

CENTERS FOR MEDICARE & MEDICAID SERVICES
Ambulance Open Door Forum
Moderator: Jill Darling
December 1, 2016
2:00 p.m. ET

Operator: Good afternoon. My name is (Virgil) and I will be your conference facilitator today. At this time, I would like to welcome everyone to the Centers for Medicare & 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 then the number one on your telephone keypad. If you would like to withdraw your question, press the pound key. Thank you.

Jill Darling, you may begin your conference.

Jill Darling: Thank you, (Virgil). Good morning and good afternoon everyone. My name is Jill Darling in the CMS Office of Communications. And welcome to the Ambulance Open Door Forum. This is – will be the last one for 2016.

So, before we get into the agenda, just two quick announcements 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. If you have any inquiries, please contact CMS at press@cms.hhs.gov.

Also, a new update. Now, all CMS Open Door Forums will be available through podcast. So, if you have the agenda, it was sent to you. There is a link for podcast and transcripts. So, give us about a week or so to get it posted, just take sometime to review the transcript and the audio as well. So that is a new update for us. So now, I'll hand the call over to Dr. Rogers.

Bill Rogers: Thank you, Jill. So sort of a bittersweet call for me. It will be my last Ambulance Open Door Forum. I'm leaving CMS after 14 years and I will be working at the Veterans Administration Hospital in New Orleans. It's been a great pleasure working with dedicated people here at CMS. And it's been an honor to be able to have help those of you who take care Medicare beneficiaries to provide care and get paid appropriately for the care you provide. And I will thank with great affection about these decades that we have spent together. With that, let's move on with the agenda.

Jill Darling: Thanks, Dr. Rogers. First, we have our co-chair, Valerie Miller, who will go over the Staffing Requirements for ALS transport.

Valerie Miller: Good afternoon and welcome everyone to today's Open Door Forum. We received this question following the last Open Door Forum about ambulance staffing. In particular, the question is, is it permissible to bill at the ALS level if the ambulance is staffed by a registered nurse rather than a paramedic?

So, I just want to first point out that the staffing requirements for ambulance transports are located two places. First, in the federal register – I'm sorry, in the Code of Federal Regulations in Title 42. It's in Section 410.41. And in our manual, it's in the Medicare Benefit Policy Manual, Chapter 10, Section 10.1.2.

And to answer the question specifically with regards to nurses staffing ALS transports, just too generally note that our guidance specifies the minimum staffing (regards) ambulance transport. And it recognizes that states or localities may have additional requirements that allow for a higher level of skilled staff such as nursing particularly for the specialty care transports. And I just wanted to also point out that if the nurse is performing this service that does not result in any higher payment for that level of transport. That's it.

Jill Darling: All right, thanks Valerie. Next, we have (Eric Coulson) who has an update to the Claims Processing Manual pertaining to the SNF Ambulance Transport.

(Eric Coulson): Hi, good afternoon, everybody. So I just want to take a quick, probably it'd be less than a minute just to make sure that all were aware of the manual updates

that we made recently. Our change request C.R. number 9791, which issued back at the beginning of October, October 7th to be exact.

And very simple, all we did is we added some cross references in our Chapter 15 as the manual for the ambulance. We just added some cross references in there to a couple of sections in this skilled nursing facility, IOM Claims Processing chapter. That's Chapter 6.

And just those references just into the SNF chapter just have to do with, you know, ambulance services that are provided to SNF patients. And, you know, and whether or not they would be bundled into the SNF Part A or not, or separately payable under Part B and not bundled into the SNF Part A instead. So just some updates if you haven't already seen them to the claims process – the ambulance chapter of the claims processing manual.

Jill Darling: And (Eric), I believe you have one more announcement about the ASF Public Use Files.

(Eric Coulson): Sure. Yes, that's a little bit further down in everybody's agenda. But next couple of bullet points down. So just to let everybody know, the public use file, we're going in a little bit – a bit of a different direction as far as the information that we post.

I'm still going to get an excel file spreadsheet and post it out there for everybody. I hope to have it out there but in the next week or two, certainly before the end of the year. But hopefully, either next week or the week after.

