MDHHS Michigan Department of Health & Human Services | Bureau of Emergency Preparedness, EMS and Systems of Care

EMSCC Patient Movement Ad Hoc
Minutes
November 27, 2023
9:00 a.m. – 11:00 p.m.
Click here to join the meeting
248-509-0316 Conference ID: 311 036 897#
1001 Terminal Road, Lansing, MI 48906

Members: Debbie Condino-chair, Dr. Bigsby, Ken Cummings, Dr. Krohmer, Angela Madden, Ralph Ortiz, Connie O'Malley, Rob Warnemuende, Doug Pratt, Ron Slagell, Alyson Sundberg, Ed Unger.

Absent: Lauren LaPine, Jason MacDonald.

Guests: Curtis LeSage, UPHS; Katie Arens, Life EMS; Kelsey Ostergren, MHA; Bruce Trevithick, Genesee County MCA; Mark Meijer, Life EMS; Kristy Perez, Trinity Health; Andrea Abbas, MCRH; Jeremy Kelly, Corewell Health; Lynn Weber, Clinton Area Ambulance Service; Kevin Henderson, Washtenaw Livingston MCA; Lance Corey, Kent County EMS; Dustin Hawley, Superior; Kolby Miller, Medstar; Lacey Crabb, OSF Healthcare.

Staff: Babb, Bergquist, Schaible, Piette, Burke, Worden, Baker, Brown, Chadderton, Detro-Fisher, Dr. Fales, Kapnick, Jean, Verlinde, Flory, Bliss.

1. **Call to Order: The meeting was called to order at 9:03 a.m. by Debbie Condino.**
2. **Roll Call-We have a quorum today.**
3. **Approval of Agenda and minutes from 10/23/2023: Motion to approve (Cummings, Bigsby). Approved.**
4. **Old Business**
5. **New Business**
   - **Billing, Payment, and Finance with Ron Slagell and Katie Arens**
     - Debbie advised Ron and Katie are here to give us a presentation and education and billing and payment and finances and all the good things that we don't understand and know a whole lot about. Emily Bergquist asked the group to hold their questions until the end. The presentation is attached to these minutes.
   - **Discussion/questions**
     - Jeremy Kelly asked about ABN for air transport. Katie advised that she would check on this, as it is not used for ground ambulance and she is not as familiar.
     - Ed Unger asked a question about a transport to a facility that is not the closest. Documentation and additional information would be required if not the closest facility, and the claim may be auto rejected at first pending that information. Make sure you are documenting the reason.

- Kolby Miller asked about free standing EDs. Katie said this is based on how the freestanding is licensed and related to the parent hospital. More information would be required on a case-by-case basis. NPI numbers and how they might come into play was discussed. Everything has to be billed the same. Emily advised the department is working on rules for freestanding. She asked if there is value for the department to call the question on NPI when they apply. Ron said yes and explained. Their intent and plan would be valuable information. Katie said there are some hospitals that have a site close by and they bill the same NPI and they bill under the same number and it looks like there is no interruption in care, even they were moved.
- Dr. Fales asked if closest appropriate issue would result in the entire thing being denied or just the additional mileage. Katie said just the difference and discussed.
- Ron spoke about ALS ordinances and how those no longer apply, and a new fee schedule came out. If your local 911 provider do not use some type of EMD or similar protocols, then you have to bill differently. He also said as we do more things at the MFR or BLS level, it benefits patient care but comes at a cost of billing ability. Emily discussed scope of practice and how it could affect billing. Limited and advanced life support all bill at the ALS level. Discussion ensued. What is an emergency for interfacility transfers and getting facilities to understand this was discussed. MCAs, administrative rules, and protocols were discussed.
- Emily brought up documentation, and the group discussed.
- Eileen discussed health care mergers and keeping patients in the healthcare system. The group discussed. Emily brought up possible development of an algorithm and discussed. Proper documentation can help. Katie discussed nuances in coverage rules between public and private insurers. Emily discussed regional review in the trauma regions and Eileen discussed the benefits.
- Behavioral health transfers were discussed. Katie and Rob discussed. This area is ripe for a solution.
- Dr. Bigsby discussed sending patients back to the facility where the procedure was done when there are post procedural complications and if an ABN is required. Ron addressed. It's a case-by-case basis, do what is best for the patient, and DOCUMENT. Alyson spoke about documentation. Emily spoke about making a checklist of things that are needed and creating a tool/document that could be distributed with the help of partners. Kelsey Ostergren spoke about how MHA could help.
- Jeremy Kelly asked Katie to address lump sum payments. She said that falls under the same rules as readmission/interrupted stay and discussed.

- How can the department help?
    - Administrative rules for freestanding EDs. Add NPI to that discussion.
    - Talkgroups/communications
    - Training/checklists/concepts for clinicians.

