

Centers for Medicare and Medicaid Services
Ambulance
Open Door Forum
Moderator: Jill Darling
November 15, 2018
2:00 p.m. ET

Operator: Good afternoon. My name is (Sia) 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, simply press star and the number one on your telephone keypad. If you would like to withdraw your question, press the pound key. Thank you.

At this time, I would like to turn the conference over to Jill Darling. Please go ahead, ma'am.

Jill Darling: Great. Thank you, (Sia). Good morning and good afternoon, everyone. I'm Jill Darling, in the CMS Office of Communications. And thank you for joining us today for the Ambulance Open Door Forum.

Before we get into today's agenda, I have one brief announcement. 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. If you have any inquiries, please contact CMS@press.cms.hhs.gov.

I will now hand the call off to Amy Gruber for our first agenda items.

Amy Gruber: Thanks, Jill. My first announcement is about the calendar year 2019 physician fee schedule final rule changes to the regulations associated with the ambulance fee schedule.

The Bipartisan Budget Act (BBA) of 2018, which was enacted on February 9th, 2018 included three provisions for ambulance services. We addressed two of the provisions in the physician fee schedule proposed and subsequent final rule.

The first provision is the ambulance extender provisions. Under the Ambulance Fee Schedule (AFS), payment for ambulance transports includes three components – the base payment, a separate payment for mileage to the nearest appropriate facility and a geographic adjustment factor.

AFS also incorporates two permanent add-on payments and three temporary add-on payments to the base rate and/or mileage rate. The three temporary add-on payments includes a three percent increase to the base and mileage rate for ground ambulance transports that originates in rural areas, a two percent increase to the base and mileage rate for ground ambulance transports that originate in urban areas, and a 22.6 percent increase in the base rate for ambulance transports that originate in “super rural” areas.

These provisions were set to expire on December 31st, 2017, but has been extended for five years. Section 50203(a) of the BBA of 2018 amended sections 1834ll-12(a) and 13(a) of the Act to extend the (inaudible) to – excuse me – to extend these temporary permanent – to extend these temporary payment add-ons through December 31st, 2022.

And the final rule, we finalized our proposal without modification to revise 42 CFR Section 414.610 (c)(1)(ii) and (c)(5)(ii)) to conform the regulations to this statutory requirements.

The second provision addresses payments for non-emergency ESRD ambulance transport. For services furnished on or after October 1st, 2013, AFS includes a 10 percent reduction in payments for certain non-emergency basic life support transports of beneficiaries with ESRD for renal dialysis

services as required by Section 1834(l)(15) of the Social Security Act. Section 53108 of the BBA of 2018 amended Sections 1834(l)(15) of the Act to increase reduction from 10 percent to 23 percent effective with the services on or after October 1st, 2018.

In the final rule, we finalized our proposal, without modifications, to revise 42 CFR 414.610(c)(8) to conform the regulations to this statutory requirements.

The display copy of the physician fee final rule can be viewed at federalregister.gov website. The document number is CMS-1693. Discussion on ambulance services begins on page 736 and the final rule will be published on November 23rd, 2018.

My second announcement is regarding the development of a data collection systems for ground ambulance providers and suppliers. Section 50203(b) of the BBA of 2018 adds a new paragraph 17 to Section 1834(l) of the Act, which directs the Secretary to develop a data collection system, which may include use of cost survey to collect cost, revenue utilization, and other information determined appropriate by the Secretary, with respect to providers and suppliers of ground ambulance services.

Section 50203(b) of the BBA of 2018 states that such system should be designed to collect information: needed to evaluate the extent to which reported costs relate to payment rates; on the utilization of capital equipment and ambulance capacity, including information consistent with the type of information described in Section 1121(a) of the Act; and with different types of ground ambulance services furnished in different geographic locations, including rural and super rural areas.

Not later than December 31st, 2019, the Secretary must specify the data collection system and identify representative sample of providers and suppliers required to submit information under the data collection system for the first year.

