



Compliance

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by Anthony W. Minge, MBA and Matthew R. Streger, Esq

Scrutiny of ambulance operations highlights need for compliance

- » Increased attention on ambulance use demonstrates the need for compliance plans to include emergency and non-emergency ambulance operations.
- » The U.S. Department of Health and Human Services (HHS) Office of Inspector General (OIG) has published voluntary compliance program guidance for ambulance suppliers.
- » Ambulance billing should reflect the care provided by the emergency medical services (EMS) personnel, not the hospital diagnosis of the patient.
- » Training for billing personnel and EMS providers on documentation and billing for ambulance services is often inadequate.
- » Ambulance suppliers should conduct regular claims reviews to ensure problems are identified and corrected prior to an audit.

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In 2015, nine Florida hospitals and one ambulance service paid \$7.5 million to settle a case involving accusations of billing Medicare for unnecessary ambulance transports. According to media reports, the hospitals and ambulance company were accused of using ambulances to take people home from the hospital when a taxi or family member's car would have been appropriate instead.¹ In addition to the fines, the ambulance service entered into a corporate integrity agreement with U.S. Department of Health and Human Services (HHS).

Rather than an aberration, this story is part of a trend.

Not long after the case was settled, the HHS Office of the Inspector General (OIG) released a report entitled, "Inappropriate

Payments and Questionable Billing for Medicare Part B Ambulance Transports."² In a review of ambulance billing claims over a six-month period in 2012, investigators determined that 20% of ambulance providers had "questionable" billing practices, and that Medicare paid tens of millions of dollars for ambulance transports that were not justified.

The OIG report concluded that these billing practices pose "vulnerabilities to Medicare program integrity," and made several recommendations, including enhanced monitoring of ambulance billing. As the Florida case shows, even hospitals that do not own or operate an ambulance service are at risk. In that case, the hospitals were accused of benefiting from improper ambulance utilization, because they were able to discharge and admit patients more quickly.



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The potential fraudulent practices described by HHS include:

- ▶ Improper transport of individuals where other means of transportation are more appropriate,
- ▶ Medically unnecessary trips,
- ▶ Trips claimed but not performed,
- ▶ Misrepresentation of the transport destination to make it appear as if the transport was covered,
- ▶ False documentation,
- ▶ Billing for each patient transported in a group as if they were transported separately,
- ▶ Upcoding from basic life support (BLS) to advanced life support (ALS) services, and
- ▶ Payment of kickbacks.

In addition to increased scrutiny from regulators, unnecessary ambulance transports have also become a popular target in the media. Recent reports have questioned the billing practices of services that provide both 911 response and non-emergency transports.³ With the public, private insurers, and HHS looking for ways to reduce costs, it appears that the use of ambulances will be a prime target.

What hospitals need to know

For many hospitals, ambulance transport constitutes such a small part of overall operations that it is often overlooked. But, the increased scrutiny on billing practices should raise concerns for every hospital executive, especially those that own or operate ambulance services. More than ever, hospitals need to consider ambulance and other transport services when creating and maintaining compliance plans. The OIG has voluntary guidelines for ambulance compliance programs, published in the Federal Register in 2003.⁴ The guidelines for

ambulance providers are similar to those for other healthcare organizations, but reiterate the importance of including ambulance programs within a hospital's compliance efforts. There are, however, some specific aspects of compliance for ambulance providers that might be unknown to other hospital or healthcare compliance officers.

Compliance programs

It has become common place for hospitals to maintain compliance programs, but many often forget to include the ambulance service in the plan or to educate the ambulance billing representatives or contractor on plan specifics. Compliance plans must be regularly reviewed and updated, and the leaders of the hospital-based ambulance service must be periodically trained on the plan to ensure they are up to date on these changes. Even if an organization contracts with an outside billing service or an outside ambulance provider, it is the hospital's responsibility to verify the compliance and training efforts implemented by their partners.

Critical elements of an EMS compliance program include:

- ▶ A risk analysis of program status,
- ▶ Written policies and procedures,
- ▶ Initial and ongoing training for employees and partner agencies,
- ▶ Regular internal review of documentation practices and billing procedures, and
- ▶ External validation of documentation practices and billing procedures.

Ambulance billing

Billing for ambulance services differs from billing for in-hospital care and other outpatient services. Like other areas of healthcare, such as dialysis or durable medical equipment, transport services have specialized

Table 1: Levels of Service

Basic life support (BLS)
Emergent
Non-Emergent
Advanced life support (ALS)
Emergent
▶ALS1: The administration of at least one medication
▶ALS2: The administration of at least three medications and at least one of the following:
• Manual defibrillation/cardioversion
• Endotracheal intubation
• Central venous line
• Cardiac pacing
• Chest compression
• Surgical airway
• Intraosseous line
Non-Emergent
Specialty care transport (inter-facility transfers)

billing processes. Knowledge of rules and regulations specific to billing for reimbursement of ambulance service is either not known or is overlooked by centralized billing offices where representatives may have the responsibility of billing for a variety of services.

