
Medical Transportation- Making Sense of the Ambulance Compliance Conundrum



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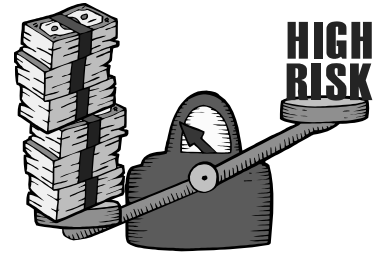
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Overview

- What are the various modes of medical transportation available in the marketplace today?
- What are the compliance risks unique to each mode of transport?
- Medicare's Ambulance Fee Schedule
- Kickbacks, Swaps, and the "Substantially In Excess Of" rule
- Recent Advisory Opinions
- Sample Contract Provisions
- Questions and (hopefully) Answers

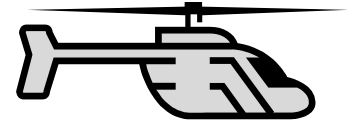
Why is there ANY risk at all?



- “Medicare patients compris[e] 50% of total transports for our industry on average” American Ambulance Association Past President Mark Meijer's Testimony, Senate Hearing on Medicare Ambulance Payment Policies, Nov. 15, 2001.
- ONE out of EVERY TWO trips involves Federal Healthcare Program Compliance Liability
- That figure doesn't even include Medicaid, FEHBP, Black Lung, and the myriad of Federal Healthcare programs OTHER than Medicare.



Medical Transportation Modes



- **AMBULANCE:** usually a vehicle equipped with lights and sirens, that is licensed by the state EMS authority, equipped with certain life-saving equipment, and is staffed by emergency medical technicians-basic (EMT-B). Sometimes called SCTU/CCTU when highly advanced care is involved. **Medicare-reimbursable**, if regulatory criteria and medical necessity rules are met.
- **INTERCEPT MICU:** any vehicle that does NOT transport patients, but does bring advanced care providers (usually mobile intensive care unit paramedics) to the scene where an ambulance will transport the patient. Generally **NOT Medicare-reimbursable** (very limited circumstances)

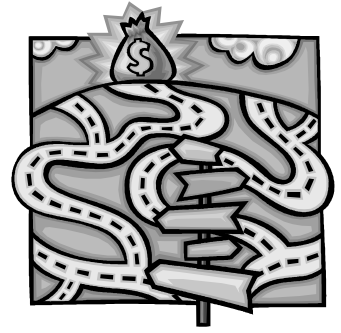


Medical Transportation Modes-Con't.

- **AMBULETTE/STRETCHER VAN:** usually a van that is modified to accept a stretcher during transport; may not be staffed by EMTs; may not contain any life saving equipment; NO lights and sirens. ***NOT Medicare-reimbursable.***
- **INVALID COACH/MOBILITY ASSISTANCE VEHICLE:** usually a “high-top” van with a ramp or lift that can accommodate a wheelchair bound patient. May be staffed by a “Patient Assistance Technician”. ***NOT Medicare-reimbursable;*** Medicaid allowable.
- **MEDICAL LIVERY/AID CAR:** nothing more than any motor vehicle used to transport a patient to/from a “medically-related” destination. ***NOT Medicare-reimbursable.*** Generally Medicaid allowable



National Medicare Fee Schedule



- Implemented April 1, 2002 (April Fool's?)
- Result of a “negotiated rule making process”
- Completely overhauled Medicare’s ambulance reimbursement system
- 5 year “phase-in” of the new reimbursement methodology (moving from “charge-based” to a national “fee schedule”)
- Multiple rates for mileage charges eliminated
- Physician Certification requirements changed/clarified
- Assignment Made Mandatory
- New Levels of Service Identified
- New Payment Policies for Multiple Patients Transported in a Single Ambulance
- New Rules to Obtain Enhanced “Emergency” Response Reimbursement