In addition, among other things, Section 50203(b) of the BBA of 2018 adds section 1834l (17)(d), of the act which requires, subject to certain conditions,

a 10 percent reduction to the ambulance fee schedule payments made to a provider or supplier that is required to submit information under the data collection sessions under the data collection system with respect to a period and does not sufficiently submit such information as determined by the Secretary.

We have included a summary of the – of the provisions and a copy of the BBA of 2018 on our Ambulances Services website.

On June 28, 2018, CMS held a listening session where we raised five questions to gather valuable feedback from the ambulance industry. Questions included, "What specific comments or concerns do you have with the legislation? Please include potential solutions or things to consider to alleviate these concerns."

Question number two with, "What data elements should we collect and why." Third question was, "What costs would be difficult to define and report and why?" Fourth question is, "How can we address potential cost variations among providers and suppliers?" And the fifth question was, "What else should we consider?"

You can view the presentation, audio recording and transcript on this listening session at CMS' Outreach and Education website.

The easiest way to obtain this material is to Google: Ambulance National Provider call June 2018. CMS is currently working to develop proposals to implement this provision through rule making.

This completes my announcements. Back to you, Jill.

Jill Darling: Great. Thank you, Amy. For those speakers who were on, if you please mute your end, we were hearing some background noise.

Our next speaker is Angela Gaston, who has a prior authorization update.

Angela Gaston: Thank you, Jill. We wanted to make you aware of a new service we have for beneficiaries. CMS has contracted with Fed Pro Services to assist Medicare

beneficiaries do not qualify for coverage of repetitive scheduled non-emergency ambulance transport under the Medicare benefit. Beneficiaries who receive a non-affirmed prior authorization decision letter are encouraged to contact Fed Pro Services for assistance. The number is included in the – in the letter that they received.

Customer service representatives will discuss the beneficiaries' transportation needs and direct them to the most appropriate transportation resource in their area. For more information, you can visit www.fedpro.net. And please note that Fed Pro does not provide transportation but whether they help connect the beneficiary with the most appropriate resource and the service is only for beneficiaries who received a non-affirmed prior authorization decision as part of the model in the limited states.

And regarding that model, the prior authorization model for repetitive scheduled, non-emergent ambulance transports in the states of Delaware, D.C., Maryland, New Jersey, North Carolina, Pennsylvania, South Carolina, Virginia and West Virginia is currently scheduled to end on December 1st, 2018 based on date of service. Any prior authorization request with a start date of December 2nd or later will not be reviewed at this time.

We are currently exploring our options. When we extended the model last year, we issued a federal register notice and posted an announcement on our Ambulance Prior Authorization website. If there are any changes to the model end date we would take that same approach again, and that website – and I believe it was included on the agenda is <http://go.cms.gov/PAAmbulance> and we'll stay on the line for questions today. But you can always submit questions anytime to our Ambulance Prior Authorization mailbox, and that's ambulancepa@cms.hhs.gov.

Thank you. I'll turn it back over to you, Jill.

Jill Darling: Great. Thank you, Angela. (Sia), please open the lines for Q&A, please,

Operator: At this time, I would like to remind everyone that if you would like to ask a question to press star one on your telephone keypad now. Again, that's star one for any questions over the phone line. We'll pause for just a moment.

The first question will come from Mark Miller with Department of Public.

Mark Miller: Hello?

Jill Darling: Yes, go ahead.

Mark Miller: Hi. Yes, this is Mark Miller from the Office of the E&S at Massachusetts. I was just calling to ask questions about the ESRD and whether you looked at whether this 23 percent cut actually makes it costs negative to do their transports for ESRD patients?

Amy Gruber: This is Amy. We haven't looked at the data. This update was just done recently or will be done recently October 1st, 2018. So no, we haven't looked at the – at the data.

Mark Miller: OK, (inaudible).

Amy Gruber: But if there's any information that you would like to share with us, please submit that to our Ambulance Open Door Forum mailbox and we'd be ...

Mark Miller: OK.

Amy Gruber: ... happy to take a look at that – happy to take a look at that data. Thank you.

