EMS|MC

Revenue Cycle Management 101

A Preliminary Guide to EMS Billing

E-Book

emsmc.com

Introduction

Behind the fast-paced, high-stakes environment of the emergency medical services (EMS) industry lies a complex and intricate financial framework — the budgetary engine that keeps your agency going and enables you to deliver life-saving care with precision and speed.

But maintaining this framework requires finesse and strategy, and the industry is filled with several roadblocks that challenge the total revenue that EMS agencies can collect. Denied claims and delayed reimbursements often lead to substantial revenue losses, resulting in a financial imbalance where the cost of providing emergency services often exceeds the profits that you'll be able to keep.

That's where the process of Revenue Cycle Management (RCM) comes in. RCM — otherwise known in a simpler fashion as EMS billing — is defined as the financial process utilizing billing software and procedures that EMS providers use to track patient care episodes. From the moment patient care is provided and documented all the way to securing the final payment of a balance, RCM encompasses the entire life cycle of a claim, which only ends once your agency has accepted all due payments.

Key Challenges in RCM

- Evolving Regulatory Requirements
- Payor Variability
- Prolonged Billing Cycles
- Verification of Patient Eligibility
- Accurate Documentation of Services Rendered
- Complex Billing and Claims Submissions
- Denials and Underpayments
- Reimbursement Disputes

Because of this, the importance of RCM cannot be overstated or undermined. After all, the effectiveness of your agency's RCM processes is key in maintaining the sustainability and integrity of your revenue streams. How efficient your RCM processes are — and by extension, how much you can maximize your revenue — will also significantly impact your agency's ability to operate, invest in new technology, hire essential personnel, and ultimately, deliver quality patient care.

The RCM process is one that is crucial for EMS providers to understand and master, and the inability to efficiently manage your revenue cycle can come with severe financial repercussions. In the year 2020, it was shown that inefficient RCM practices collectively cost the healthcare sector billions of dollars on an annual basis, and it was projected that the industry could have saved $16.3 billion in the United States alone[1].

Inaccurate billing and coding, inefficient data collection, and poor follow-up on essential claims are all inefficient RCM practices that lead to significant revenue loss and a severely affected bottom line. This fiscal strain can compromise your agency's ability to expand upon your facilities and resources, and even impact the overall availability and quality of the services that you provide. In the worst-case scenario, mismanagement of your revenue cycle can also result in organizational insolvency — reducing your community's access to critical emergency care.

To prevent such detrimental repercussions, it's important to recognize the gravity of RCM in stabilizing your agency's financial health and day-to-day operations. Every step in the process should be optimized for both efficiency and compliance, which will allow your team to fulfil their primary mission of saving lives without the added strain of financial uncertainty.