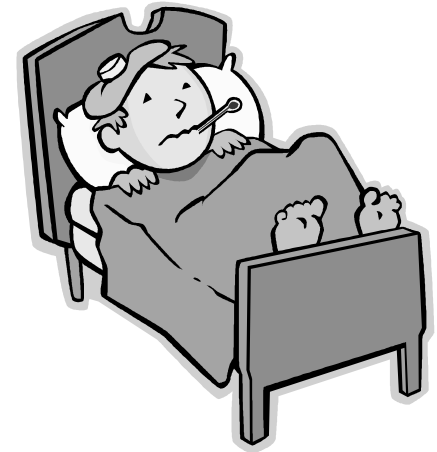
What are the Rule's Compliance Pitfalls

- Medical Necessity-Ambulance transportation is a covered benefit of Medicare Part B. Coverage is based on the following criteria:
 - The services must be **medically necessary** AND **reasonable** for the condition of the patient;
 - If non-emergent, must obtain a PCS form, or prove that you couldn't get it with a certified mail receipt. Don't have either? Don't submit a claim to Medicare.
 - "Needs to be restrained"= one medical necessity ground; was the patient actually restrained? Does the PCR support the restraint?



Fee Schedule Compliance Pitfalls-Con't.

- **Bed confined:** The patient “is unable to get up from bed without assistance; [is] unable to ambulate; and is unable to sit in a chair or wheelchair.” For purposes of ambulance medical necessity, the term “bed confined” is NOT synonymous with the terms “bed rest” or “non-ambulatory.” Physicians are often unaware of this.
- **BED CONFINEMENT ALONE DOES NOT CREATE MEDICAL NECESSITY FOR AMBULANCE SERVICE**-other methods of transportation must be “contra-indicated” as well.



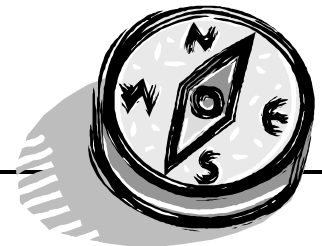
Fee Schedule Compliance Pitfalls-Con't.



- The condition of the patient must contraindicate transportation by any other means;
 - For example, if the patient is on oxygen, but can travel in a car with their own portable O2 supply, then ambulance transport is **NOT** medically necessary
- The ambulance personnel's record must support the medical necessity for ambulance transportation
 - Training the EMS personnel to prepare complete, timely, and compliant patient care reports is daunting, at best.

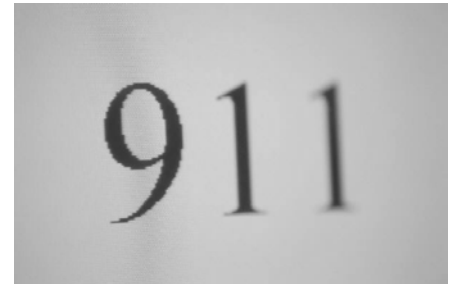
Fee Schedule Compliance Pitfalls-Con't.

- If the transport is inter-facility, the care required by the patient must not be available at the first hospital, the patient must be admitted to the second hospital, the second hospital must be the closest appropriate facility for the patient based on their medical condition.
 - Closest “appropriate” doesn’t mean “best” or even “preferred”; just closest facility that is able to care for the patient. Physicians often don’t agree with this, and patients end up with non-reimbursable trips as a result (or worse, trips that are billed incorrectly!)



Fee Schedule Compliance Pitfalls-Con't.

- Emergency vs. Non-Emergency; how to code?
 - Call must come in by “9-1-1” or equivalent. What’s the “equivalent”?
- New ALS service levels; ALS 1 vs. ALS 2:
 - ALS-1 service=transportation by ground ambulance vehicle, and EITHER an ALS assessment by ALS personnel OR the provision of at least one ALS intervention. ALS-2 is defined as ALS-1 service plus the administration of at least three medications
 - Some medications DON'T qualify as “medications” for ALS service level determination (i.e., glucose, aspirin, etc.)



Fee Schedule Compliance Pitfalls-Con't.

