Centers for Medicare & Medicaid Services
Ambulance Open Door Forum
Moderator: Jill Darling
June 14, 2018
2:00 p.m. ET

Operator: Good afternoon. My name is (Amy), and I will be your conference facilitator today. At this time, I would like to welcome everyone to the Centers for Medicare and Medicaid Services, Ambulance Open Door Forum.

All lines have been placed on mute to prevent any background noise. After the speakers' remarks, there will be a question and answer session. If you would like to ask a question during this time, please press star, then the number one on your telephone keypad. If you would like to withdraw your question, please press the pound key.

I would now like to turn the call over to Jill Darling. Please begin.

Jill Darling: Thanks, (Amy). And good morning and good afternoon, everyone. I'm Jill Darling in the CMS Office of Communications, and welcome to today's Ambulance Open Door Forum.

Before we get into today's agenda, one brief announcement from me. This Open Door Forum is not intended for the press and the remarks are not considered on the record. If you are a member of the press, you may listen in but please refrain from asking questions during the Q&A portion of the call.

Do you have any inquiries? Please contact CMS at press@cms.hhs.gov. And now I'll hand it off to our new chair, Sarah Shirey-Losso.

Sarah Shirey-Losso: Thank you, Jill. And thank you for the opportunity to chair this Open Door Forum. Again, my name is Sarah Shirey-Losso, and I'm the deputy director in the Division of Ambulatory Services.

I've actually been with CMS for 20 years but fairly new to the ambulance world in CMS. In the last three years, I've been deputy director in this division and we handle an array of different payment policies in the Center for

Medicare, including RHCs and FQHCs, Part B drugs, the clinical lab fee schedule as well as the ambulance fee schedule.

So, I'm really excited to be part of this forum. And my colleagues and I look forward to continuing our dialogue with the ambulance community. So, with that I'll move right on to the first agenda item.

At the last open door forum, we announced the Bipartisan Budget Act, BBA of 2018. This law had some new initiatives for – that impacts ambulance industry, and included three major Medicare ambulance provisions, pertaining to extensions of certain ground ambulance add ons, development of a data collection system for ground ambulance providers and suppliers, and the payment reduction for nonemergency ESRD ambulance transport.

We recently posted a summary of these provisions on our ambulance webpage and you can find that by looking at going to www.cms.gov. And then you can, in the search box, put in ambulance, and it'll take you right you are ambulance page. And this – the summary of the law as well as the law itself is in the Spotlight section there.

And along with that, we are actually having a national provider call between session. And that will be held on June the 28th this month from 1:30 to 3:00. And this will be an opportunity to part – to for affected stakeholders, ambulance suppliers and providers to provide input on the development of our system, and includes – we are looking for recommendations on the data elements that we could collect, identifying costs that might be difficult to define, addressing the potential where there might be a variation in cost, among different types of ambulance suppliers and providers, and any other general comments that you feel that CMS should consider as we start developing, as we move forward with this provision.

And, again, it will be a set – listening session for interested suppliers and providers and other stakeholders to provide us any initial considerations. You can find information on registering. If you go to cms.gov and then click in the Outreach and Education tab at the top of that page and it'll come up with

National Provider Calls and Events, and you'll see our event listed there. Again, it's on June 28th and registration is open.

Thank you. And with that, I will turn it over to Eric Coulson for the next agenda item.

Eric Coulson: Hi, everybody. Thank you, Sarah, for that – for that introduction. As Sarah mentioned, the Bipartisan Budget Act of 2018 was signed a couple months ago and contained the ambulance provisions that Sarah mentioned.

As a result of the signing of that legislation, we issued – pardon me – two recent change requests, both of which I'll give you just a brief overview of them. If you haven't already seen them, you could go out and find them on the CMS website at some point. They are change requests 10531 and 10549.

First one, change request 10531 was issued March 20th of this year, transmittal 2047. Its title is Claims Processing Actions to Implement Certain Provisions of the Bipartisan Budget Act of 2018, and the CR contained BRs specifically related to ambulance services.

Many of you are probably aware, we had created and given to our claims processing contractors for the purposes of processing ambulance claims the 2018 fee schedule.