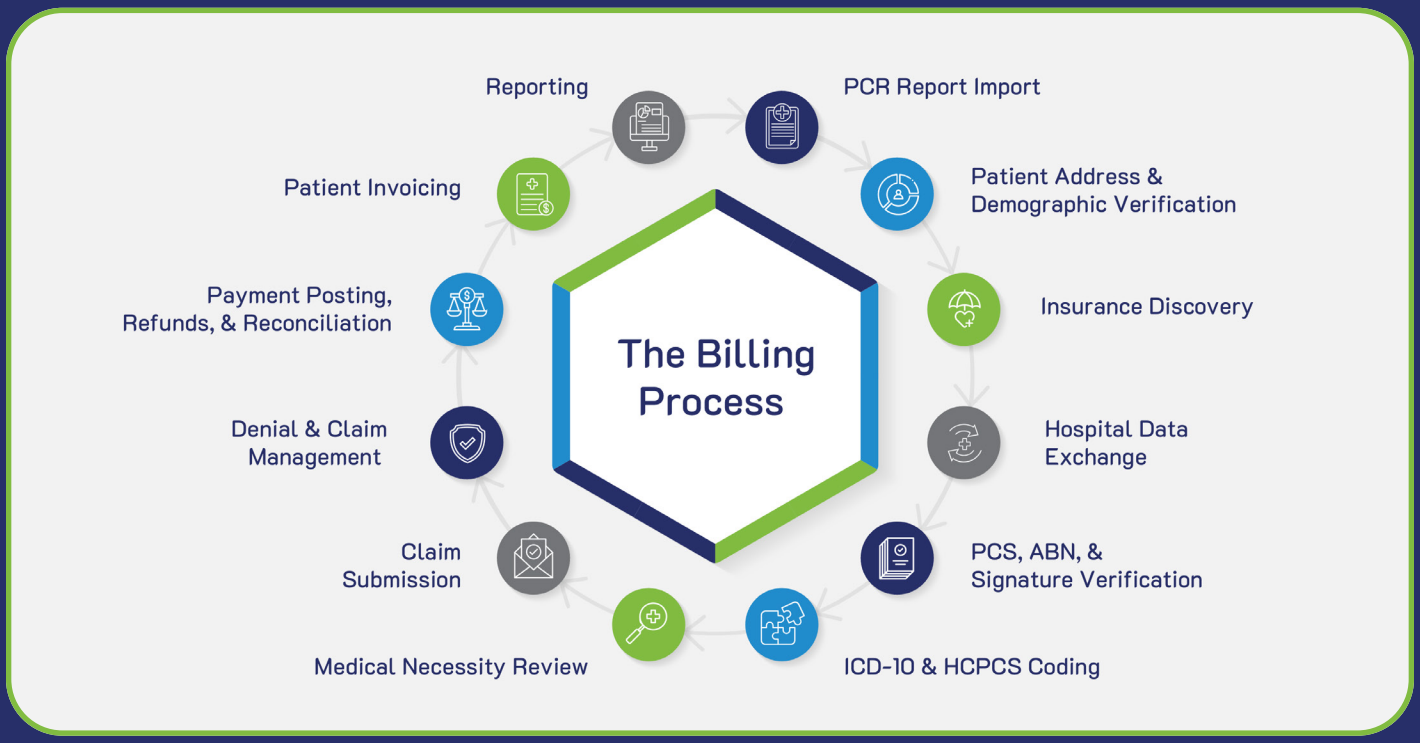
1) *How much revenue is your healthcare practice losing due to efficient revenue cycle processes?* Medical Group Management Association.

Revenue Cycle Management 101

The Billing Process

In the world of RCM, optimizing each step of the billing process requires a strategic approach, be it from first response to final reimbursement. The billing process is a multifaceted sequence of actions, where each step plays a vital role in ensuring the financial sustainability and operational efficiency of your EMS agency.

While each claim is different and can take a life of its own, here's what the billing process can look like for your average claim:



PCR Report Import

The Patient Care Report (PCR) that's filled in upon first response is the main source of data upon which all medical billing claims are based. Because of this, accuracy is paramount during this initial stage. PCR records are maintained for a period of up to 7 years, and ensuring that the patient's information is correctly and comprehensively documented from the outset can significantly reduce the likelihood of billing issues down the line.

When documenting Medical Condition Codes (MCCs) on PCRs, first responders must ensure that they are specific to the chief complaint, and that they accurately reflect the location, severity, duration, and onset of the circumstance. Aggravating or alleviating factors should also be included, as well as associated signs and symptoms. The aim is to always paint a clear picture of the patient's condition.

This constitutes what we call the Narrative Field — an important element of the PCR that helps create a detailed snapshot of medical necessity, and provides vital information that cannot be captured in the pull-down menus or specific treatment fields.

Utilizing advanced software solutions for data capture and verification can streamline the PCR documentation process, reducing human errors and enhancing efficiency. Providing continuous training and education for your first responders is also crucial in obtaining the detailed data that you need.