One of the biggest mistakes ambulance providers make is inappropriate assignment of service levels. For ambulance transports, Medicare currently reimburses by the level of services required: basic life support (BLS), advanced life support (ALS), or specialty care transport (SCT). Within ALS, two categories, ALS1 and ALS2, differentiate between patients, based on multiple factors, including but not limited to patient condition, the number of invasive procedures performed or medications administered. Furthermore, both BLS and ALS have emergent and non-emergent billing designations for billing that may require additional certification to meet the criteria for medically necessary provision of service in those non-emergent instances. With minimal exception for instances that allow for the billing of ALS emergent assessment, these categories are to be determined by the level

of care required by the patient's condition at the time of transport. Table 1 is a very simple outline of the categories. For a more complete description, see the Medicare Benefit Policy Manual, Chapter 10.⁵

Another common mistake is the use of the patient's inpatient diagnosis for coding and determination of the billing rate. A patient who was in the hospital for several days with a cardiac problem may seem like an obvious choice for an ALS transport but, at the time of discharge, they often require only BLS care. These determinations must be made by reviewing the documentation from the ambulance transport, not the hospital inpatient records.

SCTs are reserved for inter-facility transfers in which the patient requires the services of a specialist, such as a registered nurse, respiratory therapist, physician, or paramedic with additional training. Not all inter-facility transfers meet this criteria. Additionally, not all transfers to a higher level of care are emergent in nature, which is another common misconception resulting in billing errors.

EMS provider documentation

Most education for emergency medical service (EMS) providers, including both emergency medical technicians (EMTs) and paramedics, focuses on the provision of emergency care in response to 911 calls. Documentation is a very small portion of the training, typically centered on liability and transfer of care, but not billing practices. Many EMS practitioners have no concept of how their services are billed, or how what they document can impact reimbursement or open up an agency to allegations of fraud. Training providers to ensure they accurately and appropriately document care in all transport settings is critical to any hospital-operated ambulance service's compliance program.

For example, in addition to a physician's certification of medical necessity for a patient to qualify for scheduled transportation, the EMS providers may also need to document bed-confined status of the patient confirming that they are:

- ▶ Unable to get up from bed without assistance,
- ▶ Unable to ambulate, *and*
- ▶ Unable to sit in a chair and wheelchair.

Although the physician's certification is required, it does not provide the final determination of medical necessity and the EMS providers who conduct the transport must also document these requirements. And although drop-down fields or check-boxes help ensure completeness, written documentation of these elements in the report's narrative is also beneficial.

With electronic records, organizations can also create automated systems that flag reports with missing critical information, such as zip codes, Social Security numbers,

or signature forms. Often the fields that are essential for billing practices can be set as required fields, even prior to submission of the record, so the EMS provider must complete them in order to close and submit their chart.

This can assist with compliance and improve time from transport to submission of the claims for reimbursement.

Prepare for an audit

With the heightened scrutiny on ambulance services, it is almost a question of when, not if, a service will be audited. A compliance program should put a high priority on maintaining a complete and secure records system, with appropriate access to dispatch records, patient care reports, billing records, patient signature forms, and physician certification statements. Billing representatives need access to each of these elements to submit accurate claims. When an audit happens, you must be able to provide those records in a timely and orderly fashion.

Maintaining a consistent claims review process at all times will assist in preventing an audit by uncovering unknown issues. It is much easier to identify and correct a problem (e.g., not collecting patient signatures) when it occurs, rather than trying to explain it months or years later to an investigator.

OIG exclusion list

Checking the HHS Inspector General's exclusion list on a regular basis is also critical—and that means more frequently than once a year. Often EMS practitioners work multiple jobs, and many are part-time employees with healthcare organizations, such as nursing homes or other EMS services, making it even more likely that an event might occur that places them on the

