Fraud and Abuse

Emergency Medical Services and Ambulance Services

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What I Will Share

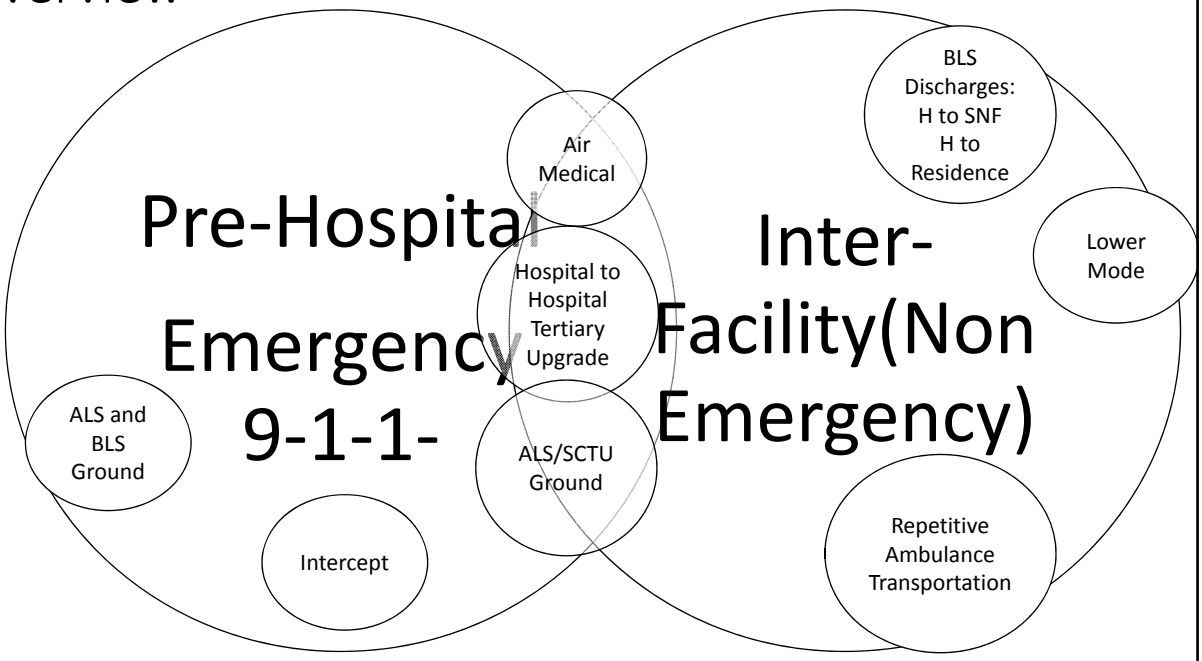
- Overview of Emergency Medical Services
- The Problem
- OIG Compliance Guide
- Coverage Requirements
- Targeted Scrutiny
- More on Medical Necessity
- In Pari Delicti:the Physician Certification Statement
- Experiment in Repetitive Transportation
- Institutional Discounting-Swapping Arrangements
- Implications 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

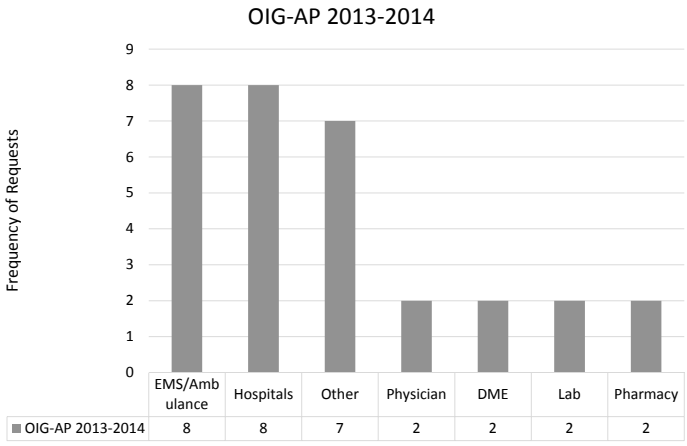
- Basic Life Support
- Advanced Life Support
- Specialty Care (Critical Care)
- Air Medical(Critical Care)


