GAPB

GROUND AMBULANCE AND PATIENT BILLING ADVISORY COMMITTEE

Ground Ambulance & Patient Billing Advisory Committee

Overview of EMS Billing for the Oceanside (CA) Fire Department

CMS

Peter Lawrence

Disclaimer

- This presentation is a high level view of how the Oceanside Fire Department bills for EMS responses and transports.
- It is not all inclusive.
- It is not indicative of how any other Fire Service entity bills for service.

Designing an EMS System

To paraphrase Jim Page, the “father” of EMS…

You want an EMS System to be three things:

- Fast
- Efficient
- Cost Effective

But you can only choose two…

Background

- The City provides ALS first response and both ALS and BLS transport units from 8 fire stations.
- Current total call volume is 22,000 calls per year, 80% of which have a medical aspect reported (medical aid, traffic accident, rescue, etc.).
  - 60% of EMS calls result in a transport
  - 40% of EMS calls result in NO transport
- Ambulances are staffed with a combination of Firefighter Paramedics and Emergency Medical Technicians.

Billing

- Oceanside performed their own billing until 2010 when we contracted with a professional billing service, Wittman Enterprises.
- For Insurance claims, Oceanside bills:
  - Base Rates (BLS-E, ALS1-E, ALS2)
  - Mileage
  - Disposable Supplies (when certain conditions are met)
  - Medications
  - Assessment (small fee and only when called by patient/family/caregiver)
  - Dead on Scene (when assessment/care is provided)

Base Rates

- Oceanside does not recover our cost of providing EMS through the reimbursements received. Other City funds (e.g. property and sales taxes) have to be used to support the EMS system.

- Oceanside's Base Rates are broken down into Resident and Non-Resident charges.
  - Since the EMS program is subsidized by other City funds, the non-resident rate offsets the amounts residents already pay in the form of taxes, etc.

Level of Service

- We bill using the Medicare definition of each Ambulance HCPCS Code.
  - BLS Emergency (standard 911 call without ALS)
  - ALS1 Emergency (at least one medication/ALS skill)
  - ALS2 (high acuity ALS calls with multiple meds and or airway, defibrillation, cardioversion, etc.)
- The ALS2 criteria was established as part of the Medicare Ambulance Fee Schedule in 1999-2000 and does not take into account high level ALS skills or expensive single dose medications introduced since then. Total ALS2 calls are 1-3% of system volume.

Annual Adjustments

- In 2007, the base rates were set to adjust annually based on the CMS published Ambulance Inflation Factor (AIF).
- When the AIF became subject to a reduction (via the ACA) due to the use of a “productivity factor”, the City switched to CPI-Urban as a more appropriate adjustment method.
  - CMS’ own Actuaries have stated that the application of a productivity factor to “Suppliers” such as Ambulance Services (and the AIF) is inappropriate.

Time on Task

- The base rate is the same charge for a transport that takes 45 minutes or takes 3 hours.
  - There is no extra charge for waiting time at the hospital. This can add 1-2 hours or more to the time the unit is there.
  - There is no additional charge for performing additional cardiac monitoring, repeated vitals or assessment.
- Patients don't wait for an Oceanside ambulance to become available. If we are not available, then an adjacent agency handles the transport for us and bills directly. Oceanside receives nothing for providing the ALS engine on the response.

Mileage and Medications

- The Mileage charge is adjusted annually and is based on the ACTUAL cost to repair, fuel and replace the ambulance fleet. Only loaded miles can be charged.

- Medications are charged at cost +100% to account for wasting, expiration and the cost of storage and secured distribution system.
  - Ambulance Suppliers are not allowed to charge for the cost of administration.
  - When we administer medications to a patient who is not transported they are not billed (e.g. dead on scene, OD or diabetic, etc.) as they are often not covered by insurance.

Disposable Supplies

- Supplies are bundled into two charges:
  - $50 for services such as spinal immobilization, etc.
  - $80 for services like childbirth, airway, CPAP, etc.

- An analysis was done in 2012 to determine the cost of the supplies, as well as ordering, storage and distribution for the different types of calls.

- Only one “bundle” is charged, regardless of how many services are provided.

Assessment

- A paramedic/ALS equipped engine is dispatched to every medical call along with an ALS or BLS ambulance.
  - The engine arrives on scene first the majority of the time
- If we are called to the scene of a medical emergency and do not transport, we charge an Assessment Fee of $100.
  - We only charge if the patient or a family member/caregiver calls. We do not charge if a bystander calls.
- Many insurance companies do not pay for non-transport services, leaving the patient to pay the full amount of the bill.

Dead on Scene (DOS)

- In the event a patient is pronounced at the scene, a fee of $600 is charged.
  - It is coded using the modifier QL
  - It is often reimbursed at the Medicare level of BLS.
- Had we transported the patient to the hospital for pronouncement, it would have been billed and reimbursed at the ALS2 rate and substantial ER related charges would be incurred by the patient and the insurance provider.

Destinations

- The destination the patient is taken to is determined based on patient request or because of acuity or special status (e.g. trauma, burns, pediatric, etc.).
- As a 911 provider, we can only deliver patients to hospitals. There is limited movement to begin allowing for transport to urgent care, etc. (e.g. ET3)
- The goal is to take the patient to the hospital of their choice so they are not subjected to out-of-network charges or excessive co-pays.
  - Insurance companies routinely consider ambulance suppliers to be “out-of-network” even though the patient does not have a choice when they call 911. This results in increased patient cost.

Insurance Collections

- Some insurance companies immediately pay the billed amount minus the patient co-pay.
- In CA, we get paid directly by the insurance payor.
- Most classify the transport as “out-of-network” and reimburse what they feel is the “*appropriate”* amount.
- Some require the patient to appeal the amount paid and some require the transporting agency to appeal.
- An analysis of Oceanside’s 2019 data shows:
  - % of a ALS bill paid by insurance = 53% to 100%
  - % of a BLS bill paid by insurance = 48% to 95%
  - Kaiser pays 91% or greater on all claims and is our largest single insurance payor

Questions?

- Pete Lawrence, Deputy Fire Chief
- Oceanside (CA) Fire Department
- PLawrence@oceansideca.org