- “ALS interventions” include an ALS assessment, even if that assessment results in the finding that no further ALS treatment is warranted.
 - What to do if an ALS intervention is performed, and then the patient is not sent to the hospital? Bill base ALS-1, but NO miles, IF the BLS unit DOESN'T BILL FOR ITS' SERVICES.
 - IF THE BLS SERVICE IS VOLUNTEER, THAT DOESN'T NECESSARILY MEAN THAT IT WILL NOT BILL FOR ITS' SERVICES.



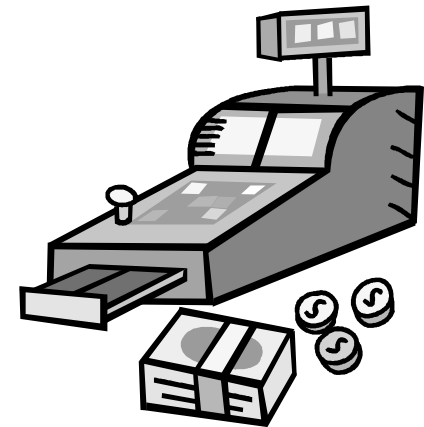
Fee Schedule Compliance Pitfalls-Con't.

- Elimination of multiple billing methods-charges for supplies have been “bundled” into the base rate raises
 - Is the DHHS “Ambulance Restocking” safe harbor implicated? The Safe Harbor provides that, “[u]nder no circumstances may the ambulance provider and the receiving facility BOTH bill for the same replenished drug or supply.” Replenished drugs or supplies may only be billed (including claiming bad debt) to a federal healthcare program by EITHER the ambulance provider (or first responder) or the receiving facility.
 - If payment for replenished supplies is included in the base rate, then hospitals that engage in restocking programs cannot bill for the supplies issued to ambulance suppliers, if the suppliers bill for their services.



Fee Schedule Compliance Pitfalls-Con't.

- It seems that the Fee Schedule rule has the practical effect of eliminating Safe Harbor coverage for replenishment arrangements with ambulance providers that bill for their services, if the replenishing hospital cannot ensure that it will not bill for the replenished supplies (VERY Difficult to do).



Fee Schedule Compliance Pitfalls-Con't.

- One single mileage code (A0425) for ground ambulance.
 - Balance billing patients correctly will be difficult; most providers have different mileage rates for different mileage types; Medicare beneficiaries are only responsible for co-payments at the new “all in one” rate.



Fee Schedule Compliance Pitfalls-Con't.

- When transporting two patients in the same ambulance, the payment allowance for the Medicare beneficiary (or for each of them, if both are Medicare beneficiaries)
 - ❑ 75% of the applicable base rate (at the level of service provided to the beneficiary), plus
 - ❑ 50% of the applicable mileage payment allowance.
 - ❑ Most EMS patient care records do NOT indicate that multiple patients were transported in the same ambulance; to the coder/biller, each PCR looks like a separate call and is likely to be billed at 100% of the base and mileage.
 - ❑ 3 or more? It's even MORE difficult.



Referral Agreements

- Facility Ambulance Service referral agreements come in many “flavors”:
 - Exclusive Provider Contracts
 - “Preferred” Provider Contracts
 - Willing Provider Contracts
- All have the potential to create compliance liability



Referral Agreements-Con't



■ Exclusive/Sole Provider Agreements

- Oftentimes, providers offer to pay a fee in return for an exclusive “franchise”.
- The Anti-Kickback statute prohibits payment of anything of value in exchange for a referral of federal healthcare business
- “Anything” means just that- “anything”; including-
 - the free services of an “on-site transport coordinator” who performs services for the facility
 - Discounted rates for associated goods/services (for example, in many cases, ambulance services also operate DME companies)

Referral Agreements-Con't.



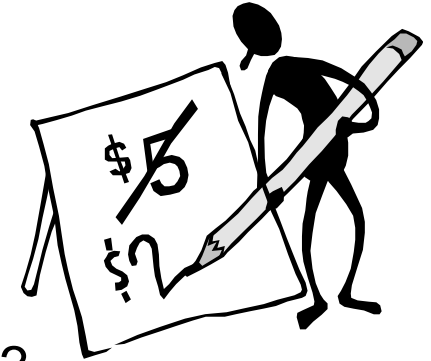
- Exclusive providers may offer to facilitate completion of PCS forms; there is substantial compliance risk for the facility (whose personnel will likely sign the forms) associated with surrendering control of the PCS process.
- What if the PCS forms aren't accurate? Who is at risk? The ambulance supplier who relied on them, or the facility that prepared them, or both?

