Fraud and Abuse
Emergency Medical Services and Ambulance Services
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What I Will Share
• Overview of Emergency Medical Services
• The Problem
• OIG Compliance Guide
• Coverage Requirements
• Targeted Scrutiny
• More on Medical Necessity
• In-Pari Delicti: the Physician Certification Statement
• Experiment in Repetitive Transportation
• Institutional Discounting-Swapping Arrangements
• Implications for the Pre-hospital Arena
• Settlements and CIA
• Other Compliance Concerns
• Unintended Consequences

Overview of Emergency Medical Services
• Lower Mode
• Pre-Hospital Care
• Non Emergency Ambulance Transportation
• Basic Life Support
• Advanced Life Support
• Specialty Care (Critical Care)
• Air Medical(Critical Care)
Overview

Pre-Hospital Emergency
9-1-1-

Inter-Facility(Non Emergency)

The Problem

- 4.9 Billion Each Year (583 Billion) 0.8%
- ~350 Million Fraud
- Blatant Criminality
- Frequent Advisory Opinion Requests
- Medical Necessity
- Mileage Up-coding
- Level of Service (Case Mix) Up-coding
  - Routine Waiver of Copayments
  - Membership Programs
- Highly Scrutinized Areas
OIG Compliance Guide 2003

- improper transport of individuals with other acceptable means of transportation;
- medically unnecessary trips;
- trips claimed but not rendered;
- misrepresentation of the transport destination to make it appear as if the transport was covered by a federal health care program;
- false documentation;
- billing for each patient transported in a group as if he/she were transported separately;
- Up-coding from basic life support to advanced life support services; and
- payment of kickbacks

Medical Necessity Verses Reasonable and Necessary

Medical Necessity
- Contraindication
- Reasonable and Necessary
  - Why They Are Going
Covered Origins (Pick Up)

- Origins
  - Hospital
  - SNF
  - LTAC
  - Rehab Hospital
  - Scene
  - Residence
  - Helicopter/Fixed Wing Air Transport LZ

Destinations (Drop Off)

- SNF
- Hospitals
- Renal Dialysis Centers (Hospital Based or Free Standing)
- Residence
- Helicopter/Fixed Wing Air Transport LZ

- Closest Appropriate Rule
  - Excess Miles-Statutory Exclusion

Scrutiny: OIG Targeted Areas

- Hospital to Nursing Homes
- ED to Nursing Homes
- Hospital to Residential Facilities
- Hospital to Private Residence
- Repetitive Transportation
General Rule

• Transport by Other means is Contraindicated
• Statutory Exclusion
• Lack of a Bright Line Rule (Totality of the Circumstance)

Bed Confined
Medicare’s National Definition

• The Beneficiary is:
  • Unable to get up from bed without assistance;
  • Unable to ambulate;
  • Unable to sit in a chair, including a wheelchair;

*** ALL THREE CRITERIA MUST BE MET ***

• Bed confinement is NOT the sole criterion for medical necessity.

Other Indicators of Medical Necessity

• Patient’s Medical Condition Requires Advanced Life Support
• Severe Dementia or Reduced Level of Consciousness
• Acute Need for Oxygen (Clinical Evidence of Hypoxemia)
• Airway Monitoring/Aspiration
• Injurious to Self or Others (Physically or Chemically Restrainted)
• Active Isolation for a Contagion
• Frequent Seizures
• Special Handling Needed for Movement (Bariatric)
Physician Should Execute

- Physician Assistant (PA)
- Nurse Practitioner (NP)
- Clinical Nurse Specialist (CNS)
- Registered Nurse (RN)
- Discharge Planner
- Personal knowledge of the beneficiary's condition at the time the ambulance transport is ordered or the service is furnished.
- Physician Must Execute for Repetitive Transportation (3 in 10 Rule)
In Pari Delicti

- Physician Certification Statement
Routine Waiver of Copayments (Subscriptions)

- Proscribed in Some States
  - NY
  - May Require Jurisdictional Approval (California)
- Actuarial Soundness
- Language
- Tax Based Government Providers—OIG Safe Harbor

Repetitive Transportation

- 60 Days
  - Start at 45 Days
  - PCS and Repetitive Survey
- 3 or more Transport in 10 Days or
- 1 per week for 3 weeks
- MUST BE PHYSICIAN WHO IS KNOWLEDGABLE ABOUT PATIENT LOOK TO PCP
Issues With Pre-Hospital

- EMTALA
  - Doesn’t Apply to Independent Agencies
- Umbrellas
  - Medical Command
  - Hospital-owned Ambulances
- Restocking Implications-Safe Harbor
- Intercept Agreements
- MAC Local Coverage Determination Policies More Liberal
- Coders Typically Use Presumptive ICD-9 (10)
- Dispatch Fees-AKS
- Dispatch Determinants and Medical Priority Dispatch
- Waiver of Copayments and Deductibles
- Safe Harbor Regulations

Pilot (New Jersey, South Carolina, and Pennsylvania)
Institutional Discounting

- OIG Advisory Opinion 99-2
  - Substantial in Excess
  - Deep Discount/Swapping
    - Average Total Loaded Costs
    - Referral Pattern Related to Level of Discount
- Klaczak V. Consolidated Medical Transports, Et Al 458 F.Supp.2d 622
- American Medical Response CIA-Swapping
- Potential Impact of Safe Harbor Regulations

CIA-Settlelements

- Lynch Ambulance($3M) QT
  - Medical Necessity
- First Call Ambulance ($500k)
  - Up-coding: BLS to ALS
- Trans-Star Ambulance Service ($948K) QT
  - Medical Necessity
- Tri-County Ambulance
- Rural/Metro Corporation($5.4M) QT
  - Up-coding Non-Emergency to Emergency
  - Medical Necessity
- American Medical Response, Inc.($9.0m) (QT)
  - Swapping Arrangement –Institutional Discount

Other Compliance Concerns

- Referral Liaisons-AKS
  - Assist with Compliance
- Lower Mode Medical Transportation and Safe Harbor
Unintended Consequences

- Criminal and Civil Monetary Penalties to EMS Agency
- Financial Impact to Ambulance Provider-Bad Debt
- Patient Responsible for Expensive Unnecessary Ambulance Transport
- Increased Financial Costs to Referring Agency
- Depletion of Vital Resources
- Joint Culpability

Risk Mitigation

- Repetitive Reviews
- Engage Medical Director
- Train All Ambulance Coders
- Use Transport Liaisons as Compliance Soldiers
- Educate Referral Points
- Assemble Non Biased Supporting Documentation
- Study Demand Pattern
- Use Medicare Data/CBR to continuous Review Experience against Peers

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