 | 250 |
| Wkly Total | | | | | 1,044 | | | | | 1,150 | | |

Calculating Staffing for each Department
Average Daily Trip Volume = 230
Productivity Expectation Pre-bill = 65 / day Pre-billers needed 230/65 = 3.5 or 4
Productivity Expectation Coding = 80 / day Coders needed 230/80 = 2.8 or 3

### Analyzing Your Data:

Daily Productivity – refer to productivity example above.

- Review the productivity trends for consistency. It is best to view the productivity trended over a period of time as in the example above.
  - JDoe consistently meets or exceeds the coding expectation of 80 transports per day.
  - JDoe 2 meets the expectations the majority of the time but has days where the productivity is below.
  - JDoe 3 is very inconsistent or is out of the office sick. Evaluate the reason for the inconsistency and determine a plan of action.

- Use the productivity in conjunction with the average daily trip volumes to determine if their daily output meets or exceeds the average daily trip volume. Staffing was calculated based on productivity so if the team is not producing, most likely the billing lag timelines are increasing. If the average daily trip volume is 230 the staff must produce 230 or more per day. In the example above, there is an issue. The average productivity for the 12 days in the example above is 218 which mean we are not meeting the daily trip volume. Over time, the billing lag will increase.

- Another consideration is when to supplement your existing pool with additional staff or overtime support. If the staff is meeting their productivity guidelines and volume continues to increase, additional effort may be needed.

## Payor Mix Analysis

The "payor mix" is the distribution of trips across the various payer classes such as; Medicare, Medicaid, Insurance, etc. The payor mix can significantly affect the revenue within an organization. Although it is most often determined by the demographic area in which your organization provides services, front-end billing processes can skew the outcome impacting revenue and requiring additional effort in the billing department.

## Data and Calculation

1. Determine the payor mix. Run the report, Reports>Billing>Trends>Trip Count by Primary Payor Type or the Trip Count by Primary Payor Category. Include the statuses; billing, closed, complete, and verified. I recommend reviewing the information for a rolling year from the most recent month. If it is November 12, 2012 my date range would include 11/1/2011 – 10/31/2012. This report is a current snapshot of the distribution of trips across the payer classes. Therefore, depending upon the thoroughness and consistency of the front-end processes, the payor mix can change for previous months. If the report does not show percentages, download the report into Excel and add a formula to calculate percentages by dividing each monthly payor class subtotal into the monthly total.

## EXAMPLE

| Payor Mix Report Example | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| Payor Class | Mar-12 | Apr-12 | May-12 | Jun-12 | Jul-12 | Aug-12 | Sep-12 | Oct-12 | Avg |
| Medicare | 1,576 | 1,475 | 1,527 | 1,426 | 1,456 | 1,395 | 1,305 | 1,340 | 1,438 |
| Patient | 800 | 732 | 753 | 756 | 866 | 787 | 908 | 1103 | 838 |
| Insurance | 820 | 737 | 815 | 859 | 843 | 825 | 753 | 685 | 792 |
| Medicaid | 434 | 463 | 505 | 467 | 487 | 512 | 441 | 380 | 461 |
| Contract | 290 | 239 | 278 | 282 | 279 | 256 | 306 | 212 | 268 |
| TOTAL | 3,920 | 3,646 | 3,878 | 3,790 | 3,931 | 3,775 | 3,713 | 3,720 | 3,797 |
| | | | | | | | | | |
| Payor Class | Mar-12 | Apr-12 | May-12 | Jun-12 | Jul-12 | Aug-12 | Sep-12 | Oct-12 | Avg |
| Medicare | 40% | 40% | 39% | 38% | 37% | 37% | 35% | 36% | 38% |
| Patient | 20% | 20% | 19% | 20% | 22% | 21% | 24% | 30% | 22% |
| Insurance | 21% | 20% | 21% | 23% | 21% | 22% | 20% | 18% | 21% |
| Medicaid | 11% | 13% | 13% | 12% | 12% | 14% | 12% | 10% | 12% |
| Contract | 7% | 7% | 7% | 7% | 7% | 7% | 8% | 6% | 7% |
| TOTAL | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% |

## KPI – Payor Mix

KPI's for payor mix are slightly different for each ambulance company. It can be dependent upon the demographic area, the type of business model, and contracts with facilities and payors. Emergency organizations may have a higher Insurance and Medicaid percentage as Contracts typically aren't applicable.

