Medicare and Reimbursement Update
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  - Must attend entire conference to earn full 12 credits
  - CACs: Log into your NAAC account enter your CEUs
  - CACOs and CAPOs: Email completed certificates to: j.leet@ambulancecompliance.com

- **AAPC**
  - Each CE-approved session has a CEU code and approved number of CEUs
  - Codes will be given at each session
  - Copy them down and enter on your CEU Code Card

Orlando
Rosen Centre Hotel

April 12-13

April 9-11

St. Louis
Hyatt Regency at the Arch

June 8-9

June 5-7

New Features:
- Ambulance ICD-10 Codes
- Common EMS abbreviations
- Medicare appeals info
- Revalidation tips
- MAC-specific info
And all ambulance codes, modifiers, definitions and billing tips!

Facility Contracting Tool Kit

- Model facility contracts for SNFs, hospitals, hospices
- PWW Cost Analysis Tool
- Facility Education Packet
- Detailed explanation of pricing compliance strategies

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Includes:

• Sample Social Networking Policy
• Staff training materials
• Approved for CEU credit
• Detailed explanation of the law and your rights

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And Our Latest Publication…

Includes:

Model Compliance Plan
Model Code of Conduct
Model Policies and Forms
Model Compliance Training
Day One General Sessions

- The Medicare and Reimbursement Update
- A Holistic Look at the Ambulance Revenue Cycle
- CDI for EMS
- The Top 10 “Phrases of Rejection”
- A View From the Other Side

2016 Reimbursement Items

2016 Ambulance Inflation Factor

- Negative 0.4%
  MLN Matters Number: MM9412

Bonuses Extended Through 12/31/17

- Medicare Access and CHIP Reauthorization Act of 2015
Medicare Ground Ambulance Bonuses
• 3% for rural transports
• 2% for urban transports
• 22.6% for super-rural transports

Here’s the problem…

The Last “Doc Fix” Bill
• This bill permanently repealed the Sustainable Growth Rate (SGR) for physicians
• “Doc fix” bills were typically the vehicle used for getting ambulance bonuses extended

CY 2016 Final PFS
• Effective as of January 1, 2016

FEDERAL REGISTER
Vol. 80
No. 130
July 19, 2016

3 Things the Rule Does
1. Updates regulations for bonus payments through 12/31/17
2. Maintains geographic changes from CY 2015 Rule (zip code related)
3. Revises ambulance staffing regulations

The Staffing Regulations
• Revised regulations to require that all ambulances be staffed by at least two people who meet the requirements of applicable state and local laws where the services are being furnished
Medicare Cost Sharing 2016

- Part B Monthly Premium - $104.90
- Part B Deductible - $166.00

2016 Enrollment Fee

- $554.00
- Applicable to:
  - Initial enrollment
  - Revalidation
  - Addition of a practice location

2016 Poverty Guidelines

https://aspe.hhs.gov/poverty-guidelines

Current HHS Interest Rate

- For overdue debts due to HHS, current interest rate is: 9.75%

A Big Report From the OIG

What the OIG Looked At

- Claims data for 7.3 million ground ambulance transports during the first half of 2012
Overall Findings

• Medicare paid $24 million in first half of 2012 transports that didn’t meet program requirements
• An additional $30.2 million paid for transports where the beneficiary didn’t receive Medicare services at either the pick-up or drop-location, or anywhere else

More Medicare Payments Than Suppliers in Other Metropolitan Areas

<table>
<thead>
<tr>
<th>Metropolitan Area</th>
<th>Average Number of Beneficiaries per Supplier</th>
<th>Average Medicare Payments per Beneficiary</th>
<th>Average Medicare Payments per Supplier</th>
</tr>
</thead>
<tbody>
<tr>
<td>Los Angeles, California</td>
<td>69</td>
<td>$1,525</td>
<td>$105,968</td>
</tr>
<tr>
<td>New York, New York</td>
<td>68</td>
<td>$1,264</td>
<td>$85,608</td>
</tr>
<tr>
<td>Philadelphia, Pennsylvania</td>
<td>38</td>
<td>$1,507</td>
<td>$56,667</td>
</tr>
<tr>
<td>Houston, Texas</td>
<td>24</td>
<td>$1,432</td>
<td>$34,961</td>
</tr>
<tr>
<td>All Other Metropolitan Areas</td>
<td>18</td>
<td>$880</td>
<td>$16,120</td>
</tr>
</tbody>
</table>

In this report, the OIG developed “7 Measures of Questionable Billing for Ambulance Transports”

In other words, if the supplier had a high percentage of these things, they were engaging in “questionable billing”

1. No Medicare Services at Origin or Destination

• “Such transports may indicate billing for transports:
  • To noncovered destinations or
  • Transports that were not provided.”