Mark Miller: Sure. The other – I did hear also that there would – there is a pending CMS review of non-emergency medical transportation funding for May. And, I guess, looking at it from our – that would be about half of all the volume in the state of Massachusetts that – for transportations and 911, so it's about half of the – half of the volume so about 800,000 calls. It does seem like that would significantly impact the amount and availability of ambulances to do that type of work.

The – moving it to private pay would vastly encumber the ambulance industry with following up in collection rates. And I think they would have a – have a difficult time.

Now one of the things is – to note is that emergency medical services and emergency preparedness need to have that good cooperation between private ambulances, municipals and contractor organizations in order to provide that layer for disasters of any type.

So, I guess, that's my big concern is if we make a huge change in the payment process, and we lose a lot of private industry, we also are losing a huge return on investment for making sure that patients arrive at those locations.

And the return on investment for that has been anywhere from \$6 to \$20 per dollar spent on transportation, making sure that they follow up and take good care of their; themselves. So, yes, I'm very concerned about that as well.

Amy Gruber: This is Amy. Thank you for your comments. Can you please submit those to us in writing? We would appreciate that. And I believe I misspoke, this reduction was in effect October 1st 2018. My apologies.

Operator: As a reminder, ladies and gentlemen, 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 press star one again to rejoin the queue.

The next question is from Marsha Simon with Simon & Company.

Marsha Simon: Thank you. I have a question for Angela. The last time we discussed the ambulance in EMT prior authorization demonstration, you said that the CMS actuary was reviewing the results of the nine-state demo and I wondered what, the current status of that review is?

Angela Gaston: Yes. There hasn't been any change on that right now. They're still reviewing or we're still exploring whether we meet the requirements, so there's no update or projected timeline at this time.

Marsha Simon: Thank you.

Angela Gaston: Yes.

Operator: The next question is from Andi Gillentine with Superior HealthPlan.

Andi Gillentine: Hi, thank you. I'm curious. I've been looking into the medically unnecessary edits surrounding non-emergent transport for basic life support. And there's a discrepancy between the Medicare limit and the Medicaid limit, where for one of the codes, Medicare allows four trips per day, but Medicaid only allows two, and I'm curious the reason for that distinction and why they aren't aligned it for?

Amy Gruber: This is Amy. Can you please submit your inquiry to us at our mailbox? I don't believe we have contact that can address the Medicaid issue on this call.

Andi Gillentine: OK. Can you repeat that please? The mailbox that I should submit it to?

Jill Darling: Sure. Its ambulance O-D-F @cms dot H-H-S dot G-O-V.

Andi Gillentine: Thank you.

Amy Gruber: You're welcome.

Operator: The next question is from Brandy Knight with Ambulance Pro.

Brandy Knight: Hello. Yes. I would like some clarification please. I was in a meeting a couple of weeks back with some (committed) GBA representatives, in regards to prior auth and several other agencies and entities were present to kind of get some clarification on some issues we were having in obtaining (UCAM's) prior authorizations.

And one of the clinicians had stated that the actual date that is completed on the prior authorization form, the actual request form that we complete with the minimum fiduciary provider number of transports, et cetera.

At the bottom, you're supposed to print the submitter's name, of course, sign in and (data here).

We had all been under the assumption since 2014 that that date on the bottom is the date we are actually submitting that request. However the clinician made the remark if she was reviewing this prior authorization and the date at the bottom is way past the start date because we get to try and keep trying and keep trying until we get it.

That she would have just tossed it on that face value alone that the date range was so far out because what she had done is let examples of true prior authorization submissions that she personally reviewed and she was given its advice because she saw this, it made it ineligible. Or because she saw that, it made an ineligible.

And the start of care date is what she referred to as your requested date of starting the 60-day period. And the date at the bottom right hand side next to the submitter's signatory was about six months out.

Well, that happens a lot and routinely. And, yes, it takes sometimes forever for us to get it because we also know that there are different clinicians that do different reviews, and I assume bring different perspectives to the table in who's affirmed and not affirmed.