Medical Condition Code Examples

MCC/MCC2 (Medical Condition Codes)		Condition (Specific)	Comments and Examples (Not All-Inclusive)
MCC	Severe Abdominal Pain	With other signs or symptoms	Nausea, vomiting, fainting, pulsatile mass, distention, rigid, tenderness on exam, guarding
MCC	Abdominal Pain	Without other signs or symptoms	-
MCC	Abnormal Skin Signs	-	Diaphoresis, cyanosis, delayed cap refill, poor turgor, mottled
MCC2	Allergic Reaction	Potentially life threatening	Other emergency conditions, rapid progression of symptoms, prior history of anaphylaxis, wheezing, difficulty swallowing
MCC2	Allergic Reaction	Other	Hives, itching, rash, slow onset, local swelling, redness, erythema
MCC	Chest Pain (Non-Traumatic)	-	Dull, severe, crushing, substernal, epigastric, left-sided chest pain associated with pain of the jaw, left arm, neck, or back, nausea, vomiting, palpitations, pallor, diaphoresis, decreased LOC
MCC2	Cardiac Symptoms Other than Chest Pain	Atypical pain or other symptoms	Persistent nausea and vomiting, weakness, hiccups, pleuritic pain, feeling of impending doom, and other emergency conditions
MCC2	Abnormal Cardiac Rhythm/Dysrhythmia	Potentially life threatening	Bradycardia, junctional and ventricular blocks, non-sinus tachycardia, PVC's >6, bigeminy and trigeminy, ventricular tachycardia, ventricular fibrillation, atrial flutter, PEA, asystole, AICE/AED fired

Medical Condition Code Examples

MCC/MCC2 (Medical Condition Codes)		Condition (Specific)	Comments and Examples (Not All-Inclusive)
MCC2	Neurologic Distress	Facial drooping; loss of vision; aphasia, difficulty swallowing; numbness, tingling extremity; stupor, delirium, confusion, hallucinations; paralysis, paresis (focal weakness); abnormal movements; vertigo; unsteady gait or balance; slurred speech, unable to speak	-
MCC2	Alcohol Intoxication or Drug Overdose (Suspected)	Unable to care for self and unable to ambulate; no airway compromise	-
MCC2	Severe Alcohol Intoxication	Airway may or may not be at risk; pharmacological intervention or cardiac monitoring may be needed; decreased level of consciousness, resulting or potentially resulting in airway compromise	-
MCC2	Pain, Severe Not Otherwise Specified	Acute onset, unable to ambulate or sit due to intensity of pain	Pain is the reason for the transport. Use a severity scale (7-10 for severe pain) or indicate the patient receiving pharmacological intervention.
MCC	Abnormal Vital Signs * *Includes abnormal pulse oximetry*	With or without symptoms	-
MCC	Convulsions, Seizures	Seizing, immediate post-seizure, postictal, at risk of seizure and requires medical monitoring or observation	-
MCC	Altered Level of Consciousness	Non-traumatic	Acute condition with Glasgow Coma Scale <15

Patient Address & Demographic Verification

Patient address and demographic verification is more than just a preliminary step — it's another critical component that ensures the accuracy and efficiency of the entire revenue cycle.

This verification process confirms the validity of the patient's personal details, such as their name, address, date of birth, and insurance information. Accurate patient records are foundational for successful claim submissions, as errors or discrepancies can lead to claim denials, delayed payments, and ultimately, a potential loss of revenue for your agency. Because of this, the verification also acts as a safeguard against inaccuracies that could derail your efforts in obtaining the proper reimbursement for your services.

For patient address and demographic verification here at EMS|MC, our system does what we call a 4-Point Match. Specific fields like the correct name, date of birth, and social security number each carry point values, and there must be at least a four-point data match in order to identify the correct patient that received emergency care. Through this process, we're able to determine whether the patient is eligible for insurance, what kind of policies they're under, and how much coverage they have so that the billing process can be facilitated more effectively.

