Maximizing Your Reimbursement

A Primer on How to Lose the Least Amount of Money While Operating Your Ambulance/EMS Service.

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Director of EMS & Disaster Services
Heart of America Medical Center - Rugby
A Little Bit About Me

• Been in EMS since 1973
  • Paramedic School in 1975

• Worked in both ground and air medical transport programs.

• EMS Educator for over 35 years

• Live & Work in Rugby, ND
  • EMS Director – Rugby EMS
    • Certified Community & Critical Care Paramedic
    • ND EMS Advisory Board
    • NDEMSA Secretary-Treasurer
And....... I Manage an Ambulance Billing Service
No financial conflicts to disclose

I’m Not Looking For New Billing Customers
What Will We Cover Today?

• Understand what is eligible for reimbursement
• How to set rates for services
• Documentation requirements
• What is on the horizon?
WHERE DOES THE MONEY COME FROM TO OPERATE AN EMS SERVICE?

• Tax Supported
  • Mill Levies
  • Special Tax Districts
  • Contractual Payments

• Grant Program

• Donations
  • Monetary
  • Time (Volunteer Labor)

• Fund Raisers

• Cash Reserves

• BUT........

• The majority of the funds will come from event-generated revenue
  • Third Party Payers
  • Patient Self-Pay
The Federal Medicare Program Sets the “Standards” by which most other third party payers will base their payment process.

Medicare is also the Largest Payer of Ambulance Services.
The Medicare Ambulance Benefit

• Medicare will cover:

   “...ambulance service **where the use of other methods of transportation is contraindicated by the individual's condition, but only to the extent provided in regulations**”

• With limited exceptions, the Medicare Ambulance benefit is:

   **TRANSPORT BENEFIT ONLY!**
Coverage Requirements

• Enrolled Medicare Supplier
• Valid “Ambulance & Crew”
• Medically Necessary
• Reasonable & Necessary
• Covered Origin/Destination
• Not be paid, directly or indirectly, by Part A
  • SNF PPS
  • Hospital Inpatient Bundling
  • Hospice
Medical Necessity

- Patient’s condition is such that the use of any other means of transport is contraindicated.

- In other words:
  
  “Why couldn’t this patient be transported by Car, Wheelchair (stretcher) van?”
Presumed Medically Necessary if...

1. Emergency
2. Patient needed to be restrained
3. Patient was unconscious or in shock
4. Patient required oxygen or other emergency treatment
5. Patient exhibited signs of acute respiratory distress
6. Patient exhibited signs of acute stroke
7. Patient needed to be immobilized d/t a possible fracture
8. Patient was experiencing severe hemorrhaging
9. Patient could only be moved by stretcher [need reason]
10. Patient was bed confined before & after the transport [need reason] i.e., “at the time of transport”
Bed Confined Defined

• Need All three:
  • Unable to get up from bed without assistance; &
  • Unable to ambulate; &
  • Unable to sit in a chair/wheelchair
Levels of Ambulance Service
Definition of “Emergency”

• “Emergency Response”
  • They Wanted it Now!
• BLS or ALS-1 Level
• 911 Call or Equivalent
  • Can be on Private Line

• LIGHTS/SIRENS IS NOT THE TEST!
• Basic Life Support (BLS)
  • BLS Non-Emergency (A0428)
  • BLS Emergency (A0429)
• Advanced Life Support (ALS)
  • ALS Non-Emergency (A0426)
  • ALS Emergency (A0427)
    • ALS Assessment, or
    • ALS Intervention
• **ALS Intervention**
  - Procedure beyond the scope of EMT-Basic or as defined by State & Local Laws
  - E.g., EKG, IV, etc.

• **ALS Assessment**
  - Assessment done by a Paramedic (or AEMT/EMT-I85) as part of an emergency response that was warranted based on patient’s condition as reported to Dispatch
  - **Note:** the assessment does not need to result in a determination that the patient requires an ALS intervention
ALS–2 (A0433)
The provision of one or more designated ALS-2 procedures or the administration of 3 or more qualifying medications by IV push/bolus or continuous infusion

• Manual Defibrillation
• Cardioversion
• Endotracheal Intubation
• Central Venous Line
• Cardiac Pacing
• Chest Decompression
• Surgical Airway
• Intraosseous Line

• Typical ALS-2 Medications
  • Epinephrine
  • Atropine
  • Sodium Bicarbonate
  • Narcan
  • Morphine
  • Fentanyl

• Do NOT Qualify:
  • Aspirin
  • Oxygen
  • Crystalloid, hypotonic, isotonic or hypertonic solutions (e.g., Dextrose, Saline, Ringer’s Lactate)
  • IM, Nebulizers, Sprays, Tablets
Specialty Care Transport (A0434)