And that cleared up the whole question of why we can submit the same paper work over and over. And eventually, we will get an affirmation for the date range we've requested.

So – and also that date, in my mind, helps us clarify, when we get back a response. It says for the submission dated and it puts the date that we usually sign at the bottom, it – well, if we keep us on the same date what she recommended to start a start of date over and over, then we're never going to be able to determine which one they are denying – which one got an affirmation or a non-affirmation if we're using the start of care date.

But that's what she recommended. Now, she said she was one back to get clarification on that. But I didn't know if CMS can provide us some clarification on that.

Angela Gaston: Let me go back and talk to Palmetto too. I don't want to say the wrong thing.

So if you could just send in your contact to our ambulancepa@cms.hhs.gov. I've got your question all written down. And I'll go back and make sure we get that right.

Brandy Knight: Yes. I get it because these things be on the same page because...

Angela Gaston: Yes.

Brandy Knight: The – it – that's it – we had been using in my mind if I'm signing and dating something, it's the date I'm doing. That's just in my mind.

Angela Gaston: Right. Again, thank you.

Angela Gaston: We have limited submissions. And we've never – we've never put a limit on the timing of that. So let me go back and make sure.

Operator: The next question will come from Rhonda Foresman with Change Care.

Rhonda Foresman: Hi. Yes. I missed the first few minutes of the call. And I was wondering, did you announce the ambulance inflation factor for 2019?

Amy Gruber: This is Amy. No, we did not address that issue on this open door forum.

Rhonda Foresman: Do you know, when that will be released?

Amy Gruber: As soon as it goes through our clearance process, we will be able to – we'll be able to announce that.

Rhonda Foresman: OK, thank you.

Operator: The next question is from (Mary Kerns) with Kanawha County Emergency.

(Mary Kerns): Yes, ma'am. My question is, I had a patient that was temporarily affirmed and I've submitted just the change of modifiers, it was for the same – it – date range, because she – the patient was going to (them) from home, and then ended up in a nursing home.

And I kept getting non-affirms, even though she was already approved. All it was changing for that time was the change of modifiers. And it's my understanding that if you originally fax in like a prior (auth or a) date range, that you cannot end up scanning it and doing it electronically through eServices.

And my problem is, is originally (faxes in), there are times that there's been trouble with the website and there's also been times when we've had some computer issues. So I had faxed it in.

And I keep getting the non-affirmed and I'm not understanding why. I mean, it says that you did not receive all the information. I sent the copies of the faxed confirmation with the number of pages and everything and all the different letters with different UTN numbers. I sent those in and showing – I even wrote on there, “This should have already been approved. All that was going on was a change of modifiers.”

So I don't really understand why it keeps getting denied, and plus this patient passed away.

Angela Gaston: OK. That's something I'll definitely have to go back and research. If you could send in, please – don't send any personal identifiable information. But if you could send in those UTNs to our mailbox, I can go back and research that.

(Mary Kerns): OK. So what – where do you want me to send them to?

Angela Gaston: Yes, to the ambulancepa@cms.hhs.gov.

(Mary Kerns): Ambulancepa and I'm sorry what was – CMS?

Angela Gaston: CMS.HHS.GOV. And who was your MAC?

(Mary Kerns): OK. And we are in the mid-Atlantic region. We are in West Virginia.

Angela Gaston: OK, you're Palmetto?

(Mary Kerns): Yes.

Angela Gaston: OK.

(Mary Kerns): So all you want is like a brief, I guess, e-mail with the actual UTN numbers?

Angela Gastonr: Yes.

(Mary Kerns): OK.

Operator: OK. The next question will come from (Gregory Gus), with medical – (Medics Medical Transportation).

(Gregory Gus): Yes. Good afternoon. First of all, I want to thank (Mark) for his good question a few minutes ago.

We wanted to touch base with you on that December the 2nd date for prior authorization. Last year, we had a lot of confusion and, obviously, you went back at the end of the period and (started) prior authorization again. How true do you think that is going to be as far as it stopping? Or do you have a feeling (if it's) going to reoccur?