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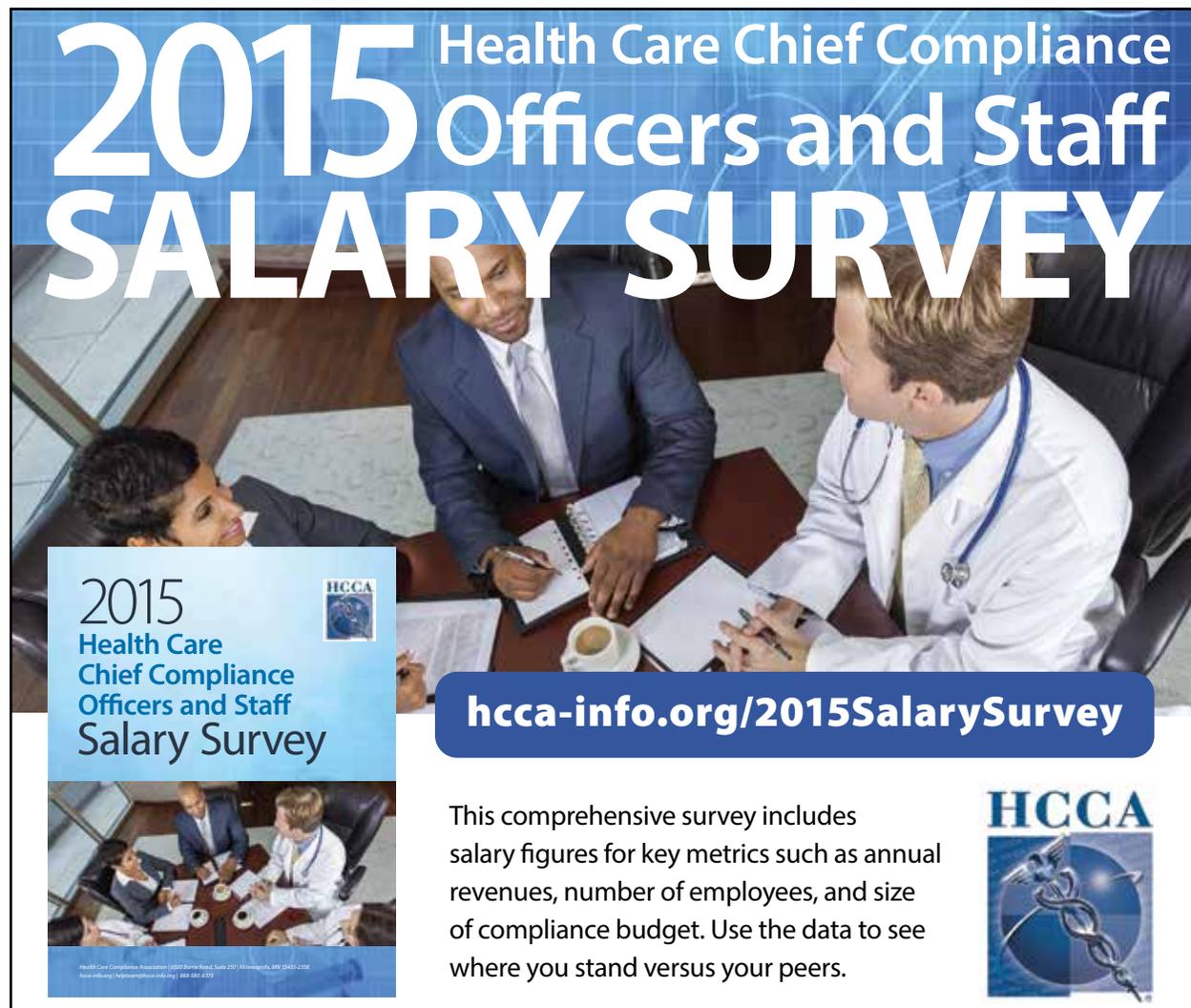
exclusion list. In these instances, an ambulance provider that employs them may not know they are excluded, unless they are regularly checking their employees against the published list. In some cases, services have owed thousands of dollars after it was discovered that an individual who was involved in the care and transport of dozens of patients had been on the exclusion list. It is important to check employees involved in the dispatch and billing processes as well.

Conclusion

A robust compliance plan that is regularly reviewed, updated, and communicated with hospital-based ambulance providers and outside partners is the heart of a healthy revenue

cycle management process for any ambulance program. Although ambulance operations may only make up a small proportion of operating costs and revenue for a hospital system, recent attention from the media and regulators makes compliance critically important in all emergency and non-emergency ambulance operations. 

1. John Carreyrou: "Florida Hospitals Agree to Settle Medicare Fraud Allegations" *Wall Street Journal*, April 30, 2015. Available at <http://on.wsj.com/2acetYQ>.
2. HHS Office of the Inspector General: "Inappropriate Payments and Questionable Billing for Medicare Part B Ambulance Transports" September 2015. Available at <http://bit.ly/2ayf83s>.
3. Elizabeth Rosenthal: "Think the E.R. is Expensive? Look at How Much it Costs to Get There" *The New York Times*, December 4, 2013. Available at <http://nyti.ms/2angzDA>.
4. Federal Register Vol. 68, No. 56; March 24, 2003; OIG Compliance Program Guidance for Ambulance Suppliers. Available at <http://bit.ly/2aKUf46>.
5. Medicare Benefit Policy Manual, Chapter 10 is available at <http://go.cms.gov/14j4wQB>



2015 Health Care Chief Compliance Officers and Staff SALARY SURVEY

2015 Health Care Chief Compliance Officers and Staff Salary Survey

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