According to the OIG

• These were transports where beneficiaries did not receive Medicare services within 1 day of transport at the origin or destination indicated
  • And, they didn’t receive Medicare services at any other facility within 1 day of transport
Noncovered Destinations

<table>
<thead>
<tr>
<th>Noncovered Destination</th>
<th>Number of Transports for Which the Beneficiary Received a Service at the Noncovered Destination</th>
<th>Medicare Payments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physician office</td>
<td>25,629</td>
<td>$8,724,151</td>
</tr>
<tr>
<td>Community mental health center or psychiatric facility</td>
<td>18,097</td>
<td>$5,015,778</td>
</tr>
<tr>
<td>Independent laboratory or other diagnostic or therapeutic site</td>
<td>12,019</td>
<td>$4,990,113</td>
</tr>
<tr>
<td>Nursing facility (non-SNF) or long-term-care facility</td>
<td>6,220</td>
<td>$1,971,327</td>
</tr>
<tr>
<td>Other noncovered destinationa</td>
<td>1,779</td>
<td>$541,263</td>
</tr>
<tr>
<td>Hospital facility</td>
<td>1,203</td>
<td>$391,012</td>
</tr>
<tr>
<td>Totalb</td>
<td>52,421</td>
<td>$17,440,431</td>
</tr>
</tbody>
</table>

To Be Covered by Medicare…

- Ambulance transports must be for the purpose of receiving or returning from a Medicare-covered service
  Medicare Benefit Policy Manual Ch. 10 §10.2.1

- OIG excluded claims where patients died
- But, they didn’t account for things like:
  - Patient refused care at hospital
  - Other provider didn’t bill, or mistakenly billed for wrong date
  - CMS’s system didn’t work properly
  - Other reasons

2. Excessive Mileage for Urban Transports

- “Such transports may indicate billing for more miles than suppliers actually drove or transports to facilities other than the nearest appropriate facilities.”

Use onboard Odometers

If you’re using internet mapping, use the shortest distance

Document Why You Went Further

- Patient choice
- Closer facility lacking resources
- Diversionary status
- Construction
- etc.
3. High Number of Transports Per Beneficiary

- “Such transports may indicate billing for transports that were medically unnecessary”

Calculate Your Average NE Transports Per Patient:

<table>
<thead>
<tr>
<th>Number of Services</th>
<th>Number of Beneficaries</th>
<th>Average Submitted Charge</th>
<th>Average Medicare Allowed Amount</th>
<th>Average Medicare Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>1241</td>
<td>288</td>
<td>$467</td>
<td>$208.95</td>
<td>$166.66</td>
</tr>
</tbody>
</table>

- $1241 \div 288 = 4.30$
- Each beneficiary received an average of 4.3 BLS-NE trips

4. Compromised Beneficiary Number

- “Such transports may indicate billing for transports that were medically unnecessary or were not provided.”

5. Inappropriate or Unlikely Transport Level

- “Such transports may indicate:
  - Upcoding or
  - Transport levels that were medically unnecessary”

Trips the OIG is Looking At

- SCT transports between facilities other than hospitals or SNFs
- Emergency transports that went to nonhospital destinations

“Emergency transports to nonhospital destinations are presumed to be inappropriate.”

Emergency Transports

- Most common “inappropriate” destination was SNFs
- Second – residences
Emergencies: On the Radar

• HCPCS Codes A0427 & A0429 with a destination modifier of:
  ▪ R (residence)
  ▪ N (Skilled Nursing Facility)
  ▪ E (Other Custodial Facility)
  ▪ J (Free-Standing Dialysis Facility)

SCTs: On the Radar

• HCPCS Code A0434 with an origin or destination modifier of:
  ▪ R (residence)
  ▪ N (Skilled Nursing Facility)
  ▪ E (Other Custodial Facility)
  ▪ J (Free-Standing Dialysis Facility)

Consider Edits in Your Billing System

6. Beneficiary Sharing

• High average number of suppliers providing dialysis transports to the same patient
  • “Such transports may indicate:
    ▪ Misuse of beneficiaries’ numbers or
    ▪ Shopping by beneficiaries among suppliers to receive higher kickbacks.”

7. Transports To or From Partial Hospitalization Programs

• “Such transports are likely to be medically unnecessary because beneficiaries who meet Medicare coverage requirements for PHPs generally do not meet the requirements for transports.”