The Bipartisan Budget Act was signed after that fee schedule had already been released and after we had already begun processing 2018 calendar year date of service ambulance claims. So, therefore, we needed to – or after the signing of the Bipartisan Budget Act, we needed to go back and issue a revised ambulance 2018 fee schedule file so claims could be processed according to the payment rates set or allowed by the Bipartisan Budget Act.

So, the instructions in change request 10531, essentially, just told the MACs to go back and process claims using the new, revised, updated 2018 ambulance fee schedule file and reprocess any date of service 2018 claims that may have been paid under the original or initial 2018 ambulance fee schedule file.

So, the specific instruction was for the MACs to complete or at least to initiate reprocessing actions within six months of the issuance date of the C.R. So, we are still within that six-month window but hopefully, by now, you should have seen at least some early 2018 date of service ambulance claims having been reprocessed using the new fee schedule or the revised fee schedule rates in the 2018 fee schedule file.

If you haven't, you probably will soon. Hopefully. If it gets to the point where you're concerned that you may never see them, please contact your local Medicare administrator contractor and make sure that they are – you can – I guess you can just give them a call and give – ask for a status update as to any claims that may have been paid, not incorrectly, but under the initial fee schedule file.

The second change request was change request 10549. Its title is Increased Ambulance Payment Reduction for Non-Emergency Basic Life Support Transports To and From Renal Dialysis Facilities.

That C.R. was issued April 6 of this year. And, again, that C.R., with instructions for our shared system maintainers and the MACs were for them to be sure to implement changes so that come October 1st, 2018 dates of service any nonemergency BLS transport of individuals with end-stage renal disease to and from renal dialysis treatment entities, those trips will be subject to a 23 percent payment reduction per the section in the Bipartisan Budget Act of 2018.

So, not much more to say about that. Again, those changes are effective October 1st of this coming – this year. So that's everything I have on that.

Jill Darling: All right. Thank you, Eric. Next, we have Amy Gruber, who will talk about the C.R. 10550, Ambulance Transportation for a SNF Resident in a Stay Not Covered by Part A.

Amy Gruber: Thank you, Jill. On April 13th, 2018, CMS released transmittals 243 and 4021, Companion Change Requests 10550, providing clarifications to the Medicare Benefit Policy Manual, Chapter 10 in two sections – 10.3, The Destination; and section 10.3.3, Separately Payable Ambulance Transport

under Part B versus Patient Transportation that is Covered Under a Packaged Institutional Service.

This C.R. is also providing clarification to the Medicare Claims Processing Manual, Chapter 15 in two sections – Sections 10.4, Additional Introductory Guidelines; and Section 30.2.2, SNF billing.

In MLN Matters Article, M.M. 10550 was also released. The effective and implementation date is July 16th, 2018. Each transmittals provide clarification on coverage of an ambulance transport for SNF resident in a stay not covered by Part A, who has Part B benefits to the nearest supplier of medically necessary services, not available as a SNF including the return trip.

In the June 17, 1997, ambulance proposed rule citation 62 F.R. 32720, CMS proposed a provision under Part B that permits ambulance transportation from a SNF to the nearest supplier of medically necessary services not available at the SNF, where the beneficiary is an inpatient including the return trip.

CMS finalized this proposal in the January 25, 1999 final rule, citation 64 F.R. 3648 at 42 CFR 410.40 (e)(3). CMS is adding this policy to the Medicare Benefit Policy Manual and the Medicare Claims Processing Manual.

If a beneficiary is residing in a SNF with Part B benefits and there is no coverage for the SNF services under Part A, a medically necessary ambulance transport to the nearest supplier of medically necessary services not available at the SNF, where the beneficiary is a resident (including the round-trip), may be covered under Part B.

For example, this includes the transport of such residents from the SNF reported with ambulance modifier N to the nearest diagnostic or therapeutic site other than a physician's office or a hospital, such as an independent diagnostic testing facility, cancer treatment center, radiation therapy center, and wound care center, as reported with the ambulance modifier D. For SNF residents receiving Part A benefits, this type of ambulance service is subject to SNF consolidated billing.

Thank you. Back to you, Jill.