Angela Gaston: We certainly understand your frustration. And we're working to provide as much notice as possible on any changes and we'll let you know as soon as we have any information. We'll keep you updated on that website.

(Gregory Gus): And do you feel like we need to go ahead and internally process those that would be going from December the 2nd and just not turn them in until you give us the go ahead?

Angela Gastonr: That is certainly your call. I can't answer that one for you. But you can't submit them at this time and they're not going to review them at this time.

(Gregory Gus): Thank you.

Operator: The next question will come from (Lisa Melbased) with (Golden Hour).

(Lisa Melbased): Hi, everyone. I have a question for you. And it's really a question regarding joint responses and the difference between a supplier of ambulance services and a provider of ambulance services.

So what's happening for some of our customers; are that they will get a call from a local (EMS) agency that's certified at the BLS level. That agency will encounter a patient – this is typically happening in rural areas. They'll encounter a patient that is beyond their scope of practice.

They'll reach out to an ALS agency, a different ambulance agency. That ALS agency will intercept, basically, with the BLS agency. The ALS crew gets onboard the BLS vehicle and cares for the patient to the hospital.

So we've been told and advised in a few different manners that billing follows the vehicle that transported the patient. So in essence, the BLS agency would submit a bill to Medicare, and the ALS agency could bill the patient for the ALS level of care. Now just because they can, doesn't make it right. But what we want to know – and this is assuming there's an agreement on file between BLS and ALS, the BLS agency that can then submit at the ALS level of service.

However, when we're dealing with ambulance providers, so they are hospital-based ambulance program and that same scenario occurs, the mandatory – or I'm sorry, the claims processing manual for ambulance has a clause in it that states where a provider furnishes ambulance services under arrangements with the supplier of ambulance services then the provider can submit the bill to their a – MAC.

Now I'm looking for clarification on this. Wondering if you can provide any insight or if it truly is always going to follow the vehicle that transported the patient? Thank you.

Amy Gruber: This is Amy. Have you spoken to your MAC regarding this issue?

(Lisa Melbased): We have several MACs, Amy that we deal with. And this is an issue that's been occurring all over the United States. And part of the other problem is that if these – what we've been advised, obviously, like I said, the vehicle – the claim follows the vehicle that transported the patient.

And we understand Medicare doesn't – we don't want to be submitting duplicate claims for the same situation. But when these two entities have an agreement, and most often, these BLS agencies want the ALS agency to submit the claim, they don't want to deal with it, and they have that agreement on file, should that be sufficient for a provider of service versus a supplier of service, having that arrangement on file?

There's no kickback to this. This is really providing service to the community and the BLS agency having limited capabilities needs a higher level of service to properly transport and treat that patient.

Amy Gruber: Can you please submit that question in writing to us, please? (That'd be) ...

(Lisa Melbased): Sure. Did you want me – I'm sorry. Go ahead.

Amy Gruber: ... at the ambulanceodf@cms.hhs.gov.

(Lisa Melbased): Yes. I've submitted this question to different MACs. I've yet to get a response on this.

Amy Gruber: I apologize. We apologize for that.

(Lisa Melbased): That's OK.

Amy Gruber: If you could submit that to us, we'll take a look at it at...

(Lisa Melbased): Yes, because there's a difference in an enrollment – 855 enrollment for a Part B supplier has an area to (lift) vehicle information.

So in the event, one of these BLS agencies says, OK. We're going to allow X agency to bill any of these joint responses, the Part B enrollment has a place to add any vehicle types that that supplier would be utilizing. But the Part A, application does not have an area for vehicles. So I'll go ahead and submit that. Thank you.

Amy Gruber: Thank you.

Operator: The next question will come from Shann Barnes with Georgia MedPort.

Shann Barnes: Yes. I have a question for Amy Gruber. Amy, how will we know if we have been selected to do the data collection survey? Will we receive a letter or...