• Interfacility
  • e.g., Hospital to Hospital
  • e.g., SNF to Hospital
• ‘Critically Injured or Ill” Patient
• Beyond the Scope of Standard Paramedic
  • i.e., RN, RT or ‘Paramedic with Additional Training’

• Typical SCT Procedures & Medications
  • Ventilators
  • Balloon Pumps
  • Heparin Drips
  • Nitro Drips
  • Propofol Drips
  • Cardizem
  • Antibiotic Drips
  • Blood Transfusions
Loaded Mileage

• When Medicare will cover a transport, it will also pay for mileage to the nearest appropriate facility

• “Nearest Appropriate” means an institution that is generally equipped to provide the care the patient requires, at that time, on that day
  • i.e., if the facility has no beds at that time, it is not an “appropriate facility”

• Effective January 1, 2011, Medicare requires that all mileage be billed to the nearest tenth of a mile
  • e.g., 3.4 miles
  • Exception: transports of more than 100 miles should still be rounded up to the next whole number
You Can Only Bill for a single Base Rate and “Loaded Mileage”

• Cannot Bill for Supplies, Procedures or Response Fees
  • Exceptions
    • Response fee for Limited Situations
    • Deceased or Treatment on scene
So How Do You Decide What to Charge?
IF THE WORLD WAS SIMPLE....... 

- Set-up a Budget 
  - Expenses 
  - Overhead 
  - Capital Items 
- Estimate your annual number of billable runs 
- Divide what you need by what you need to collect 
- Equals Price per run
Unfortunately, It’s Not Simple

• You can charge whatever you want, but?
• Third party payers impose their policies upon you.
• Non-Assignment means that patient files claim and gets the check

• Assignment of Benefits
  • You agree to accept what the payer authorizes
  • You must “write-off” any unauthorized amounts
    • Contractual Allowance
Payment for Ambulance Services

• Medicare pays 80% of the allowed charge, and patient is responsible for 20% coinsurance
  • **Note:** ~90% of all Medicare beneficiaries have a Medicare supplemental that will pay their deductibles and coinsurance

• Medicare pays lower of:
  • Your billed charge, or the Medicare allowable

• Medicare allowable is determined by national fee schedule
Medicare Fee Schedule - 2016

- Does not include -1.6% Sequestration reduction per claim

<table>
<thead>
<tr>
<th>Payment Rates Applicable in This ZIP Code</th>
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<tbody>
<tr>
<td>Effective Base Rate Conversion Factor</td>
</tr>
<tr>
<td>Base Rates</td>
</tr>
<tr>
<td>A0426 ALS1</td>
</tr>
<tr>
<td>A0427 ALS1–Emergency</td>
</tr>
<tr>
<td>A0428 BLS</td>
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<tr>
<td>A0429 BLS–Emergency</td>
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<tr>
<td>A0432 PI</td>
</tr>
<tr>
<td>A0433 ALS2</td>
</tr>
<tr>
<td>A0434 SCT</td>
</tr>
</tbody>
</table>

| Mileage, Per Mile (urban/rural/superrural eliminated 2018 and later) |
|-----------------------------|-----------------|
| Fee schedule payment rate, miles 1-17, rural | $ 10.79 |
| Fee schedule payment rate, miles 18-50, rural  | $ 7.20  |
| Fee schedule payment rate, miles 50+, rural    | $ 7.20  |
### BC/BS of ND Fee Schedule - 2016

**Blue Cross Blue Shield of North Dakota**

**Ambulance Fee Schedule**

**Effective 1/1/2016**

**RESTRICTED AND CONFIDENTIAL**

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Description</th>
<th>2015 Rate</th>
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<tbody>
<tr>
<td>A0225</td>
<td>Ambulance service, neonatal transport, base rate, emergency transport, one way</td>
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<td>A0425</td>
<td>Ground mileage, per statute mile</td>
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<td>Ambulance service, advanced life support, non-emergency transport, level 1 (ALS 1)</td>
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<td>Ambulance service, advanced life support, emergency transport, level 1 (ALS 1 - emergency)</td>
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<td>Ambulance service, basic life support, non-emergency transport (BLS)</td>
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<td>Ambulance service, basic life support, emergency transport (BLS - emergency)</td>
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<td>A0431</td>
<td>Ambulance service, conventional air services, transport, one way (rotary wing)</td>
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<td>Fixed wing air mileage, per statute mile</td>
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<td>Rotary wing air mileage, per statute mile</td>
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<td>Ambulance response and treatment, no transport</td>
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<td>S9961</td>
<td>Ambulance service, conventional air service, nonemergency transport, one way (rotary wing)</td>
<td>7,897.23</td>
</tr>
</tbody>
</table>
What Will We Collect?