Your Documentation Better be Rock Solid on Medical Necessity
1 in 5 Suppliers had “Questionable Billing”

But, most met none or only one of the OIG’s “Questionable Measures”

And…

• The OIG found that only 2.7% of the total claims they looked at were questionable
• Only 21% of all suppliers had one or more questionable claims

Note From the OIG:

“The seven measures of questionable billing used in this study do not provide conclusive evidence of fraudulent billing.”

The OIG’s 5 recommendations...

1. Expand Temporary Moratoria

• CMS should consider whether the existing moratoria (in Houston and Philadelphia) should be expanded to New York and Los Angeles
• CMS said it will continue to monitor these areas
CMS Already Expanded Through July, 2016…

- Moratorium on newly enrolling ground ambulance suppliers in:
  - Philadelphia area
  - Houston area

2. Inclusion of NPI

- When PCS is required, physician’s NPI should be listed on:
  - Claim
  - PCS forms
- CMS will consider the best way to implement this recommendation

Recommendations

- Consider including line on PCS forms for physician’s NPI
  - Already required for NE repetitive transport prior authorizations
  - May be required to maintain physician’s NPI for 7 years under a proposed rule

3. New Claims Edits

- CMS should update edits to prevent payment for transports:
  - To non-covered destinations
  - With inappropriate combinations of the destination and the level of service billed
    - e.g., emergency transports to a patient’s residence

4. Increase CMS Monitoring

- CMS should continue to monitor billing of ambulance claims using the measures of questionable billing from OIG
- CMS said it would continue its current monitoring

https://npiregistry.cms.hhs.gov/
5. Take Action on Claims From This Report

• OIG will provide CMS with a separate memorandum that lists the claims it identified that did not meet Medicare billing requirements
• CMS said it wanted to review the data before taking any action

Some other interesting quotes in the Report…

“In 2012, Medicare Part B paid $5.8 billion for ambulance transports, almost double the amount it paid in 2003.”

“Medicare billing for ambulance transports warrants scrutiny, given its rapid growth and its vulnerability to fraud and abuse.”

Some Legitimate Reasons

• More providers are billing and doing so more efficiently
   Fee schedule
   Electronic records
• Aging, sicker Medicare population
• More dialysis facilities
• Increased number of beneficiaries

But, That Said…

• The OIG and other Federal enforcement agencies believe that there is proportionately more fraud and abuse of ambulance services than other types of healthcare services
• Careful attention to documentation, coding and compliance is crucial
Revenue Integrity is the Goal

The Take Home

• Focus on key areas identified by OIG
  • Perform internal audits
    – A0427 & A0429 with H origin
  • Promptly identify, report and repay overpayments
  • Conduct periodic outside audits
  • Much more tomorrow in the Compliance Update

ICD-10 Update: They're Here!!!

CMS Ambulance Condition Codes

CMS Ambulance Condition Codes

• CMS's decision to crosswalk the Ambulance Condition Codes is a great step
• Recognizes that CMS sees value in the continuing use of Ambulance Condition Codes

ICD-10 Update: They're Here!!!

Find the list at: https://www.cms.gov/Center/Provider-Type/Ambulances-Services-Center.html

ICD-10 CM/PCS Crosswalk for Medical Conditions List - 2016
CMS Ambulance Condition Codes

- CMS used 3M's ICD-10 CTT (Code Translation Tool)
  - This is essentially a direct, electronic translation from ICD-9 to ICD-10
  - Because of the way CMS selected the original list of ICD-9 codes, some of the direct ICD-10 translations are not optimum for ambulance claims

- The CMS Crosswalk is actually 74 separate PDF files – one for each condition on the Ambulance Condition Code list

CMS Ambulance Condition Codes

- Use of the CMS condition code crosswalk list is voluntary
  - We applaud CMS for issuing a crosswalk
  - But, because of the methodology they used to convert ICD-9 to ICD-10, there are better lists to choose from

Good ICD-10 Ambulance Condition Code Crosswalks

- You are free to use any ICD-10 codes supported by your documentation
  - If your MAC issues an LCD, you must follow that
  - But even in Novitas, their primary codes are merely suggested codes – not mandatory
    - Only the Novitas secondary code list is mandatory

We've Made Your Life Easier!

Clearing up the Crosswalk Confusion
The process of ICD-9 to ICD-10 conversion requires a combination of technical translation and educated interpretation. It’s an art and a science. All of the published crosswalks are simply tools to help you narrow down the list of 68,000 ICD-10 codes to a manageable set of ambulance codes.