## Analyzing Your Data:

| Payor Class | Range |
|---|---|
| Medicare | 40% -50% |
| Insurance | 18% -23% |
| Contracts | 13% -18% |
| Medicaid | 9% -15% |
| Patient | 3% -9% |

Refer to the Payor Mix Example above

- Look at the trend from one payor class to another. Items worth reviewing include; any increase in transports or variances in one payor class over another. With the recent economy challenges, many ambulance providers saw a slight shift in their payor mix from insurance to patient.

- Use the example above to compare Oct-12 percentages to 6 months prior, May-12 for example. Look how the percentages change. The Patient Class in Oct-12 was 30% but decreased to 19% in May-12. This is most likely due to the staff finding an insurance company to bill as a result of patient's calling regarding their account or follow-up calls. There is evidence of this because the May-12 Medicare and Insurance percentages increased approximately 6% compared to the Oct-12 figures. The Patient percentage of 19%-20% is the truer percentage and is still high. Look at the front-end processes and determine if there is opportunity for improvement. If the front-end staff doesn't have the tools, information, or billing processes in place to bill insurance rather than the patient, it can delay a payment out 4-6 months.

- Weak front-end processes mean costly departmental and staffing costs. There is a higher cost of time and money affiliated with having to initiate the billing process multiple times.

- If the pre-billing processes are strong, the trending of the payor mix volume can be used as a tool for forecasting payments.

## Back-End Measurements

Key measurements for KPI's for back-end processes are:

- Accounts Receivable Analysis
- Follow-up Productivity
- Denials

## Accounts Receivable Analysis

An Accounts Receivable (AR) Summary gives an account of balances not yet collected. Normally, a report can be accessed by a variety of criteria including; by patient, insurance plan, and payor class or class. To use the AR Report as a billing benchmark, accessing the data by "payor class" is recommended. Running the aging by the "trip date," the majority of the AR should be resolved before 90 days. However, if 40% or more of the AR is greater than 90 days then problems in the billing process obviously exist. Review the aging report and attempt to identify "why" claims are getting denied or not paid.

### Data and Calculation

1. Run an Aging by Payor Type/ by Trip Date report for all unbilled accounts receivable. The Period Closing Aging report can be used.
2. To calculate the percentage of AR greater than 90 days…add the total dollar amount for the AR buckets greater than 90 days.
3. Divide this subtotal into the total amount of AR on the books.

## EXAMPLE

| Aging by Payor Type | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| Payor type | 0-30 | 31-60 | 61-90 | 91-120 | 121-180 | Over 180 | Total Bal | $ >90 | % >90 |
| Bill Patient | 309,061 | 488,344 | 429,237 | 301,018 | 564,116 | 1,098,904 | 3,190,680 | 1,964,038 | 62% |
| Contract | 88,427 | 126,060 | 43,641 | 3,405 | 3,699 | 6,489 | 271,720 | 13,592 | 5% |
| Insurance | 169,996 | 62,136 | 27,377 | 9,460 | 11,929 | 15,286 | 296,185 | 36,676 | 12% |
| Medicaid | 43,085 | 16,961 | 5,372 | 3,217 | 2,635 | 5,301 | 76,572 | 11,154 | 15% |
| Medicare | 376,405 | 85,117 | 23,684 | 11,304 | 5,903 | 11,937 | 514,350 | 29,144 | 6% |
| Private Pay | 3,920 | 1,950 | 1,320 | 0 | 100 | 2,380 | 9,670 | 2,480 | 26% |
| Grand Total | 990,892 | 780,569 | 530,632 | 328,404 | 588,383 | 1,140,297 | 4,359,177 | 2,057,084 | |
| Amt > 90 | 23% | 18% | 12% | 8% | 13% | 26% | 100% | 47% | |

AR > 90 days – 2,057,084 / 4,359,177 = 47%

**KPI – AR greater than 90 days is 18%-25%**

### Analyzing Your Data:

Look at the report to determine whether the AR in each class is appropriate for the payment patterns for a particular group of payors. If you find something atypical, run an Aging by Payor to look at the particular payor class more closely. It can be typical that the outstanding AR greater than 90 days is higher for Medicaid given how slow they pay in some states.