Overview



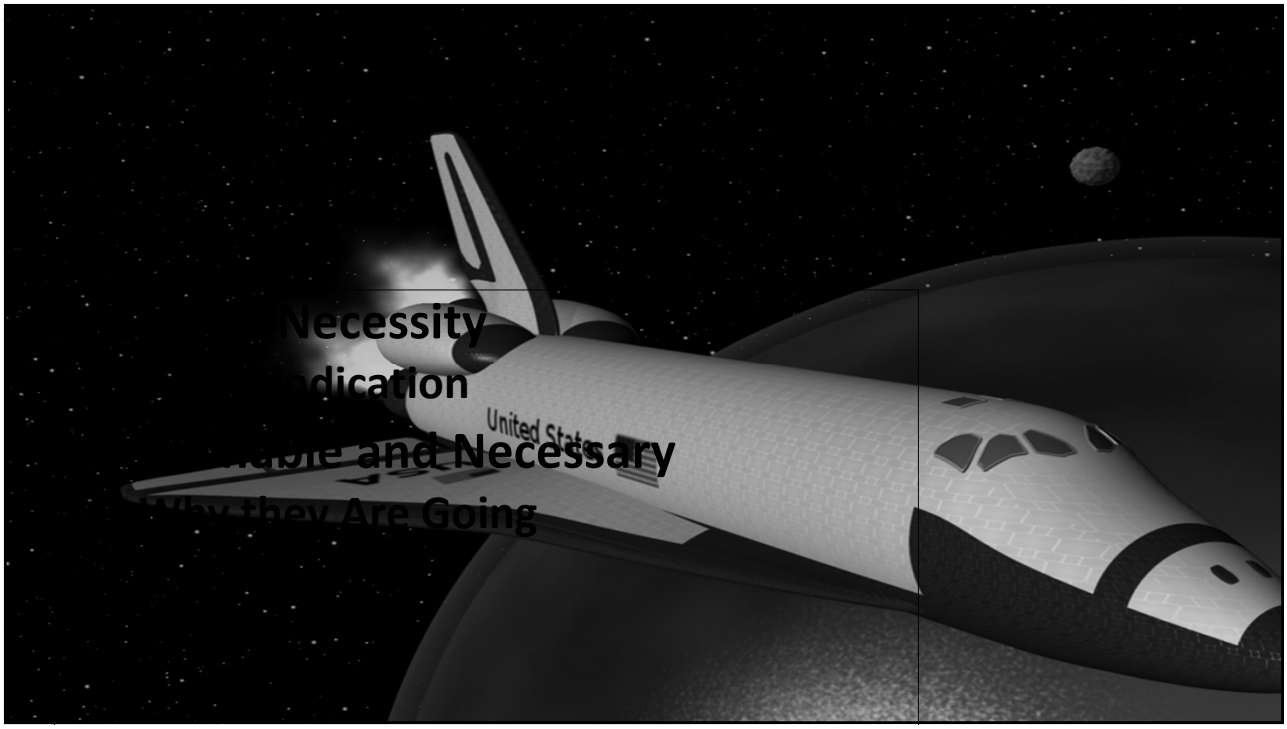
The Problem

- 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



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

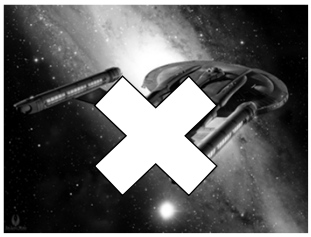
- Closest Appropriate Rule
  - Excess Miles-Statutory Exclusion

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

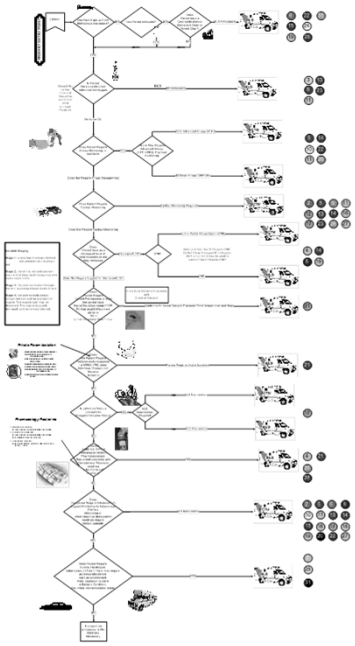
- The Beneficiary is :
  - Unable to get up from bed without assistance;
  - Unable to ambulate
  - Unable to sit in a chair, including a wheelchair