ICD-9 or ICD-10? Based on Date of Service

- Systems will need to properly process claims with both ICD-9 and ICD-10 for at least a year
  - Timely filing deadline
  - MSP claims/third party liability
  - Appeals
  - External Audits

ICD-9 or ICD-10? Based on Date of Service

- DOS before 10/1/15 – ICD-9
- DOS on or after 10/1/15 – ICD-10

Joint Press Release Announcing ICD-10 “Flexibility”

What happens if I use the wrong ICD-10 code, will my claim be denied?

“[For 12 months]... Medicare review contractors will not deny physician or other practitioner claims billed under the Part B physician fee schedule... based solely on the specificity of the ICD-10 diagnosis code as long as the physician/practitioner used a valid code from the right [family of codes]...”

“Family of Codes”

- “Family of codes is the same as the ICD-10 three-character category. Codes within a category are clinically related and provide differences in capturing specific information on the type of condition.”

Example:

K50 (Crohn’s disease)

- K50.00 Crohn’s disease of small intestine without complications
- K50.012 Crohn’s disease of small intestine with intestinal obstruction
- K50.90 Crohn’s disease, unspecified, without complications
Do the ICD-10 Medicare fee-for-service audit and quality program flexibilities extend to Medicare fee-for-service prior authorization requests?

- “No, the Medicare fee-for-service audit and quality program flexibilities only pertain to post payment reviews. ICD-10 codes with the correct level of specificity will be required for prepayment reviews and prior authorization requests.”

Does the recent Guidance mean that no claims will be denied if they are submitted with an ICD-10 code that is not at the maximum level of specificity?

- “[A] claim may be denied because the ICD-10 code is not consistent with an applicable policy, such as Local Coverage Determinations or National Coverage Determinations.”

In Other Words…

- There is some flexibility, but ambulance services must still:
  - Code as accurately and specifically as possible based on the clinical documentation
  - Abide by any requirements in a local coverage determination

ICD-10 is not just a coding challenge.

It’s a documentation challenge.

“New” Concepts

- Specificity – more detail as to types of injuries, anatomic location, location of incident, etc.
- Laterality – accurately describing which side of the body is affected by the insult or injury (left, right, bilateral)

Specificity Example - Fracture

<table>
<thead>
<tr>
<th>ICD-10-CM</th>
<th>ICD-9-CM</th>
</tr>
</thead>
<tbody>
<tr>
<td>S72031A Displaced midcervical fracture of right femur, initial encounter for closed fracture</td>
<td>82002 Fracture of midcervical section of femur, closed</td>
</tr>
</tbody>
</table>
What CMS is Looking For . . .

- “Only conditions specific for the beneficiary should be noted
- All applicable comments should concern the beneficiary’s current condition”
  - “…a clear picture of the beneficiary’s current condition requiring ambulance transport”

What CMS is Looking For....

- “Capture the “what” and “why” of a beneficiary’s condition that necessitates the transports”
- “Support the diagnosis or the ICD codes on the PCS with clinical assessment data and objective findings”

Assessing Your Progress

Some KPIs to Track

☐ Coder productivity—number of medical records coded per hour; review by individual code
☐ Volume of coder questions—number of records coders return to providers with requests for more documentation to support proper code selection

Some KPIs to Track

☐ Requests for additional information—number of requests from payers for additional information required to process claims
☐ Use of ICD-10 codes on prior authorizations and referrals—number of orders and referrals that include ICD-10 codes

Some KPIs to Track

☐ Use of unspecified codes—volume and frequency of unspecified code use
☐ Medical necessity pass rate—rate of acceptance of claims with medical necessity content
Ask Staff About…

- Specific parts of their workflow that are slowed by ICD-10
- Areas where more or different tools or training might be helpful
- Where they see opportunities for improvement
- Codes that cause the most difficulty

Are We Getting What We Need?

- Look at clinical documentation for services provided before and after October 1, 2015
- Issues with documentation might result from insufficient training on ICD-10 coding concepts and guidelines

Novitas LCD & LCA for ICD-10 Codes

The Novitas ICD-10 Rules Affect

- Anyone submitting claims in Jurisdictions JL or JH

The Big Changes - Novitas

- Dual diagnosis codes required on all Novitas ambulance claims (ICD-10)
  - Suggested primary codes
  - Mandatory secondary codes
  - Mandatory ICD-10 code for non-medically necessary transports

Primary Diagnosis Codes (Novitas)

- Novitas’ list is not an all-inclusive list
- Other diagnosis codes that accurately describe the patient’s symptoms at the time of transport may be reported as a primary diagnosis
Selecting a *Primary* Diagnosis Code (Novitas)