If the percentage of AR greater than 90 days is higher than 25% and/or near 50% then there are issues within the billing department. It is difficult to diagnose unless you look closer at the processes. It could be a combination of different issues including weak front-end processes such as;

- Patient responsibility is assigned instead of pursuing insurance responsibility
- Insurance verification is not completed
- Patient addresses are not verified at the very least against U.S. Postal Service records
- Pre-billers and coders are significantly behind
- Electronic claims submission is not implemented except for Medicare. Submitting paper claims isn't reliable and the processing time is significantly longer than using an electronic process.
- Denials and unpaid claims are not worked in a timely manner. Organizations that don't have staff specifically assigned to follow-up generally have a high percentage of receivables greater than 90 days. The longer a balance sits unworked the more likely it becomes uncollectable. Many insurance companies, including Medicare, have a time limit in which the denial must be appealed otherwise the balance becomes bad debt.
- Patient balances are not turned over to a collection company consistently after 60-75 days.

## Follow-up/Collections Productivity

Evaluating the productivity and effectiveness in the follow-up and collections area of billing can be challenging because there aren't clear indicators of success. Assigning a productivity standard sets an expectation that a certain number of claims are worked consistently every day. Frequent auditing of the notes and accounts along with evaluating the AR greater than 90 days by payor class will help to determine effectiveness.

### Data and Calculation

1. It is best if you have a report that shows a summary as well as details to include the account number to allow for auditing. Use the report, Reports>Billing>Collections>Notes Activity Report (Detail). Evaluating the number of accounts worked by the type of note is recommended. In RescueNet Administration, create 'note types' for follow-up, incoming patient calls, and denials/correspondence. Every time an account is worked for an un-adjudicated balance (no payment or denial was received from the payor) the follow-up note type should be documented within the account. Activities should include;
   - performing follow-up
   - answering incoming patient calls/correspondence
   - researching and resolving denials

2. To develop effective collections, align the follow-up staff by the payer classes. This will allow you to look at the aging greater than 90 days to see if the percentage delinquent is within the suggested range.

3. Run a payment report by payer class to determine how the payments are trending over time. This requires a custom report or modification of a current payment report. I have seen significant increases in the monthly payment amounts when employees are effective in the follow-up and collection efforts. When you first start this process and the AR greater than 90 days is 40% or higher then is clean-up that needs to be completed. The most effective way to address this issue is to create a strategy for the follow-up staff. Assign certain days or half days where new AR is worked vs. old AR or target payers where timely filing may be nearing, target high balances, etc. Additionally, you need to make sure that processes are in place so that AR needing written-off of reviewed by a manager is completed and the balance isn't left unresolved. There should be an action for 95% of the denied and unpaid balances.

**Productivity Example**

| JDoe | Oct-1 | Oct-2 | Oct-3 | Oct-4 | Oct-5 | Oct-8 | Oct-9 | Oct-10 | Oct-11 | Oct-12 | Oct-15 | Oct-16 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Denials | 15 | 10 | 8 | 13 | 9 | 8 | 11 | 7 | 12 | 6 | 9 | 11 |
| Follow-up | 36 | 42 | 48 | 46 | 48 | 22 | 37 | 47 | 38 | 44 | 26 | 32 |
| Cust Svc Calls | 22 | 18 | 11 | 9 | 8 | 23 | 20 | 14 | 11 | 9 | 22 | 19 |
| Total | 73 | 70 | 67 | 68 | 65 | 53 | 68 | 68 | 61 | 59 | 57 | 62 |