  *** 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 Restrained)**
- **Active Isolation for a Contagion**
- **Frequent Seizures**
- **Special Handling-Severe Pain on Movement-Bariatric**



10	Respiratory arrest	**Tertiary Upgrade**	Includes apnea or hypoventilation requiring ventilatory assistance and airway management
11	Respiratory distress, shortness of breath, need for supplemental oxygen Respiratory Failure	Objective evidence of abnormal respiratory function	Includes tachypnea, labored respiration, hypoxemia requiring oxygen administration. Includes patients who require advanced airway management such as ventilator management, apnea monitoring for possible intubation and deep airway suctioning. Includes patients who require positioning not possible in other conveyance vehicles. Note that oxygen administration absent signs or symptoms of respiratory distress is, by itself, inadequate reason to justify ambulance transportation in a patient capable of self-administration of oxygen. Patient must require oxygen therapy and be so frail as to require assistance of medically trained personnel.
12	Cardiac arrest with resuscitation in progress	**Tertiary Upgrade**	
13	Chest pain (non-traumatic)	Cardiac origin suspected. Obvious non-emergent cause not identified	Pain characterized as severe, tight, dull or crushing, substernal, epigastric, left-sided chest pain. Especially with associated pain of the jaw, left arm, neck, back, GI symptoms (such as nausea, vomiting), arrhythmias, palpitations, difficulty breathing, pallor, diaphoresis, alteration of consciousness. Atypical pain accompanied by nausea and vomiting, severe weakness, feeling of impending doom or abnormal vital signs.
14	Choking episode	**Tertiary Upgrade**	Respiratory or neurologic impairment
15	Cold exposure	**Tertiary Upgrade** Potentially life- or limb- threatening	Findings include temperature < 95º F, signs of deep frost bite or presence of other emergency
16	Altered level of consciousness (non-traumatic)	Neurologic dysfunction in addition to any baseline abnormality	Acute condition with Glasgow Coma Scale <15 or transient symptoms of dizziness associated with neurologic or cardiovascular symptoms and/or signs or abnormal vital signs
	Convulsions/seizures	Active seizing or	Conditions include new onset or untreated seizures or

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

PHYSICIAN CERTIFICATION STATEMENT (PCS)
REPETITIVE TRANSPORTATION REQUIRES A PHYSICIAN TO SIGN
(3 Transports in a 10 Day Period)

1. Date (s) of Transport: _____ Time of Transport: _____
Transport Origin: _____ Floor/Unit: _____
Transport Destination: _____ Gender: _____
Patient Name: _____ DOB: _____ HIC/Medicare#: _____
Physician Name: _____ Phone: _____ Fax: _____
Round trip? Yes No Repetitive Transport (3 or more in 10 day period)? Yes No

❑This patient **does not** require transport by ambulance and can safely be transported by other means, such as private automobile or wheelchair van

BASIC LIFE SUPPORT AMBULANCE (BLS)

_____ _____

Current Diagnosis(es) Supporting BLS

Ambulatory Status (All three must be true to Establish Non Ambulatory Status)

❑1.Cannot Get Up From Bed **Without** Assistance Reason_____, and
❑2.Cannot Ambulate, Reason_____, and
❑3.Cannot Sit in Chair (or Wheelchair), Reason_____
❑Contractures ❑Sacral Decubiti Grade III or IV and transport > 1 Hour

Other Reasons:
❑Confused/Combative/Comatose/or Has Decreased Level of Consciousness
❑Receiving Oxygen-Unable to Self Administer
❑Moderate/Severe Pain on Movement
❑Unstable Fracture(s)
❑Airway Monitoring/Management (Suctioning)
❑Need for Possible Restraints/Dangerous to Self or Others
❑DVT Requires Elevation of Lower Extremity
❑Special Handling/Isolation/Infection Control Required (Active Isolation)
❑Morbid Obesity requires additional personnel or special handling equipment
❑Orthopedic Device Req. (Backboard, Halo, Pins Traction etc) for special handling during transport