Referral Agreements-Con't

- “Preferred Provider” agreements
 - Watch out for prohibited “swapping” arrangements
 - “Trading” well-compensated federal healthcare referrals for poorly compensated payer beneficiary trips.



Referral Agreements-Con't.



- ❑ Discounts ALSO Can implicate “Swap” liability-
is there a sophisticated discounting arrangement?

If so, does it violate the restrictions contained in the “AML discount letter”

(<http://oig.hhs.gov/fraud/docs/safeharborregulations/amldiscount.htm>)

- arrangements involving ambulance companies that give hospitals and nursing facilities deep discounts for business that the facilities pay for out of their own pockets, in return for the referral of more lucrative Medicare Part B business for which the ambulance companies receive direct reimbursement ... these arrangements raise potential issues under both the [AKS] ... and the exclusion authority relating to charges to the Medicare or Medicaid programs that are substantially in excess of a provider or supplier's usual charges

Referral Agreements-Con't



■ Willing Provider Agreements

- Not for Profit facilities should watch out for unusual patterns of charitable giving by the competing ambulance vendors
- Charitable giving that varies directly with the volume of referrals may be a violation of the AKS.
- Discrimination in accepting referrals based on payer-may be a violation of state licensure regulations

Discounting-How Much is Too MUCH?

- Medicare's "substantially in excess of" rule (most) favored nation clause) §1128(b)(6)(A) prohibits charges to Medicare in excess of a supplier's "usual charges"
- Don't try to play games with charge levels to achieve "seeming" compliance. The Government has LOTS of VERY GOOD forensic accountants.



Discounting-Con't.



- If a facility is referring Medicare ambulance business to a supplier, and is receiving a substantial discount on bundled trips/RUG trips in return, the arrangement may have risk.
 - AML discount letter: Ambulance service can discount nearly “half of its non-Medicare/Medicaid business” without fear of compliance risk. Which half? How much?
 - Advisory Opinion 99-2: 10% discount from Medicare allowable, to reflect decreased costs, is acceptable; 50% is not.
 - Risk is to BOTH parties, NOT just ambulance service.

Advisory Opinion Bingo-Where's the "Free Space"

- ❑ Advisory Opinion's-the Government's "Stay Out Of Jail Free" Card.
- ❑ Advisory Opinions bind the OIG and the REQUESTER ONLY.
- ❑ OIG's Advisory Opinions ONLY address the Anti-Kickback Statute and the Exclusionary Authority.
- ❑ 121 issued since 1997
- ❑ 27 of these (nearly 25%) concern ambulance/medical transportation issues
 - Ambulance is less than 2.5% of Medicare's annual reimbursement, yet 25% of the advisory opinions address ambulance reimbursement

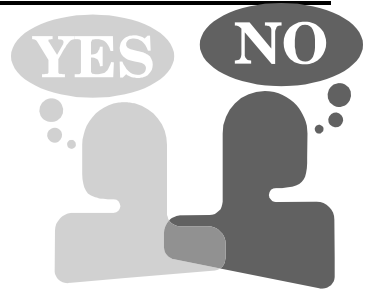


Notable Advisory Opinions

- 99-1: The seminal opinion on waivers of ambulance co-payments in emergencies. Fact specific, but good explanation of the OIG's usual rationale:
 - no harm to the program
 - no harm to the beneficiaries
 - state-law safeguards exists to protect against future harm
 - positive opinion will permit a good program to continue in compliance with local law, rule and custom)



Notable Advisory Opinions-Con't.