4-Point Match System

Demographic Details	Point Value
First Name • First 4 characters, ***OR*** • Obvious Misspelling (Allan VS Allen vs Alan), ***OR*** • Known Nickname (Michael VS Mike)	1 Point
Last Name • First 4 characters, ***OR*** • Obvious Misspelling (Schurter VS Shurter)	1 Point
Date of Birth (DOB)	1 Point
Patient State	1 Point
Social Security Number (SSN)	3 Points
Insurance Subscriber ID	1 Point

Insurance Discovery

Identifying the correct insurance coverage for each patient serviced is a key endeavor in the RCM process. This involves the discovery and verification of all potential payor sources, including primary, secondary, and tertiary insurance plans, as well as any plans under Medicaid or Medicare. The insurance discovery process directly impacts the ability of EMS providers to secure the maximum reimbursement for any services rendered, and without a thorough discovery process, your agency risks underbilling or experiencing delays in payment due to incorrect information.

Optimizing the insurance discovery process requires the leveraging of both technology and diligent oversight. It's vital to integrate your systems with national insurance databases, significantly expediting the verification process and reducing the likelihood of errors and omissions. Such systems automatically update insurance information, ensuring that you have the most current and comprehensive data at your disposal.

Additionally, establishing a dedicated team to oversee this process could also enhance its efficiency. The team should possess a deep understanding of insurance verification nuances, and be skilled in navigating the complexities of various insurance plans and coverages. Regular training sessions to update the team on the latest in insurance regulations and policies are recommended, and protocols to verify patient insurance eligibility in real-time should be established to preemptively identify any potential coverage issues.

Hospital Data Exchange

Encompassing the systematic exchange and integration of patient care records from hospitals to EMS providers, the Hospital Data Exchange (HDE) process aids in the collection of accurate medical and billing information. This influences the efficiency of your billing cycle and fosters a more integrated approach to RCM, as obtaining precise patient data from hospitals can significantly reduce the potential errors and discrepancies found in your billing claims.

The retrieval of hospital face sheets, which provide a concise yet comprehensive summary of a patient's demographic, insurance, and clinical data upon admission, is also crucial to this process. These documents contain vital information necessary for accurate billing submissions, including verifications of insurance coverage and patient identifiers. Leveraging electronic health record systems that interface directly with hospital databases can also streamline this retrieval, ensuring that you can access the most current information on your patient.

PCS, ABN, & Signature Verification

Physician Certification Statements (PCSs), Advance Beneficiary Notices (ABNs), and signature verifications are pivotal in validating the medical services that you've provided. They ensure that your patients or their representatives are informed about—and consent to—their potential financial responsibilities. During this process, steps should be taken to capture, store, and verify these documents securely and efficiently. The use of electronic signatures and automated verification tools not only streamlines and expedites this process, but also minimizes errors and compliance risks.

ICD-10 & HCPCS Coding

Accuracy in ICD-10 and HCPCS coding is more than just a regulatory requirement — it's essential when it comes to categorizing medical procedures and diagnoses for billing purposes, and guaranteeing that your EMS agency is well compensated for your services. Precise coding can have a direct effect on your reimbursement rates and organizational compliance, while incorrect or non-specific coding can lead to negative consequences like claim denials or underpayments. Taking this into account, it's important for your agency to invest in continuous coding education for your team, and ensure that the training program stays current with any changes or updates to payer-specific billing requirements. Establishing regular auditing practices will also aid in reviewing coding accuracy, providing opportunities for corrective action and education.

Medical Necessity Review

To evaluate whether the services provided to a patient were essential for the diagnosis or treatment of their condition, a medical necessity review is required. This step in the RCM process is crucial to validate that the services you have billed for are justified, laying the groundwork for successful claim submissions and minimizing the risk of any denials based on medical necessity disputes. Optimizing your medical necessity review process involves drafting comprehensive review protocols, training your team in the task of proper documentation, and accurately assessing medical necessity against current clinical guidelines.