SPECIALITY CARE TRANSPORT(ALS)

Current Diagnosis(es) Supporting ALS

❑ Advanced Airway Management
❑ Ventilator Dependent
❑ ECG Monitoring Required During Transport
❑ IV Medications Required During Transport
❑ Hemodynamic Monitoring
❑ Other Situation Requiring Advanced Life Support During Transport

I certify that the above information is true and correct based on my evaluation of this patient, and represent that the patient requires transport by ambulance and that other forms of transport are contraindicated. I understand that this information will be used by the Centers For Medicare and Medicaid Services (CMS) to support determination of medical necessity for transport by ambulance and I represent that I have personal knowledge of the patient's condition at time of Transport.
❑ If this box is checked I also certify that the patient is physically or mentally incapable of signing the ambulance service's claim and that the institution with which I am affiliated or employed by has provided care/services to the patient. My signature below is made on behalf of the patient pursuant to 42CFR §424.36(b)(4). The reason(s) the patients cannot sign is _____ Universal Transfer Form Completed ❑

_____ _____
Signature of Physician or Health Care Provider Print Name and Credentials/Date
(Valid only if PAsC, CRNP, CNS, Discharge Planner/Social Worker, RN)

(For **Repetitive Transport**, this form is not valid if older than 60 days and is not signed by a Physician)

Medical Necessity Criteria for Ambulance	Support documentation What and Why an Ambulance is Required	Criteria
	COGNITIVE STATE	
Altered Mental Status		Clinical presentation must demonstrate that it would deleterious to patient to ambulate **and** sit in a wheelchair. Documentation of GCS should be included. GCS must be at or below 14. Include etiologic factors when patient is severely confused resulting undue harm as a result of ambulation or sitting in a chair. Include as appropriate analgesic or other type medications that cause alteration in mental status
	MEDICAL STATE	
Morbid Obesity		Patient has a BMI >= 80%, thereby sitting in a chair or ambulating will prove deleterious to patient. Document height, weight, BMI and ability/inability to ambulate and sit in chair.

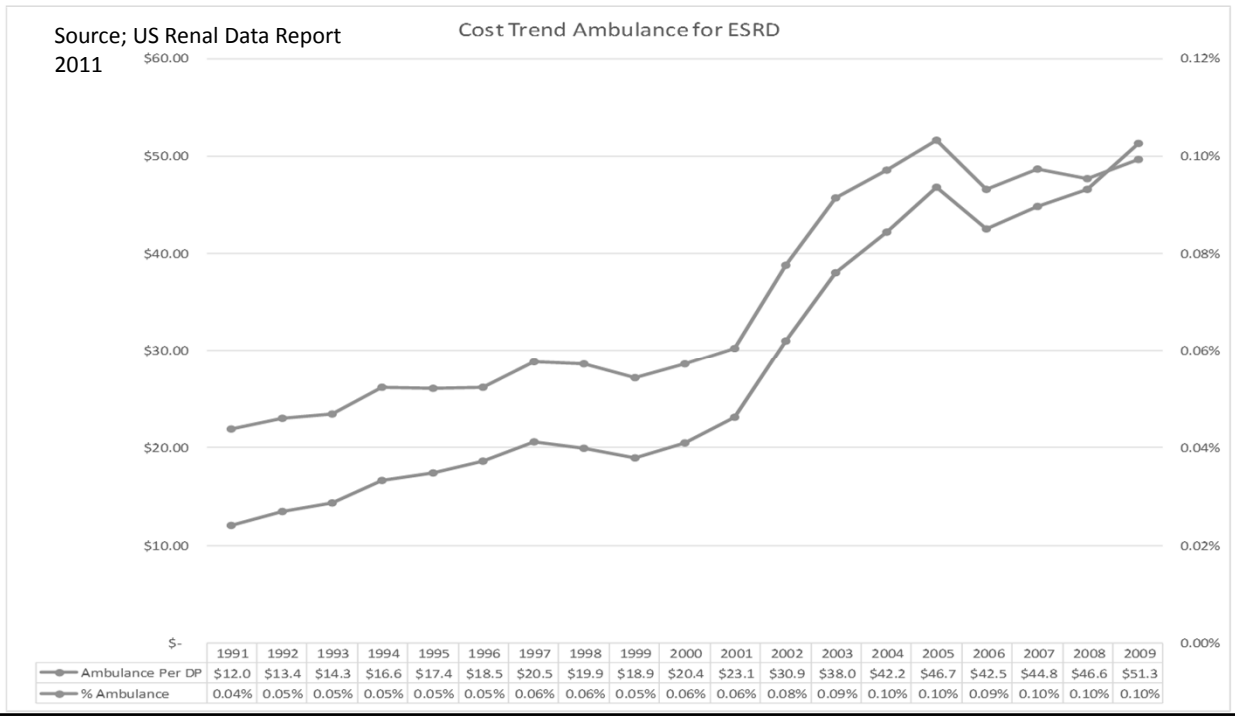
Routine Waiver of Copayments(Subscriptions)