Amy Gruber: We are still – we are we are still working on those proposals. You will – any proposals that we do needs to go through rulemaking. So you will see any proposals that we make with this data – with the data collection system in a future federal register.

Chances are usually you see the ambulance fee schedule updates in the physician fee schedule final and proposal rule. So you will be – any – we haven't ironed out how we're going to proceed with making those announcements or notifications.

However, any development for this data collection system will be in the rulemaking, and you will have an opportunity to comment on our plan to implement this provisions.

Shann Barnes: OK. So this isn't something that's right around the corner, we're still in the developmental stages?

Amy Gruber: We're still in the developmental stages and we need to have that out no later than December 31st, 2019.

Shann Barnes: OK. All right.

Amy Gruber: So we are busy working on proposals. And like I said you'll see that in our future federal register notice where we will outline how we think we should –

we should go about implementing these different steps within the provision and the public will be provided 60 days to submit – to submit their – to submit comments.

Shann Barnes: OK. All right. Thank you so much.

Amy Gruber: Thank you.

Operator: The next question is a follow-up from Brandy Knight with Ambulance Pro.

Brandy Knight: Hello. Actually this is – kind of goes along with the question that – the previous person was asking about the joint response.

We have a similar scenario where it is our county's protocol. Cardiac arrest is dispatched, two different agencies respond – (its best) protocol that – they both respond. And I know in the Medicare guidelines, as far as (best) beneficiary, if you are dispatched 911 emergent response cardiac arrest and you arrive on the scene and you call the code on the scene, you never transport the patient, that you are able to bill the BLS emergent rate, regardless if you worked the code or not, with the Q.L. modifier and no mileage because there's not a transport benefit.

So we have seen denials similar to what she was speaking of, of the same level of service already provided by another provider of same data services, the kind of wording on it. I can't remember word per word.

But in other words, Medicare received two claims from two ambulance suppliers. Most of the same BLS emergent code with Q.L. modifiers, and one of us is from getting denied. So what is your – how do we kind of explain the situation?

Amy Gruber: This is Amy. Can you please submit that question in writing to us?.

Brandy Knight: Yes, and I had a – go ahead.

Amy Gruber: ... at ambulanceodf@cms.hhs.gov?

Brandy Knight: Sure. And I have one quick question about the new Medicare policy numbers. I know in the billing guidelines, it said we've always had to maintain social security numbers on Medicare beneficiaries. Is Medicare going to move away from that? And (has there) been any release or change in that language in the billing guidelines that we are no longer required to do that since we're going to the beneficiary I.D. versus using Social Security numbers?

Amy Gruber: This is Amy, I don't believe that we have the appropriate person to address – to address that issue on this call. If you can (just)...

Brandy Knight: OK.

Amy Gruber: ... submit that e-mail – so please (submit that) question via e-mail to us, we'll forward it to the appropriate staff member.

Brandy Knight: Thank you.

Operator: There are no further questions at this time.

Jill Darling: Great. Thanks everyone for joining. Our Chair, (Sarah), has joined, if she has any closing remarks?

(Sarah Shirey-Losso): Yes, and thank you. This is Sarah Shirey-Losso. I apologize for dialing in a few minutes late. I appreciate everyone's time on the call today and thank you to our speakers, Amy and Angela.

I think we got a lot of good and interesting questions this afternoon. And quite a few we need to take back and take a look at. And so I appreciate everyone's enthusiasm and bringing these issues to our attention. Thanks.

Jill Darling: All right. Thank you, (Sarah). And everyone, remember, you can e-mail any of your questions or comments into the ambulanceodf@cms.hhs.gov. So thanks everyone. Have a great day.

Operator: Thank you for participating in today's Ambulance Open Door Forum. This call will be available for replay beginning at 5:00 P.M. Eastern Time today through 11:59 P.M. Eastern Time on November 19th, 2018.

The conference I.D. number for the replay is 340-17-146. The number to dial for the replay is 855-859-2056. Thank you for participating in today's conference. You may now disconnect.

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