**Note Detail Example**

| Run# / Time | Cus Name / Note | Type | Trip Date | Schedule | Event | Payor | Balance |
|---|---|---|---|---|---|---|---|
| 1456 | Maynerd, Mayo | Cus Svs | 1/4/2012 | Denial Review | Commercial | BCBS | 640.00 |
| 8:00 | Customer called to provide new insurance information | | | | | | |
| 1832 | Smith, Kathy | Follow-up | 9/14/2012 | Commercial | Acct. Review | Aetna | 832.00 |
| 8:11 | Called Aetna, paper claim not received. Address on payer is not correct, corrected address and refiled claim | | | | | | |

**Payment by Payer Class Example**

| Payer Class | Jun-12 | Jul-12 | Aug-12 | Sep-12 | Oct-12 |
|---|---|---|---|---|---|
| Bill Patient | 58,164 | 60,600 | 51,094 | 49,129 | 57,501 |
| Contract | 94,194 | 194,278 | 115,050 | 250,349 | 173,008 |
| Insurance | 244,593 | 318,332 | 359,275 | 284,230 | 366,948 |
| Medicaid | 65,815 | 61,115 | 70,992 | 90,285 | 112,610 |
| Medicare | 383,487 | 412,043 | 411,304 | 404,551 | 444,122 |
| Total | 846,253 | 1,046,368 | 1,007,715 | 1,078,543 | 1,154,188 |

## KPI – Follow-up/Collections Productivity 50-65 trips per day

### Analyzing Your Data:

The KPI range will need to be adjusted for your organization depending upon the roles responsibilities and the level of effort needed to work the accounts. For example, if the staff is responsible for answering incoming customer service calls, this will impact the number of accounts where follow-up can be completed. If several of the claims need to be appealed than this is time consuming and the lower range of 50 trips may even need to be adjusted to a lower expectation. If the staff can access adjudication status on a payor's website and not sit on hold, the higher range of 65+ trips per day might be appropriate.

Auditing of the notes, payment and aging trends by payer class will help to determine an individual's effectiveness. It is helpful to get a detailed notes report that shows the time of the phone calls, the patient names, payer, schedules, account balance, note type, and the specific note. This will is helpful to analyze the strategy used, time management, and diligence when working the accounts. Did they work the outstanding accounts by payer, patient, high balances, old accounts, etc? The effectiveness can be seen in the aging and payments trends. Is the aging class for which they are responsible within the billing department's guideline? Are the aging decreasing and the payments are increasing for their area of responsibility?

Additionally, it is important to understand the issues that the follow-up and collections staff is seeing. Understand the reasons that cause denials, customer service phone calls, unpaid accounts, etc. Look for areas in the billing process that can be modified to reduce the amount of work in the follow-up and collections area. For example, the format of the patient invoices may be causing unnecessary customer service phone calls.

## Denials

Denials are valuable information because they tell us why the claims are not getting paid. No matter how efficient the billing process there will always be a small percentage of denials  however, a high incidence means a delay in payment and additional effort. Reviewing claim denial specifics over a set period of time can help identify habitual problems. Once identified, long-term strategies defining ways to avoid these problems can be implemented. For example, the Medicare denial of "Name and ID do not match" can be avoided by placing insurance verification guidelines in the pre-billing department and holding staff accountable to checking the patient's information against the payor. Determining how the incidence of denials changes over time provides valuable information and feedback such as; an increase in certain denials might indicate a possible pre-payment audit, a decrease with other denials may indicate improvement in billing processes, etc.

### Data and Calculation

1. Find a report that shows the number of denials per month by denial reason. A crosstab report that shows the denial code and reason on the left and the deposit month on top works best because it allows you see date for the past 6-12 months. Run the report, Reports>Billing>Trends>Denial Code and Reason Trended by Deposit Month report. The deposit month signifies when the denial was received. If needed, export the report into Excel to sort the denial code and reason descending by the total. Upon reviewing the most common denial codes and the trend of the denials-- other reports may be needed. Helpful reports to consider are; Denial by Payor, Top Denials by Reason and Biller, a Detailed Denial report, and Denials by Modifier.