Claim Submission

A critical juncture in the RCM framework, the claim submission process centers itself around formally requesting payment from the patient's payors for any services provided. It is the final actualization of all your previous efforts in verification and documentation, and any inaccuracies prior to this stage could lead to claim rejections or denials, delaying your revenue cycle and increasing your administrative burdens.

After the claim form is completed and the proper codes are assigned, the claim is then submitted to the appropriate payor. Timeliness is important in this regard, as late submissions can result in your agency missing payor deadlines, and therefore having your claims denied by default. Timely submissions also help to enable prompt payment on the payor's end, avoiding the need for any follow-up inquiries or potential disputes.

Denial & Claim Management

Established as the systematic process of addressing and rectifying claims that payors have either rejected or denied, this step involves identifying the reasons for denials, making the necessary corrections, and resubmitting these claims. To optimize this process, being able to analyze denial patterns, identify root causes, and implement corrective actions is essential. Automating the appeals process and establishing a dedicated denial management team that's equipped with problem-solving and negotiation skills can significantly reduce your agency's claim denial rate, recovering any revenue that might otherwise be forfeit.

Payment Posting, Refunds, & Reconciliation

The accurate posting of payments is vital for your agency's financial integrity. This process ascertains that all revenue is correctly accounted for, and proves essential for the later stages of financial analysis and forecasting in RCM. Reimbursements received from payors during this stage are recorded and managed, and refunds are issued in the event of any overpayments, ensuring that all transactions are balanced.

Automating the payment posting process where possible can increase the efficiency of this RCM stage, and maintaining a robust system for reconciling the payments received with the services billed is also crucial. Regular audits can uncover discrepancies between the two, and potentially indicate any hidden issues in regards to how claims are being processed or paid.

Patient Invoicing

Patient invoicing is the final step in the billing cycle after insurance payments are processed and posted. It involves the additional generation and distribution of invoices to patients for any services rendered, taking into account any adjustments from insurance payments and contractual write-offs.

This process must be handled with sensitivity and accuracy, and it's vital to ensure that patients are only billed for the amounts that they are truly responsible for. For an effective patient invoicing process, it's important to generate clear and straightforward patient statements detailing all charges, insurance adjustments, and outstanding balances owed. The information should be presented in a format that is easily interpreted by the patient, who may not be familiar with the specific terminology found in medical billing.

At EMS|MC, invoices are mailed out on a set cycle with 30-day intervals, which can go up to a total of 90 days. These invoices may also be sent out to request specific information from patients, such as insurance demographics, accident coverage, or patient signatures for certain payors.

Reporting

Within the EMS landscape, maintaining your financial health isn't just a goal — it's a necessity for your agency to survive and thrive. This necessity is what brings us to the heart of RCM: understanding and effectively interpreting your monthly billing reports.

These monthly billing reports are dense with financial data, and enable you to gain insights that go beyond just numbers on a page. They represent the culmination of all your efforts towards the billing and revenue collection process thus far, and can spotlight areas of strength while pinpointing opportunities for improvement. Through a careful breakdown of each component and understanding what each figure signifies, you'll be able to leverage this information to make more astute budgetary decisions.

Key Definitions

Gross Charges	• The total charges billed • Our recommendation is to set your gross charges to at least 150% of the Medicare Fee Schedule (MFS) or higher, depending on your client type and regional comparisons • Hospital-based clients typically set their gross charges to 300%+ of the MFS • While government and contracted payors require contractual allowances, non-contracted commercial insurers will calculate payment based on the gross charges billed • Most insurances will pay their allowed amount or the amount billed, whichever is lower • Many EMS agencies have adopted ordinances in which the rates are set based on a percentage of MFS, with automatic increases as the MFS is updated
Contractual Allowances	• The difference between your gross charges and the contractual amount that the insurance provider allows • Represents the amount that you **cannot** legally bill the patient for
Net Charges	• Represents the difference between your gross charges minus the contractual allowance • The amount that you are legally able to collect
Revenue Adjustments	• Balance adjustments that may not be billed to the patient • Includes interest payments, small balance write-offs, or fees paid to a collection agency
Payments	• Represents the total amount of cash postings made to the account