**Step 1**
- Transport to a facility for care
- **Group 1**

**Step 2**
- Post treatment transfer
- **Group 2**

**Step 3**
- Is there a primary code in the LCA from the applicable group that accurately describes the patient’s condition at the time of transport?
- Yes → Use ICD code from the LCA
- No → Use most appropriate ICD-10 code

Secondary Diagnosis Codes That Support Medical Necessity (Novitas)

<table>
<thead>
<tr>
<th>ICD-10 CODE</th>
<th>DESCRIPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Z74.01</td>
<td>Bed confinement status</td>
</tr>
<tr>
<td>Z74.3</td>
<td>Need for continuous supervision</td>
</tr>
<tr>
<td>Z78.1</td>
<td>Physical restraint status</td>
</tr>
<tr>
<td>Z99.9</td>
<td>Dependence on other enabling machines and devices</td>
</tr>
</tbody>
</table>

For Medically Necessary Transports (Novitas)

- You must choose from one of the 4 secondary ICD-10 codes listed
  - Choose the one that most accurately describes why the transport is reasonable and necessary
  - Must be supported by documentation

Remember, Dual Codes Are for Novitas Providers

Everyone else, check with your MAC

And Remember...

- Any diagnosis code you select must be supported by the documentation in the patient care report

ICD-10 Resources

- [www.icd10data.com](http://www.icd10data.com) – online ICD-10 lookup, and tool for conversion from ICD-9 to ICD-10
ICD-10 Resources
• www.cms.gov/medicare/coding/icd10/-
  CMS-specific resources, including ICD-10
tables, and the ICD-9/ICD-10 crosswalk
  (General Equivalence Mappings or
  “GEM”)

CMS Released CY 2013
Part B Medicare
Payment Data

CMS NEWS
FOR IMMEDIATE RELEASE
June 2, 2015
Contact: CMS Media Relations
(202) 690-6144 | CMS Media Inquiries

New Medicare data available to increase transparency on hospital and physician utilization.
Data serves as a rich resource to analyze how Medicare spends, services, and trends.

Background
• In April 2014, CMS publicly released CY
  2012 Medicare payment data
• CMS released CY 2013 numbers in 2015
• Expected to release 2014 data this
  spring/summer

Your HCPCS Specific Data
• For every HCPCS Code you billed to
  Medicare (ALS2, BLS-NE, etc.):
  ◦ Total number of transports
  ◦ Number of unique beneficiaries
  ◦ Average submitted charge
  ◦ Average Medicare allowed amount
  ◦ Average Medicare payment amount

Your Total Numbers
• Total number of unique beneficiaries
  transported
• Total number of services provided
• Your total Medicare:
  ◦ Charges submitted
  ◦ Allowed amount
  ◦ Payment amount

3 Types of Data Files
(just be patient, they’re big, zipped files)

1. Supplier-Specific Files (Alphabetical)
2. Supplier Aggregate File
3. HCPCS Aggregate Files
How the 2012/13 Numbers Compare

<table>
<thead>
<tr>
<th></th>
<th>CY 2012</th>
<th>CY 2013</th>
<th>Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total ALS1-NE (A0426)</td>
<td>345,418</td>
<td>325,541</td>
<td>5.61% decrease</td>
</tr>
<tr>
<td>Total ALS1-E (A0427)</td>
<td>4,946,196</td>
<td>4,973,331</td>
<td>0.53% increase</td>
</tr>
<tr>
<td>Total BLS-NE (A0428)</td>
<td>6,057,538</td>
<td>6,112,508</td>
<td>0.89% increase</td>
</tr>
<tr>
<td>Total BLS-E (A0429)</td>
<td>2,659,294</td>
<td>2,731,935</td>
<td>2.89% increase</td>
</tr>
<tr>
<td>Total ALS2 (A0433)</td>
<td>111,795</td>
<td>111,968</td>
<td>0.15% increase</td>
</tr>
<tr>
<td>Total SCT (A0483)</td>
<td>102,438</td>
<td>104,282</td>
<td>1.7% increase</td>
</tr>
<tr>
<td>Total Ground Transports</td>
<td>14,092,560</td>
<td>15,059,560</td>
<td>6.9% increase</td>
</tr>
<tr>
<td>Total Air Ambulance - Fixed and Rotary Wing</td>
<td>68,938</td>
<td>67,318</td>
<td>2.3% decrease</td>
</tr>
</tbody>
</table>

Let's take a quick look at CY 2013 nationwide ambulance data . . .