2. Determine the number of insurance forms billed per month to calculate the denial percentage. Run the report, Reports>Billing>Trends>Forms Activity by Day.

3. Divide the total number of denials per month into the total number of insurances forms billed per month.

| Denial Reason | Jul-12 | Aug-12 | Sep-12 | Oct-12 |
|---|---|---|---|---|
| Claim not covered by this payer/contractor. You must send the claim to the correct payer/contractor. | 42 | 20 | 44 | 35 |
| Expenses incurred after coverage terminated | 2 | 7 | 9 | 32 |
| Duplicate claim/service | 26 | 134 | 71 | 25 |
| Claim denied as patient cannot be identified as our insured | 14 | 16 | 10 | 19 |
| OTHER INSURANCE IS PRIMARY - PT LIABLE | 1 | 6 | 13 | 19 |
| Patient/insured health identification number and name do not match | 30 | 20 | 31 | 18 |
| Co-payment amount | 4 | 0 | 0 | 13 |
| Payment adjusted because this care may be covered by another payer per coordination of benefits | 11 | 34 | 14 | 12 |
| These are non-covered services because this is not deemed a 'medical necessity by the payer. | 2 | 3 | 14 | 10 |
| MISSING MEDICAL NECESSITY | 22 | 12 | 2 | 8 |

### Calculating the Denial Percentage

| Denials Compared to Claims | Sept-12 | Oct-12 | Nov-12 |
|---|---|---|---|
| Denials | 1,105 | 1,058 | 1,301 |
| Total Insurance Forms | 10,856 | 10,379 | 12,347 |
| Denial Percentage | 10% | 10% | 11% |

## KPI – Denials 3-5% of the total insurance claims volume

### Analyzing Your Data:

Scan the most common denial reasons over a period of time and find answers to the following questions;

- Compare the total number of denials received for the most recent month to the trend from previous months. Have the denials improved, stayed the same, decreased?
- Review denial codes to identify trend of possible billing problems. For example; a high incidence of duplicate denials might indicate that a claim was sent to the secondary insurance after Medicare crossed over the claim. Look at the system set-up to see if unnecessary claims are sent to the payer.
- Which denial reasons seem to be increasing? Are there more 'eligibility' type denials than in the past? Are there more 'medical necessity' type denials than in the past? Denial trends can alert to possible issues and/or weaknesses with the billing processes.
- Look for areas that have a high incidence of denials where improvements can be made in the billing process.

## Summary

There is a direct correlation of measuring key performance indicators and an efficient and effective billing department. As you track these measurements and use the feedback to improve the front-end billing processes the more effective and efficient your entire billing office will become. Information not received and verified prior to claim submission, requires 3-4 times the effort on the back-end and payment timeliness is extended 4-6 months or more. You are more likely to get a high payment or any payment at all from an insurance company rather than the patient. Quality information begins with the first encounter with the patient. Work with the Operations team and facilities to obtain as complete and accurate patient and insurance demographics as possible. I understand it is not always possible for Operations to obtain complete and accurate patient and insurance details, particularly for 911 services, create relationships with the hospitals, facilities and/or use eligibility tools. You will see the benefit in quicker payments with less effort.

Implementing these guidelines will allow you to be equipped to develop your own KPIs, easily identify issues within the organization, make significant improvement, and be better positioned for future growth.

## About the Author:

Donna Magnuson, is an AR consultant and billing specialist, who has been a member of the ZOLL team since 2006. She began her healthcare career 20+ years ago as a paramedic in the US Army. After leaving military service, she spent several years managing billing operations, implementing physician practice management systems, and providing consulting services. Her experience and expertise, within the medical billing realm, allows Donna to work with clients to ensure their businesses are profitable and successful. She does this through the introduction of best-practices, business process redesign, tracking of key business criteria and preparing team members to meet the expanding demands of a growing business.

Should you require some assistance in developing your KPI's and an independent evaluation of your billing processes, please contact ZOLL for AR Consulting services. A trained and experienced AR Consultant can not only show you how to implement the KPIs but also provide best practice recommendations.