Write-offs	**Bad Debt**	• Represents the largest percentage of write-offs • After the patient has failed to respond to the invoicing cycle, the amount is captured in a bad debt write-off • These write-offs are sometimes transferred to a third-party collection agency if applicable, or a debt-setoff program if the agency participates
	Bankruptcy	• The EMS agency is legally obligated to write-off any unpaid balances if the patient notifies you of a bankruptcy settlement • Courts impose penalties to businesses that continue to bill even after they have been notified of patient bankruptcy
	Charity Care	• Represents the amounts that have been written off due to a specific hardship policy that has been implemented • In the absence of a specific hardship policy, we recommend following the facility's hardship policies
	Client Request	• This category represents any specific write-offs that were requested by the agency
	County Resident	• Certain municipal agencies have policies in which the area resident is a bonafide tax-paying citizen that treats the tax subsidies they receive as the copayment share under the patient's responsibility • In these situations, our recommendation is to bill to the extent of the insurance provided, and to not balance bill the area residents for copayments and deductibles
	Deceased (No Estate)	• After exhausting all efforts through the estate process, this category to identify the write-off as no estate becomes available
	No Signature	• This category tracks the revenue that's been written off due to a lack of patient signature • Certain government payors require a patient signature, or an applicable alternative, in order to bill the claim • An invoicing schedule should be utilized in an attempt to receive the patient signature • After this process is exhausted, the claim will be written off using this category • These amounts are forwarded to third-party collection agencies and/or debt setoff processes – if a signature is obtained, then the claim can still be filed so long as it is within timely filing limitations
	No Prior Authorization	• Certain non-emergency transports for payors like commercial, Medicare Advantage, Medicaid Brokers, and Medicare repetitive patients are required to have prior authorizations • After exhausting all efforts to obtain the prior authorizations, the trip is then written off using this category for tracking purposes

Write-offs	**Timely Filing Late Info**	• Represents claims written off under timely filing after receiving insurance information past the timely filing limitations • E.g. A Medicaid patient that does not provide their policy identification information until after timely filing has expired
	Timely Filing Admin Error	• Represents claims written off under timely filing after all efforts were exhausted towards obtaining payment after the timely filing period has expired • Certain insurers have limited timely filing to either 90 or 120 days
	Efforts Exhausted	• There are certain cases where although the claim has been billed, corrected, and appealed during an extended process, the claim remains unpaid

Refunds	• Refunds are unavoidable when it comes to the RCM process, although here at EMS|MC, we continually review our process to decrease the number of refunds required
	• For example, patients are not invoiced until all insurance payments have been exhausted to eliminate the need for unnecessary patient refunds
	• In most cases, we request for a verified overpayment to be recouped by the insurer to reduce the number of physical refunds that need to be issued
	• **Voluntary Refunds:** A credit balance in which an overpayment has occurred is identified, and the refund process is voluntarily initiated to the appropriate party
	• **Involuntary Refunds:** The payor identifies a claim that has been paid in error and initiates the refund process
	• A refund packet is created that includes the necessary documentation like required forms, copies of both payments that reflect the reason for the overpayment, and a formal request for the issuance of the refund
	• Examples of cases where refunds occur:
	  • Two payors have paid primary on the same account
	  • Both payor and patient have paid the balance on the account
	  • Payor denial is appealed and has agreed to pay more than originally requested
	  • Payor makes a payment for a service that is non-covered, or a patient that was not eligible on the date of service
	  • After an audit or review of the documentation, payor may request a refund or partial refund if they disagree with the coding decision	

Key Takeaways

An effective RCM process is the backbone of sustainable EMS operations. As EMS professionals working tirelessly on the front lines to save lives, your RCM processes should provide you with the support that you need — not hinder your operations or affect the quality of your care. As long as you have the foundational knowledge, strategies, and tools necessary to master RCM, your agency can confidently continue your invaluable commitment to your community, ensuring the seamless operation of these critical services and the vitality of your financial health.