6. **Additional Items from Attendees**
    - Behavioral Health ombudsman is still on the list for a presentation. Emily will find someone to present for us. Debbie and Emily will meet to plan.
    - Dr. Bigsby asked if there was an update on the problem list. Emily advised they neither voted on it nor offered comments. **Emily said we can clean it up and make it an official document.**
7. **Adjourn: The meeting adjourned at 11:53 a.m.**
8. **Next Meeting: ~~December 25, 2023.~~ January 22, 2024**

Introduction to Ambulance Transportation

EMSCC Patient Movement Ad Hoc

November 27th, 2023

Meet your speakers:

Ron Slagell

President & CEO

EMERGENT HEALTH PARTNERS

Chair – MAAS Reimbursement Committee (1996)
Member – American Ambulance Association
Medicaid Finance Committee

Katie Arens

Vice President of Customer Access

LIFE ems® AMBULANCE

Vice Chair - MAAS Reimbursement Committee

Chair – American Ambulance Association Data Task Force

Faculty – American Ambulance Association Cost Collection

Founding Advisor – Women in Emergency Services (WiES)

Today’s Agenda

Bird’s eye view of:

- Ambulance Service Levels
- Medical Necessity
- Payer Types & Coverage
- Closest Appropriate Facility (Locality)
- Documentation Requirements
- ABN’s
- No Surprises Act (NSA)
- Scope of Practice
- Free standing Emergency Departments
- NEMT – Non-Emergency Medical Transportation
- Q&A

Ambulance Service Levels

Service level required is determined by the patient condition at the time of dispatch.

911 or equivalent call received, and patient condition requires an immediate response = **Emergency**

Patient condition does not warrant an immediate response or transport is no needed to an ED = **Non-Emergency**

<u>Advanced Life Support (ALS)</u>
- ALS assessment
- IV access/attempt
- Medication administration

<u>Basic Life Support (BLS)</u>
- Oxygen
- IV lock or TKO
- Basic first aid

<u>ALS 2</u>
- 3 or more separate intravenous meds excluding crystalloids
- IO
- Endotracheal Intubation
- Chest decompression
- Cardiac Pacing

<u>Specialty Care Transport</u>
-Facility to Facility only
- Critically injured or ill
- Monitored by ALS licensed personnel w/ additional training
- Local protocol(s) driven

Emergency Dispatch Protocols

- The determination to respond emergently with a BLS or ALS ambulance must follow local 911 or equivalent service dispatch protocols.
- If no protocol was used, the patient's condition at the scene determines the appropriate level of care and payment. (ALS Assessment)
- Inter-facility Emergency Transfer Protocol (Region 6 Example)
  - For the purpose of this protocol, an "Emergency Interfacility Transfer" is for patients who are deemed:
    • hemodynamically unstable, or • critically ill, or injured with an immediate life, limb or sight threatening condition • **AND requiring an immediate time-dependent intervention that is not available at the sending facility**.

Scope of Practice Billing Issues

- Billing for ALS vs BLS
  - An ALS intervention is a procedure that is in accordance with state and local laws, required to be done by an emergency medical technician-intermediate (EMT Intermediate) or EMT-Paramedic.
  - If an intervention can be done by a Basic EMT or MFR, it cannot be billed as an ALS level service.
- ALS Assessment
  - An ALS assessment is an assessment performed by an ALS crew as part of an emergency response that was 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.
  - EMD Determinants, can differ by location and MCA.

Medical Necessity-Emergency Definition

- (Medicare) covers ambulance services only if they are furnished to a beneficiary whose **medical condition is such that other means of transportation are contraindicated.** The beneficiary's condition must require **both the ambulance transportation itself and the level of service provided** in order for the billed service to be considered medically necessary.

- Origin & Destination must also be covered by the plan for coverage to be extended.

Medical Necessity-Non-Emergency

- Criteria:
  - the patient is bed-confined AND the patient's condition is such that any other method(s) of transportation are contraindicated
  - OR it is documented that; his or her medical condition, regardless of bed confinement, is such that transportation by ambulance is medically required due to the needed services of the medical personnel on board
- Patients who could be safely transported by other means of transportation (i.e. wheelchair van, NEMT), do not qualify for ambulance transportation just because no wheelchair services are available at the time requested or in the region.
- Origin & Destination must also be covered by the plan for coverage.
- Closest appropriate facility rule applies

Bed Confinement is not Bed Rest

For a patient to be deemed “bed confined” the following criteria must be met:

- The beneficiary is unable to get up from bed without assistance; and
- The beneficiary is unable to ambulate; and
- The beneficiary is unable to sit in a chair or a wheelchair.

Bed Confined alone does not = ambulance coverage.