- 99-2: How NOT to offer a discount. This was an opinion asked for by a company that wanted to prove that their competitor was illegally discounting services (50% of Medicare allowable was NOT allowable).
- 00-9: How to operate a compliant ambulance restocking program (safe harbor adopted 2001, as well)
- 01-11 AND 01-12 (must read together): Municipal Ambulance Services CAN waive co-payments; private ambulance service bidders for municipal contracts CANNOT.
- 03-11: Confirming that actuarially sound “subscription programs” are permitted; raising the question concerning what to do about subscription programs that are retroactively found NOT to be actuarially sound.

Notable Advisory Opinions-Con't.



- 04-10: Exclusive Contracting for Municipal Ambulance Service is Permissible, even in the presence of a “pay to play” scheme, if appropriate. One of the most limited and circumspect opinions published by OIG to date; (“[o]ur determination not to impose sanctions in connection with the Proposed Arrangement derives from the particular facts presented”; OIG gave a laundry list of factors that, if present, would turn the opinion on its head.)

Notable Advisory Opinions-Con't.

- 04-14: Latest in a LONG line of “Municipal Ambulance Service Co-payment Waiver” opinions (citing Ch 16, §50.3 of the Medicare Benefit Policy Manual; interpreting “facility” to include “municipality”); continues 01-11 reasoning.



Sample Contract Provisions



- Warranty as to the operation of the ambulance service's operation of an effective compliance program that embodies the principles in the OIG's suggested ambulance compliance guidance. 68 FR 14245
 - Include a representation concerning receipt, review of, and compliance with the Facility's compliance plan, including specific reporting duties.

Sample Contract Provisions-Con't.

- Warranty as to the ambulance service's compliance with all state and local
 - ambulance service,
 - vehicle and
 - personnel standards, including-
 - licensing,
 - certification, and
 - inspection standards



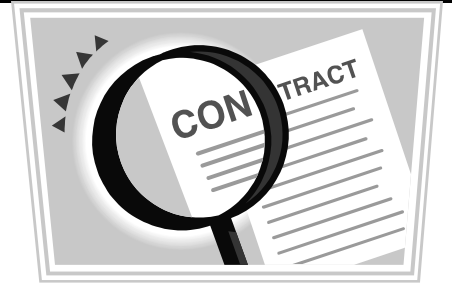
Sample Contract Provisions-Con't.

- **Rate Setting:** for services provided where the Facility is at risk, set:



1. The circumstances under which the Facility bears risk for the service and specifying payment methodology, AND
2. The rate (preferably expressed as a percentage of the ambulance supplier's Medicare allowable fee, by HCPCS code)
 - Rates of less than 90% of Medicare allowable are strongly suspect.

Sample Contract Provisions- Con't.



- **Anti-discrimination: Both the Facility and the ambulance supplier will not discriminate in connection with the transportation of patients based on the patient's payor/payment status.**
 - This prevents “cherry picking” and also protects against “accidental” swapping; if the ambulance service handles a broad range of patients, it is less likely that the supplier will end up with two universes of patients; one composed of Federal Healthcare Program beneficiaries, and one composed of

Sample Contract Provisions- Con't.



- Ambulance Restocking Warranty (for those agencies that restock); warrant and represent compliance with one of the niches found at 66 FR 62979
 - Specify which agency is charging for the supplies; given the fee schedule's elimination of the "supplies billed separately" method, it will almost ALWAYS be the ambulance supplier
 - The facility will have to keep a sharp eye on the cost report with these types of arrangements.

Sample Contract Provisions-Con't.



- My “patented” general “Compliance/AKS” warranty:
“Each party certifies that they possess the authority to enter into this Agreement, and that they enter into this Agreement ‘at arms length’, that the payments set forth herein are consistent with fair market value, and that neither party has been subject to duress or other undue influence by any party during the negotiation of this Agreement. No improper or illegal remuneration, benefit or privilege has been conferred under this Agreement or otherwise to induce the referral of patients by any party to any other party or an affiliated entity, or the purchasing, leasing, or ordering or any item or service.”
- Not GUARANTEED to save you from liability, but, IMHO, worth including, nonetheless.

Conclusion



- Any Questions?
- Follow Up inquiries to:
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- Thanks for your kind attention!