• The Best Performing Ambulance Services in US will only collect 50% of what they charge.
• Only 5-10% of that will likely be “Bad Debt”
• Majority will be Contractual Allowance
• Full Rate collection only likely from 5-10% of your patients
Who Pays The Best?

- Medicare & Medicaid reimburse below cost to deliver most EMS services
- Motor Vehicle Insurances
  - Limited Amounts Available
- Insurance Companies
  - May Offer Negotiated Payments
- People Who Pay Their Bills
You Should Charge No Less than the Highest Published Rate Schedule!

You Can Charge No Less Than you bill Medicare!
What If We Get Denied?

• Overview of Appeals Process
• Redetermination
  • Written appeal to MAC
  • 120 days to file from date of initial determination
• Reconsideration
  • Written appeal to Qualified Independent Contractor (QIC)
  • 180 days to file from date of Redetermination decision
• Administrative Law Judge (ALJ) Hearing
• Department Appeals Board
• Federal District Court
Should We Use Collections?

• Must Weigh Amounts to be Collected vs. Potential Negative Public Perception

• Collection Agencies Use Aggressive Tactics

• Keep a Substantial Percentage of the funds collected.
Membership/Subscription Programs

- Fixed Annual Rate for Ambulance Services
- Needs to be at least equivalent to Medicare Co-Pays
- Insurance Supplement
  - Right to bill and collect existing 3rd party payers
- Medical Necessity Clause
- Address out-of-area events
- A lot of work to administer
What Documentation is Required to Bill for EMS Services?
Sufficient Information to Support Medical Necessity and Level of Service
Patient Signature Requirement

• Patient’s actual signature is required to submit a claim to Medicare, unless:
  1. Patient is deceased – No signature required
  2. Patient is physically or mentally unable to sign – Claim can be submitted with an alternative signature
Alternatives to Patient Signature

1. Patient’s Legal Guardian
2. Person who receives Social Security or other government benefits for patient
3. Person who arranges for treatment or otherwise exercises responsibility for the patient’s affairs
4. Representative of an agency or institution that provided care to the patient, but who did not furnish the services being billed
Exception for Ambulance Services

• Patient mentally or physically incapable of signing; and

• None of the permitted individuals was able or willing to sign on the patient’s behalf; and

• Either
  • Signed contemporaneous statement from a representative of the receiving facility documenting the name of the patient & the date and time received; or
  • Secondary Verification
ALS 1 Justification

• Must state who completed the assessment
• What tools were used during assessment
• Provider must sign the form.
What Is On The Horizon?

The IHI Triple Aim

- Population Health
- Experience of Care
- Per Capita Cost
Value
HEALTHCARE IS TRANSFORMING

Our nation’s healthcare system is transforming from paying for volume of care to one that rewards value, known as Healthcare 3.0. EMS can be a part of Healthcare 3.0 if it undergoes its own transformation by expanding services and demonstrating value.

Outcomes and performance data

Patient-centered
Medicare Providers vs. Suppliers

Providers of Service
• Physicians
• Hospitals
• Skilled Nursing Facilities
• Long-Term Acute Care Hospitals

Suppliers
• Ambulance Services not associated with hospitals
• Durable Medical Equipment Suppliers
Why the Distinction?

Suppliers

- Do not provide health care services
- Provide commodities
  - Equipment
  - Supplies
  - Transportation
- Costs set based upon the commodity
  - DMEPOS subject to competitive bidding
  - Ambulance focuses on the transport aspect
EMS and health systems: 20 years of historically recognized potential – now more broadly incentivized, through Medicare APMs

EMS Agenda for the Future: 1996

“(EMS) of the future will be community-based health management that is fully integrated with the overall health care system…contribute to treatment of chronic conditions and community health…”
Our nation's healthcare system is transforming from a “fee-for-service” model to a patient-centered, and value and outcomes-based model, referred to as Healthcare 3.0. EMS can be a part of Healthcare 3.0 only if it undergoes its own transformation by expanding services and demonstrating value. EMS 3.0 includes:

- Post-discharge follow-up, preventive care
- Chronic disease management and support
- Alternative transportation or referral to community health or social services resources
- Emergency and critical care transport
- Nurse advice
- 24/7 emergency medical dispatch (911)
- Rapid response, medical assessment and treatment
- Urgent cardiac, stroke, trauma, mass casualty/disaster care

EMS is uniquely positioned to support our nation's healthcare transformation by assessing and navigating patients to the right care, in the right place at the right time. Let's move our profession to EMS 3.0.