Payer Types & Coverage

Medicare Part B	Medicare Part C (Advantage)	Medicaid FFS	Medicaid Managed Care	Commercial	Liability	Facility
Transport Benefit Only	Transport + Treat/No Transport*	Transport + Treat/No Transport *	Transport + Treat/No Transport*	Transport + Treat/No Transport*	Transport + Treat/No Transport*	Based on Payer Rules/Regulations
Transport only to Hospital/Residence/ Facility /Dialysis *excludes Dr. Offices	Covers Medicare destinations + Dr. Office if plan allows.	All destinations if medically necessary.	All destinations if medically necessary.	Covers Medicare destinations + Dr. Office if plan allows. Plan specific	All destinations if medically necessary.	All destinations if medically necessary.
Prior Authorization required for Dialysis only.	Prior Authorization maybe required for some plans/non-emergency.	Prior Authorization required for out of state transportation only.	Prior Authorization maybe required for some plans/non-emergency.	Prior Authorization maybe required for some plans/non-emergency. Some plans do not cover non-emergency regardless.	Prior Authorization maybe required for some plans/non-emergency.	n/a
PCS Required	PCS Required	PCS Required	PCS Required	PCS Required for BCBS	No PCS required	n/a
Average co-pay = 20% of allowable	Average co-pay = $250-$350	No co-pay	No co-pay	Deductible + co-pay	No co-pay	n/a
Payer Mix - 20-50%	Payer Mix - 20-50%	Payer Mix – 20-40%	Payer Mix - 20-40%	Payer Mix – 10-15%	Payer Mix – 3-5%	Payer Mix – 3-5%

Closest Appropriate Facility (Locality)

CMS definition: the service area surrounding the institution to which individuals normally travel or are expected to travel to receive hospital or skilled nursing services.

CMS allows the MAC (Medicare Administrative Carrier) to define locality for their claims processing jurisdictions.

WPS determines on a claim by claims basis using data analysis from the pick-up of the patient. No longer using a set # of miles. (Their previous policy was 5 miles.)

Closest Appropriate Facility (Locality)

- The bottom line:
  - The transport mileage should be covered if it is common for patients from that pick up area (facility)
  - If a patient is transported to a facility that is common for other patients to go from that same area to.
- Examples
- The burden of proof is on the ambulance provider.

Physician Certification Statement (PCS)

- **PCS forms** are required for Medicare/Medicare Advantage/Medicaid/Medicaid MCO/BCBS. A complete PCS form must contain:
    - Patient name
    - Medicaid beneficiary ID (if Medicaid)
    - Date of transport
    - Origin/Destination
    - Detailed explanation of the patient's condition that warrants transportation only by ambulance.
        - "Bed confined" itself is not an acceptable reason, what condition(s) are present which make the patient bed confined?
    - Care not available at the sending facility
    - Attending physician signature and NPI*

* NP/PA/RN/CNA/LPN/Discharge planner - may sign only if the attending physician is unable to sign within 48 hours of the transport.

Advanced Notice of Beneficiary

- Rarely appropriate for ground ambulance services
- Only applies if the service is a covered Medicare benefit but is “not medically necessary” for the situation
- An ABN is prohibited from using in emergency situations:
  - “…Ambulance companies may not give ABN-Gs to beneficiaries or their authorized representatives in any emergency transport because such beneficiaries are under great duress.”

Advanced Notice of Beneficiary – Applicable

- When ABN's may be needed:
  - Using an air ambulance when the patient could have been transported by ground ambulance.
  - When the transport from a residence, SNF or hospital for a service that could be more economically performed at the originating location.

Advanced Notice of Beneficiary – Not Applicable

- When ABN's are unnecessary and inappropriate to use:
  - If the PCS is not provided,
  - If the patient requests a transfer for their convenience,
  - The patient could have safely transported by other means,
  - The origin or destination is excluded from coverage,
  - When the patient is transferred to a hospital or location beyond the nearest appropriate facility,
  - For any emergency transport!

Voluntary ABN

- A notification from a health care provider that the services the patient may not be covered.
- Per CMS this is entirely voluntary and done as a courtesy to the patient or their family.

No Surprises Act (NSA)

A “balance bill” is a bill sent to a patient as a result of their insurer applying an unauthorized discount because the provider is out-of-network. A balance bill is not the cost sharing portion the member is normally responsible for, i.e. co-pay or deductible. **Ground Ambulance services in the state of MI are not included in any local or federal regulation banning them from balance billing practices. Air Ambulance is included.**

Free-standing Emergency Departments

- “Down the hall” approach, seen as an arm of the main campus.
- Transportation *can* be bundled into the health system depending on the payer contract. These arrangements are not always known to the ambulance provider.
- Anti-kickback statutes
- Closest appropriate facility rules still apply.

Non-Emergency Medical Transportation (NEMT)

- NEMT - Wheelchair/Ambu-cab transportation is excluded by most third-party payers, except for Auto/Work Comp.
- Medicaid beneficiaries *can* be eligible for NEMT, but reimbursement is below cost, leaving a small pool of providers to accept the client.
- Lack of NEMT services within an area does **not** = Ambulance Coverage.


Q&A