National Ground Breakdown 2013

National ALS/BLS Breakdown 2013

National Emergency Transport Breakdown 2013

National Non-Emergency Transport Breakdown 2013

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Average Submitted Charges Nationwide 2013

- ALS1-NE: $791.40
- ALS1-E: $923.39
- ALS2: $1,101.46
- BLS–NE: $537.12
- BLS-E: $669.27
- SCT: $1,865.06
- Fixed Wing: $14,438.15
- Rotary Wing: $17,309.74

Ambulance Payments in Context

- Ambulance payments constitute:
  - Less than 5% of total Part B spending
  - Less than 1% of total Medicare spending

But . . .

- These HCPCS codes are in the top 10 of total allowed charges for all of Medicare Part B:
  - ALS1-E (A0427) - #1
  - BLS-NE (A0428) - #3
  - Ground Mileage (A0425) - #5
  - BLS-E (A0429) - #7

Other Recent MAC Happenings

First, a Word About Some Misinformation from WPS

First Misstatement From WPS

- ALS-1E may not be billed based solely on a qualifying ALS assessment
  - Even if you met all qualifying criteria for ALS assessment rule
  - WPS said the only way to bill ALS-1E was if you had an ALS intervention
WPS Seminar Handout About ALS Assessments:

If the ALS Assessment has proven that an ALS transport is not medical necessary, it would only be appropriate to bill a BLS level of service.

- ALS assessment alone does not allow you to bill an ALS1 level of service
- Dispatch does not drive the payment

The ALS Assessment Regulation

- ALS1 means transportation by ground ambulance vehicle, medically necessary supplies and services and either
  1. An ALS assessment by ALS personnel
  2. The provision of at least one ALS intervention

42 CFR 414.605

The ALS Assessment Regulation

- Part of an emergency response
- Necessary because the patient's reported condition at the time of dispatch was such that only an ALS crew was qualified to perform the assessment

An ALS assessment does not necessarily result in a determination that the patient requires an ALS level of service.

42 CFR 414.605

Correction on ALS Assessments

- CMS email to PWW:
  - "WPS is updating their educational material"
  - CMS indicated that WPS will send a correction via email to seminar participants

Second Misstatement From WPS

- WPS indicated that "proof of mailing" did not satisfy PCS regulation regarding attempt to obtain PCS

The Regulation on Proof of Mailing for PCS

- If the ambulance provider or supplier is unable to obtain the required certification within 21 calendar days...the ambulance supplier must document its attempts...
- Acceptable documentation includes a signed return receipt from the U.S. Postal Service or other similar service that evidences that the ambulance supplier attempted to obtain the required signature from the beneficiary's attending physician or other individual...

42 CFR § 410.40(d)(3)(iv)
Novitas – More Documentation to Support Trips of 126 Miles

- Will begin suspending air and ground claims received on or after March 15, 2016 for ambulance mileage of 126 or greater
- Failure to return information requested in an ADR will result in denial

Norian Prepayment Reviews

- ALS1-E (A0427)
  - Northern CA
  - Southern CA
  - Nevada
  - Hawaii
  - American Samoa
  - Guam
- BLS-E (A0429)
  - Northern CA

Noridian Prepayment Reviews

- Providers will be notified of claims selected for review by the Automated Development System (ADS)
- You will have 45 days to respond or claim will deny
  - “Denials may result in future provider-specific complex reviews”

Railroad Medicare Review

<table>
<thead>
<tr>
<th>HCP Code</th>
<th># of Services Reviewed</th>
<th>Services Allowed</th>
<th>Services Denied</th>
<th>Denial Rate % by Dollar Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>A0429</td>
<td>5,164</td>
<td>3,434</td>
<td>1,730</td>
<td>33.7</td>
</tr>
<tr>
<td>A0428</td>
<td>9,600</td>
<td>6,281</td>
<td>3,319</td>
<td>24.8</td>
</tr>
<tr>
<td>Overall</td>
<td>14,764</td>
<td>9,715</td>
<td>5,049</td>
<td>34.3</td>
</tr>
</tbody>
</table>
Summary of Findings

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th># of Services Reviewed</th>
<th>Services Allowed</th>
<th>Services Denied</th>
<th>Denial Rate % by Dollar Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>A0429</td>
<td>5,104</td>
<td>3,434</td>
<td>1,710</td>
<td>33.7</td>
</tr>
<tr>
<td>A0428</td>
<td>9,600</td>
<td>6,291</td>
<td>3,319</td>
<td>34.6</td>
</tr>
<tr>
<td>Overall Totals</td>
<td>14,704</td>
<td>9,725</td>
<td>9,049</td>
<td>34.3</td>
</tr>
</tbody>
</table>