Jill Darling: All right. Thank you, Amy. And last we have Andrew Ward, who will speak on the Market Saturation and Utilization Data Tool.

Andrew Ward: Thank you. So, the Market Saturation and Utilization Data Tool is in its seventh iteration right now. The eighth iteration, the eighth release, will be on September 2018.

The tool itself defines market saturation as the density of providers of a particular service within a defined geographic area, relative to the number of beneficiaries receiving that service in the area. The tool itself originated when we were asked to monitor the behavior of moratoria states and counties.

And so, one of the metrics that we do monitor, one of these health service areas, is ambulance. And in fact, we have a number of different health service areas that we monitor in the market saturation tool.

And if you have your agenda available to you, if you look in the agenda, there is a URL there, a hyperlink. And if you click on that that will take you to the Market Saturation Data Utilization Tool.

The health service areas that are covered are ambulance emergency, ambulance nonemergency, ambulance emergency and nonemergency. Then we also cover cardiac rehabilitation programs, chiropractic services, clinical laboratories billing independently, federally qualified health centers, home health, hospice, independent diagnostic testing facilities Part A and Part B, long-term care hospitals, ophthalmology, physical and occupational therapy, psychotherapy, and skilled nursing facilities.

In the case of the ambulance services, the – we cover both nonemergency ambulance, emergency ambulance, and nonemergency and emergency combined. Or the nonemergency ambulance, we have defined those services by the Healthcare Common Procedure Coding System, HCPCS codes, A0425, A0426 and A0428, in order to determine the number of providers of these services.

The number of nonemergency providers includes both emergency and nonemergency providers because nonemergency services can be provided by both emergency and nonemergency providers.

The emergency ambulance – emergency ambulance services are defined by HCPCS codes A0427 and A0429, and they're matched with associated mileage claims A0425. And in order to specify the ambulance services are Medicare Part B, the claim type is specified as 71 and 72.

For those market saturation for the ambulance and the other services, there are a number of metrics that you can choose to look at. In particular, there are seven metrics. You can look at the number of fee-for-service beneficiaries, the number of providers, the average number of users per provider, the percentage of users out of fee-for-service beneficiaries, the number of users were users are a subset of the fee-for-service beneficiaries, who have a paid claim for a service, the average number of providers per county, and the total payments. And for Part A services, total payments are calculated from the claim level paid amounts. And for Part B services, the total payments are calculated from the claim line level paid amounts.

And looking at the tool, a couple things to keep in mind, claims data is coming from the integrated data repository here at CMS. Claims data are analyzed for a 12-month reference period and they're updated quarterly to reflect a more recent 12-month period.

So that if you were to look at the tool itself online, what you would see is that you could choose a reference period. And since this is seventh revision of it, there are seven reference periods that you can use.

The first one starts with October 1st, 2014 and goes to September 30th, 2015. The most recent one runs from April 1st, 2016 to March 31st, 2017. And in September, when we have the eighth revision, we're actually adding two reference periods. And so at that point, it will run through October of 2017.

A provider for us is defined as serving a geographic area, if during the reference your claims were paid for more than 10 beneficiaries living in geographic area. And so sometimes when you see analysis done, either with

some sort of webpage user interface or in some sort of other kind of analysis, they will look at the provider address. But instead, we're looking at where the beneficiaries are and we're defining the provider serving the geographic area in terms of who the provide – who the beneficiaries are.

A provider is defined as serving a state if during a reference year that provider serves any county in the state. A fee-for-service beneficiaries – and we are only looking at fee-for-service beneficiaries.

They are defined as being enrolled in Part A and/or Part B with the coverage type code equal to nine, which is fee-for-service coverage, or at least one month of the 12-month reference period. And during that time there must not be a death date for that month or a missing ZIP code for the beneficiary.

And that's because we need to assign the beneficiary to a county. Because when you go into the tool, we shall see immediately is a national map. You can hover over states and get information about the states relative to a reference period, a metric and a health service area.

But then you can click on the state. And what will happen then is that you will get a drill down map at the county level where you will be able to, again, choose a reference period as – select the metric and you can choose a health service area.