- 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 KNOWLEGABLE ABOUT PATIENTLOOK TO PCP

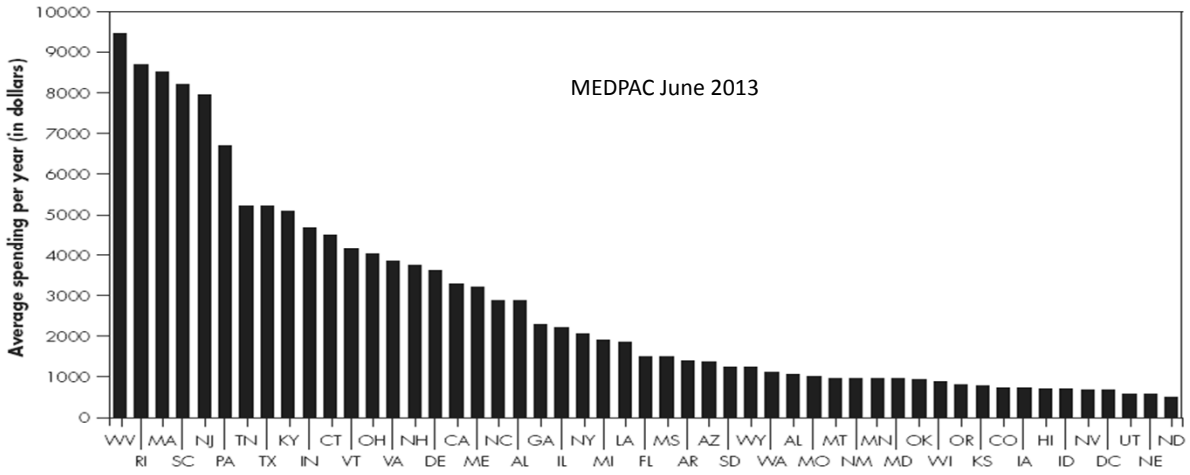
Source; US Renal Data Report 2011



	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009
Ambulance Per DP	$12.0	$13.4	$14.3	$16.6	$17.4	$18.5	$20.5	$19.9	$18.9	$20.4	$23.1	$30.9	$38.0	$42.2	$46.7	$42.5	$44.8	$46.6	$51.3
% Ambulance	0.04%	0.05%	0.05%	0.05%	0.05%	0.05%	0.06%	0.06%	0.05%	0.06%	0.06%	0.08%	0.09%	0.10%	0.10%	0.09%	0.10%	0.10%	0.10%

FIGURE 7–1

Average annual spending on ambulance services per hemodialysis beneficiary, by state, 2009



MEDPAC June 2013

Note: Puerto Rico (not shown on chart) had an average of $25,000 in ambulance spending per beneficiary hemodialysis year in 2009 (spending is adjusted for the number of months beneficiaries are actively on dialysis).

Source: United States Renal Data System, 2011 Report.

Pilot(New Jersey, South Carolina, and Pennsylvania)

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

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-Settlements

- 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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