While the complexities of RCM and EMS billing are plenty, it's crucial to understand that effective RCM isn't just about processing payments or claims — it's about creating a system where quality care and financial viability can coexist. Once you've recognized the fundamental role that RCM plays in supporting the life-saving objectives of your operations, you've taken the first step towards safeguarding the financial stability necessary for these essential services to thrive.

How EMS|MC Can Help

Rethink How You Bill

While navigating the challenges of RCM can be complex, EMS|MC is here to help.

As the largest EMS billing provider with more than 20 years of RCM experience, we provide technology-driven innovations designed to bring visibility and clarity to your revenue cycle program. We offer a measured approach towards outsourcing your billing, focusing only on the coding and billing functions associated with emergency transports that are designed to increase net collections. This empowers your agency as you continue to manage the full revenue cycle process while leveraging our internal EMS|MC resources to tackle the more complex aspects of EMS billing.

Available 24/7, EMSight™ is our proprietary online portal that enables our clients to access real-time revenue data, patient survey results, and much more. It provides one-click access to transaction-level data with supporting documentation, while our dedicated portal for patients is set up to receive payments and missing insurance information.

EMS|MC also provides comprehensive monthly financial reports that are designed to provide a snapshot of your account's performance. Coupled with trend analysis and analytics, these month-end reports aim to help drive your agency's important budgetary decisions.

Our robust RCM program includes:

- Access to powerful data analytics
- Dedicated account management
- State-specific cost recovery experience designed to maximize revenue
- Collaborative partnerships with multiple ePCR providers
- Multiple partnerships with third-party collection agencies
- Patient-focused customer service
- Personalized education and training
- Web-based, self-paced training solutions that are accessible 24/7

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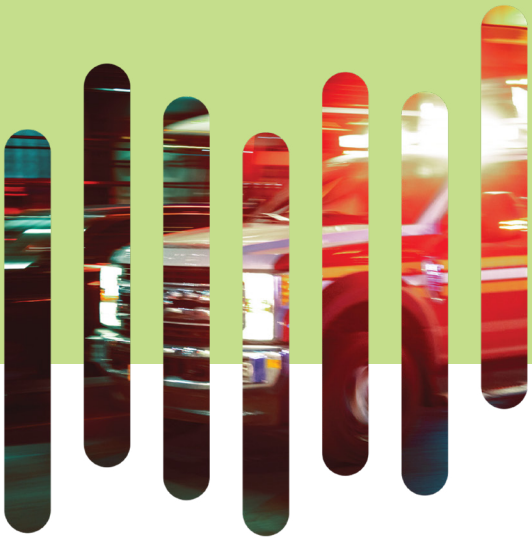

About EMS|MC

Built by paramedics and rooted in innovation, EMS|MC understands the critical nature of EMS and the exact pain points of its operations. That's why we're raising the bar through our approach, and providing you with holistic EMS solutions that enhance your most important operational functions.

We optimize reimbursement, resources, and regulatory compliance for more than 1,000 EMS providers in hospital systems, municipalities, and private companies across the country. With over 25 years of experience, EMS|MC is your operational partner that drives decision-making through services, technology, and education that's solely dedicated to the EMS industry.

Combined with consulting services from PWW Advisory Group (PWW|AG), we do what we do best so that you can focus on what matters the most — delivering quality care to your patients, and serving your community.

Ready to get started?
Request a consultation with us here.

$2.2+ billion
in revenue collected annually for clients

99.8%
compliance in payment delivery

1,500+
national clients

5.5+ million
annual transports

99.7%
claim quality levels

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