There are three exclusionary criteria that we have imposed upon the data. First is that if a beneficiary's county residence cannot be determined, then the beneficiary is excluded. Generally, that only represents a very small part of the population of less than one percent.

For purposes of privacy, providers are excluded if they had paid claims for 10 or fewer beneficiaries located in the county. And counties are excluded if 10 or fewer beneficiaries who had a paid claim resided in the county. And so, what that tends to do is to exclude, for example, frontier counties.

If you go to the webpage, as I say, what you will see is a national map, where you can hover over the states and you can get information about the states, relative to the reference period metric and health service area. You can click

on the state and you'll get information about the county, but you can also select the reference period, the health service area and the metric.

If you scroll further down, then there's information about how to use the tool. There is a data methodology section where you can go and you can see exactly what our methodology is, what are our exclusionary criteria are, how we define the various metrics and service areas that the tool makes use of.

There's a technical appendix that you can click on and that will go to more detailed account of what it is that the tool does. Because a lot of people want to be able to do their own analytics with this information, there's a tab that's in data files.

Data files will allow you to download an Excel file that contains all the information that is contained in the maps, so that if you wanted to then export that to some specific software or simply use Excel if you choose, then you can cut and dissect the data in any way that you want to, in order to be able to do the analytics that most interests you.

So, you can look at counties for particular state, you can look at states, you can look at the various health service areas, you can look at the reference period. It's entirely up to you. And we did this in order to maximize the applicability of the data that we are trying to make available for you to be able to do the analysis that you want.

We also, with this last iteration, added a trend analysis. And so, if you were to click on that, what it does is that it goes to an Excel file and the Excel file then has the analytics built into it so that you can pick service area and you can pick a metric.

And what it will do is that it will show you trend information from the first reference period back in 2014 to the current reference period in 2017. And so, I'm looking at it right now and the metric that I happen to choose was the average number of providers per county.

And so, I'm looking at the emergency ambulance and the average number providers per county nationally has dropped 6.91 percent. The average

number of providers per county or nonemergency ambulance has dropped 7.31 percent. And the average number of providers per county for emergency and nonemergency ambulance combined has dropped 7.24 percent.

You can also do a trend line graphics where, for example, if I were to pick the emergency ambulance and I was to pick the metric of total payment, what it will do is for the reference periods, again, stretching from October 1st, 2014 all the way up through March 31st, 2017. It gives me a line graph showing the total payment for emergency ambulance, nationally, over that period of time.

So, for example, the total payment for emergency ambulance for our first reference, October 1st, 2014 through September 30th, 2015, was $2,790,805,000, roughly, whereas for the latest reference period which, again, was the April 1st, 2016 to March 31st, 2017, the total payment for emergency ambulance was $2.9 million, roughly. And so, if you want to look at other metrics for emergency ambulance, then you can look at any of the metrics that the tool provides.

In the next release of the tool, which is probably in September, what we hope to do is to have the trend analysis tool available at the state level so that right now the trend analysis is at the national level. But hopefully, in September, what we will have is the trend analysis that you can get also at the state level to look at how those trends emerge at the state level.

So, we hope that the tool provides you an opportunity to look at the saturation; that is to say, the density of providers and beneficiaries for various services, such as ambulance and for a variety of metrics over a period of time. Thank you.

Jill Darling: All right. Thank you so much, Andrew, and to all of our speakers. (Amy), we'll go into our Q&A, please.

Operator: As a reminder, ladies and gentlemen, if you would like to ask a question, please press star, then the number one on your telephone keypad. If you would like to withdraw your question, please press the pound key.

Please limit your questions to one question and one follow-up to allow other participants time for questions. If you require any further follow-up, you may again press star, one to rejoin the queue.

Your first question today comes from the line of Nancy Horn of Medical Compliance. Your line is open.

Nancy Horn: First of all, I would just like to thank you for doing the clarification for 42 CFR 410.40 E3. That was extremely helpful to the community. My question is, Anthem has come out with – they've added the treated note transport HCPCS code to their fee schedule. Is there any plans of CMS possibly doing that in the future?

Amy Gruber: So, at this time I don't know if that's on our radar. And what was the codes? Do you have the codes?