34.3% Overall Denial Rate

The Top Denial Reasons

Lack of Response to ADR

- 45 days to respond to an ADR
- If response is not received, claim will automatically deny on the 46th day

Regarding ADRs

- There's really no excuse for not responding to an ADR
- Send responses via a trackable method

Insufficient Documentation

- PCS not within the appropriate time frame
- PCS not signed by the appropriate signer
- Missing crew members information and/or credentials

Curing Insufficient Documentation

- Know the PCS rules:
  - Nearly all NE transports
  - Repetitive:
    - Good for 60 days
    - Attending physician only
- Have all crew members sign the PCR with credentials
Medical Necessity

Signature Deficiencies

- **PCS**
  - Illegible signature
  - Missing
- **Crew Member**
  - Missing or illegible crew member signature or credentials
- **Beneficiary**
  - Lack of signature
  - Documentation requirements for person signing on behalf of beneficiary were not present
  - Beneficiary signature not dated

An Upcoming Railroad Prepayment Review

- A0426 – ALS 1-NE
- A0427 – ALS 1-Emergency

Limiting Scope of Redeterminations and Reconsiderations

- MLN Matters Article: SE1521
- Issued August 17, 2015

The Issue

- Generally, MACs and QICs have discretion to develop new issues and review all aspects of coverage related to a claim
- In some cases, this expanded review results in an unfavorable appeal decision for a different reason

Post Payment

- MACs and QICs must limit their review to the reason(s) the claim or line item at issue was initially denied
Post Payment Claims

- Claims that were initially paid by Medicare and subsequently reopened and reviewed by a ZPIC, RA, MAC, or CERT contractor and revised to deny coverage, change coding, or reduce payment

Here’s An Example . . .

- If a ZPIC contractor determined a claim should have been denied based upon an invalid signature, and the provider appealed (through redetermination first and then reconsideration), the MAC and QIC could only look at the signature issue, not other things like medical necessity

Signature Issues

Signature Rules

Provider Signatures

- Services provided must be authenticated by the author
- PCS and PCR signers
- First and last name
- Applicable credentials

Beneficiary Signatures

- Signature of the beneficiary, or that of his or her representative
- Statement explaining the reason beneficiary is unable to sign must be included

Update to Transmittal 327

- Transmittal 604
- Change Request 9225
- Issued July 24, 2015

Quick Refresher on 327

- “Signature Guidelines for Medical Review Purposes”
  - Issued March 16, 2010
  - Change Request 6698
- Medicare reviewers directed to verify the identity and credentials of the signer on PCSs and PCRs
Instructions to Reviewers

• If the signature is illegible shall consider:
  ▪ Evidence in a signature log, or
  ▪ Attestation statement

New Guidance to Reviewers

• If the signature is illegible:
  ▪ Look at "other documentation" in addition to signature logs and attestation statements

New Guidance to Reviewers

• This could conceivably include copies of other PCRs, forms, etc. that have known signatures on them

Signature Best Practices

• All crew members sign and date all PCRs at time of service and include printed name and credentials
• Keep an updated signature log with all crew member signatures and credentials
• Use crew attestation statements only as a last resort

Update on Scheduled Repetitive Transport Prior Authorization Program

As of December 1, 2014

• PA & NJ
  ▪ Novitas – Jurisdiction L
• SC
  ▪ Palmetto GBA – Jurisdiction M
• Jurisdiction is based on where the ambulance is garaged
As of January 1, 2016

- **DE, DC, MD**
  - Novitas – Jurisdiction L
- **NC, WV**
  - Palmetto GBA – Jurisdiction M
- **VA**
  - Arlington, Fairfax and Alexandria areas Novitas – Jurisdiction L
  - All other areas Palmetto GBA – Jurisdiction M

**Maybe** Beginning January 1, 2017

- **Nationwide**

In Order to Go Nationwide…

- CMS must evaluate pilot program and determine:
  - No impediment to access for beneficiaries
  - Cost savings for CMS

Recommendations

- Everyone outside of current states, prepare for 2017 nationwide launch
- Ask contractors to issue “Dear Provider” letters to educate physicians and facilities

Background

- Repetitive, scheduled non-emergency transports
- Review of information (by Medicare) before claim is submitted to determine if it meets payment requirements
- Suppliers only, not institutional-based ambulance providers

Repetitive Transports

- Three round trips during a 10-day period or at least once a week for 3 weeks
  - Dialysis, wound care, radiation/cancer treatments, etc.
  - Medicare Program Memorandum, Transmittal AB-03-106
How it Works