Nancy Horn: I believe it's A.L.-499 or A.L.-399 or something like that HCPCS code. It's just treated no transport is what it is.

Amy Gruber: Right. Well, at – as for Medicare fee-for-service, it is a transportation benefit, and that is statutory.

Nancy Horn: OK. Appreciate it.

Amy Gruber: Thank you.

Operator: Your next question comes from the line of (Mark Baird) of North West Ambulance. Your line is open.

(Mark Baird): Hi. I've got a question regarding TPE. So, when a providers put under TPE, they do a TPE for a quarter, come up with an error rate. However, when those denied claims are then overturned at QIC, the TPE error rate is not corrected to reflect an accurate error rate. Why is that?

Sarah Shirey-Losso: Hi. This is Sarah Shirey-Losso. Unfortunately, I am not familiar with TPE. But I would be happy if you want to send that question into our ambulance ODS mailbox and we can get that over to our area that works with, (Sir) – in those error rate files. And that is ambulanceodf@cms.hhs.gov

(Mark Baird):   Thank you. Thank you.

Operator: And, again, if – ask a question, please go ahead and press star, then the number one on your telephone keypad.

                   Your next question comes from the line of (Michael Masor) of (Symon and Co). Your line is open.

(Michael Masor): Hi. I'm just wondering if you had any update on the prior authorization demonstration including one on evaluation might come out. And if the GAO report, I recommended the demonstration be continued as having any impact on the decision to extend it or continue it.

Angela Gaston: Hi, (Michael). This is Angela Gaston.

                   Unfortunately, I still don't have much of an update for you. We're still exploring to determine if all the requirements for nationwide expansion have been met, but we're making progress. We do have that independent evaluation up on our website. It's down on the related links section.

                   And all that's been – being taken into consideration. It's going to go to our office of the actuary along with the GAO recommendation, and it's all going to get taken into consideration on whether or not we met these requirements.

Operator: Your next question comes from the line of (Alexis Caneghan) of (Clinton Medical). Your line is open.

(Alexis Caneghan):   Hi. I was wondering if there was any further information about the mass denials and recoupments that happened earlier in the year for their runs out of business that were going to cover destinations that for some area were considered noncovered destinations at a later point and then denied and recouped.

                   And every time I've called they've said, "Yes, that's going to be – that we're going to do a mass adjustment later on and you'll receive payment." And we haven't seen anything of that yet. So, I just want to make sure that what I've

been told is correct and that I don't need to be doing anything about these claims at this point.

Eric Coulson: Hi. So, I'm sorry. What was your name again?

(Alexis Caneghan). (Alexis).

Eric Coulson: (Alexis), hi. This is Eric Coulson. I'm – first of all, let me give you an email and just if you want to send an email to me, I can try to follow up by email. It's eric.coulson@cms.hhs.gov.

I can tell you that, generally, I don't know the answer to your question. But what I can tell you is that, generally, when we do mass adjustments, we do as much as we possibly can to make sure that there is no burden on the providers or suppliers who submitted the claims. So, that's going to – typically, we give instructions. You should not have to do anything in order to get your claims reprocessed.

That being said, I don't know the status of all that's going on but follow up with an email if you would, please, and I'll try to get you some additional information as best I can.

(Alexis Caneghan): All right. Thank you.

Eric Coulson: You're welcome.

Operator: And again, if you would like to ask a question, please go ahead and press star, then the number one on your telephone keypad.

Your next question comes from the line of Nancy Crenshaw of Ambulance Pro. Your line is open.

Nancy Crenshaw: Hi. My question is in regards to the – I believe that it's – is it the qualified Medicaid beneficiary initiatives that was rolled out earlier? Am I using the right terminology?

Sarah Shirey-Losso: I'm sorry. Is this related to one of the topics we discussed on today's call?

Nancy Crenshaw: Oh, no. I'm sorry. It's outside of the topic for today so (inaudible) …

Sarah Shirey-Losso: OK.

Nancy Crenshaw: Is it limited to the topics just discussed today?

Sarah Shirey-Losso: No, not at all. I was – we were just trying to understand your question.

Nancy Crenshaw. OK. Well, I had got a question here. I just wanted make sure I tell (Nagradis). The qualified Medicare beneficiary notifications that Medicare came out and told our match that to regenerate any claim that had qualified Medicare (statutory) beneficiary behind Medicare with – it was actually a zero remittance that they now – I believe it was the fourth quarter fines from October through December.

So, we went through a period of massive amounts, like 2,000 and 3,000 in mass scenario of PRAs that got reproduced by Palmetto GBA because of this. And at this – and it was supposed to be a zero pay nonmonetary associated with it.

Are they through with process in those claims yet? Are we going to still continue the C.B.s or – and the reason I asked, for every E.R. made (occurrence), my clearinghouse charged us 21 cents per line. So, this has (caused me) thousands of dollars in claims processing. So, I just wanted to know where we were on, what's happening, and will this continue going forward.

Eric Coulson: Hi. So, this is Eric Coulson again. I'm going to ask you to do the same. I don't know the answer to your question. I apologize. But follow up with me on an email. Have you tried contacting Palmetto?

Nancy Crenshaw: Oh, yes. Oh, yes. Yes. I've actually …

Eric Coulson: OK.

Nancy Crenshaw: … I – we – well, I had to actually go through my software through the clearinghouse and work our way back to Palmetto GBA.

But everybody said their hands were tied because it was an initiative that came down – I believe it was April 30th. It's 20 – it was released for Medicare and the carrier is (Mac Delubius) just to let us know so we did not inadvertently deal one of those patients that may have Medicaid as a secondary and/or in this program.

But if we were unaware that they had Medicaid, they were giving us information so as trying to help not bill a patient that should not be billed, which I appreciate. But in the – but at the end of the day, it's in the – costing me a fortune.

Eric Coulson: Right. Understand. OK. Well, I confess I'm not familiar with the issue at hand, but what I will try to do, if you send me an email – again, it's Eric, E-R-I-C dot Coulson, C-O-U-L-S-O-N. That's S as in Sam, and O as in Oscar, N as in Nancy, I will try to get you in touch with somebody either at Palmetto or here at CMS that can help you better than I.

Nancy Crenshaw: OK. And so, it's eric.coulson at…

Eric Coulson: cms.hhs.gov.

Nancy Crenshaw: Thank you so much, Eric.

Eric Coulson: You're welcome.

Operator: Your next question comes from the line of Kelly Pratt of Butler County EMS. Your line is open.

Kelly Pratt: The part where he was talking about the past for – to get to the metrics map, I lost track of what tabs to push, and so I don't know where he was at.

Andrew Ward: Hi. So, the URL for the Market Saturation and Utilization Data Tool is on the agenda. I'll read it off if you want to write it down. It's is https://data.cms.gov/market-saturation, and that should get you to where you're going.

Kelly Pratt: OK. Thank you.

Andrew Ward: Once you get – once you get there, then what you'll see right away is that you'll see a pretty blue thing that says, Market Saturation Utilization Data Tool. You just scroll down to see the national map.

And then if you scroll to the bottom, what you'll see is that there are four tabs: How To Use the Tool, Data Methodology, Data Files, and Trend Analysis; and you can just click on those.

And if U.R. – URL is too difficult, then if you just type in data.cms.gov, that takes you to the – to the landing page of all the – all the homepages that are on data.cms.gov, and then you would just search for the market saturation tool. I hope that helps.

Kelly Pratt: Yes, it does. Thank you.

Operator: And there are no further questions in queue at this time. I turn the call back to the presenters.

Sarah Shirey-Losso: Great. Well, thanks you all for joining us today. And, Jill, do we have a new call scheduled? No, not at this time?

Jill Darling: No. We'll send out the agenda when it gets – probably in the next three months.

Sarah Shirey-Losso: OK. Great.

Jill Darling: So, just look out for that.

Sarah Shirey-Losso: Thank you all for your time today.

Operator: Thank you for participating in today's Ambulance Open Door Forum conference call.

This call will be available for replay beginning today June 14th at 5 P.M. Eastern Time through June 18th at midnight. The conference I.D. number for the replay is 33271311. The number to dial for the replay is 855-859-2056.

This concludes today's conference call. You may now disconnect.

End