• Ambulance suppliers submit **required documentation** to MAC prior to fourth round-trip of a repetitive, scheduled non-emergency patient
• Obtain prior authorization for that trip and subsequent repetitive, scheduled transports

### The Possible Scenarios

<table>
<thead>
<tr>
<th>Prior authorization request is:</th>
<th>The A/B MAC decision is:</th>
<th>The supplier chooses to:</th>
<th>The A/B MAC will:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Submitted</td>
<td>Affirmative</td>
<td>Submit a claim</td>
<td>Pay the claim (as long as all other requirements are met)</td>
</tr>
<tr>
<td>Submitted</td>
<td>Non-Affirmative</td>
<td>a. Submit a claim</td>
<td>a. Deny the claim</td>
</tr>
<tr>
<td></td>
<td></td>
<td>b. Fix and resubmit a PA request</td>
<td></td>
</tr>
</tbody>
</table>
| Not submitted                   | N/A                      | Submit a claim           | • Develop the claim  
|                                 |                          |                          | • Pre-Pay Review the claim |

### Novitas Issued Helpful Documents

#### “Dear Healthcare Professional” Letter

• Provides guidance to practitioners, and facilities on how the prior authorization project will operate
• Includes the following bolded language…

You must provide a PCS and any other needed medical records

You must provide a PCS and any other needed medical records to receive prior authorization. As a physician, practitioner or other healthcare provider for a beneficiary who must be transported by ambulance, you are required to provide certain records to the ambulance supplier or beneficiary. Attending physicians must provide a physician certification statement (PCS) and medical records that support medical necessity. Other healthcare providers, such as dialysis facilities, nursing homes, wound care centers, physical therapists, etc., must provide the ambulance supplier with any needed medical records.

Novitas Providers…

1. Download the “Dear Healthcare Provider” letter at:
2. Give it to facilities
There Have Been Issues

- A lot of denials because of:
  - Incomplete records
  - Small discrepancies
  - Physician name illegibility
  - Documentation that was illegible or did not include patient name (despite other identifying information)

Update on Suspension of ALJ Assignments

Background

- OMHA suspended assignment of new requests for ALJ hearings as of July 15, 2013

Application

- Applies to newly filed requests from providers and suppliers
- Does not apply to appeals filed directly by Medicare beneficiaries
  - Continue to receive priority
  - But, not necessarily timely resolution

The Timeline

<table>
<thead>
<tr>
<th>What the Law Requires</th>
<th>Average Processing Time for FY 2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>Decision must be issued within 90 days of request for ALJ hearing</td>
<td>547.1 days (Over 18 months)</td>
</tr>
</tbody>
</table>

According to OMHA

- “Based on our current workload and volume of new requests, we anticipate that assignment of your request for hearing to an Administrative Law Judge may be delayed for up to 28 months.”
The Bottom Line

- It would take 2.5+ \textit{years} from the date you request an ALJ hearing until you get a decision
- Could be facing extended installment payments and accruing interest during that time

Our Advice on Appeals

- Encourage beneficiaries to appeal
- Fight hard in first two levels
  - Get all evidence in early
  - Medical and statistical experts
  - Legal assistance if needed

Better Yet, Avoid the Need for Appeals Altogether…

- Improve assessment and documentation skills
  - Medical necessity
  - Reasonableness
  - Loaded mileage
  - Signatures
  - PCS forms (where applicable)
Can We Prove What We’re Doing is Effective?

Hospital Readmission Penalties

- Conditions now include:
  - AMI
  - CHF
  - Pneumonia
  - COPD
  - THA/TKA
- Hospitals penalized up to 3% of Medicare reimbursement

Hospital Readmission Penalties

- More than 2,500 hospital nationwide projected to be penalized this year
- More than half of nation’s hospitals affected
- $428 million last year

It’s Affecting Some Hospitals Disproportionately

Highest Readmissions

- Hospitals with the highest readmissions had patients who were “less mobile, had more difficulty with activities of daily living, more chronic conditions, less education, lower income, lower assets…”

Shift to Population Health

- This shift will de-incentivize episodes of care and incentivize the promotion of well-being in your community
- This is the spark behind Mobile Integrated Healthcare/Community Paramedicine
The Challenges

- Prove that we benefit overall health
  - Better documentation
  - Better data
  - Rethinking service delivery models
  - Being a part of the healthcare system rather than just a means of transportation for healthcare services

One More Thought

- Remember, what we’re really trying to say is *be careful* in your revenue cycle compliance
- Sort of like…