But, so essentially, I think what we're planning to do is just I'm going to get you – I'm going to get everybody an excel spreadsheet posted out there on the site where you're used to seeing it. But all of their various attachments that are usually been part of the annual PUF package, we're not going to put that out there. Hopefully, by this time, you know, at least everybody should be aware of the, you know, how we pay for claims and what the payment rates are. And so, this Excel spreadsheet should just hasn't – has in years past, just kind of breakdown what the payment rates for all of the various services, ambulance transportation services.

And then we're going to have as much background as we can there on that as far as, you know, regulations and laws and things that have been past to setup these various payment rates and how we calculate them. That will be there on the slide as well. So look for that, again, on the next – hopefully next week. If not, certainly the week after. Thanks, everybody.

Jill Darling: Thank you, (Eric). Next, we have Amy Gruber, who will go over the Calendar Year 2017 Ambulance Inflation Factor and Productivity Adjustment.

Amy Grover: Thank you, Jill. I'm Amy Gruber and I work for Valerie in the Center for Medicare Hospital and Ambulatory Policy Group Division of Ambulatory Services. My division is responsible for ambulance payment policy. I have two calendar year 2017 ambulance fee schedule updates.

The first one is the ambulance inflation factor and productivity adjustment. On October 14th, 2016, CMS issued Change Request 9811, Transmittal 3625 and MLN Article MM9811 to provide the calendar year 2017 ambulance inflation factor.

The ambulance fee schedule base rates and mileage base rates are updated annually by an ambulance inflation factor, which is the consumer price index for all urban consumers, CPI-U, June over June over the previous year.

CPI-U is reduced by multifactor productivity. The CPI-U is reported by the U.S. Bureau of Labor Statistics for June 2015 through June 2016, CPI-U was 1.0. The multifactor productivity is determined by CMS's Office of the Actuary, MAP for the period ending June 30th, 2016 with 0.3. Therefore, the calendar year 2017 ambulance inflation factor is 0.7.

The next update I'd like to provide is regarding the expiration of the MACRA provision. The three temporary add-on payments, most recent citation is Section 203 A and B of the Medicare Access and CHIP Reauthorization Act.

MACRA of 2015 include, number one, a 3 percent increase to the base of mileage rate for ground ambulance transports that originate in rural areas. Number two, a 2 percent increase to the base in mileage rate for ground ambulance transports that originate in urban areas. And third, temporary add-

on payment is the 22.6 percent increase in the base rates for ground ambulance transports that originate in super rural areas. These three temporary add-on payments are effective through December 31st, 2017. Thank you, Jill.

Jill Darling: Thanks Amy, Valerie and Eric. (Virgil) 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 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 question. If you require any further follow-up, you may press star, one again to rejoin the queue.

Your first question comes from the line of (Tim Tacks) from North Memorial AMB. Your line is open.

(Tim Tacks): Now, thank you. So you have – I just like somebody to address and maybe it's Dr. Rogers address the issues of using a C6 indicator for transportation, and specifically surrounding around the, probably the last statement in the manual that talks about the ALS level response base upon medically appropriate dispatch protocols. Because we could theoretically have a medical director who've said everything we do is an ALS response and how appropriate is that from an organizational standpoint? Hello?

Jill Darling: Dr. Rogers, are you there? He might ...

Valerie Miller: We might lost him.

Jill Darling: Yes, we might have lost his line. But we'll – if you don't mind, send your question.

Bill Rogers: I'm sorry. Did I just get asked a question?

Jill Darling: Oh yes, go ahead Dr. Rogers. You did.

Bill Rogers: Sorry about that. I didn't hear the question. I'm sorry. (Irene) came in here and asked me a question for the Office of Legislation.

(Tim Tacks): OK, (Tim Tacks) from North Memorial Ambulance. I want to kind of maybe have you address this issue of using transport – transportation indicator C6 when we want to bill for ALS services when maybe a BLS patient exists. And at what point is it appropriate for, should we say all responses to be ALS? That would it not – it would not be appropriate or would it be appropriate to bill everything at an ALS level then?

Bill Rogers: I think the manual is pretty clear about what is required to justify an ALS level of payment, right?

(Tim Tacks): Yes. And what it requires is that you do an ALS assessment based on the nature of the call. So theoretically, the nature of the call is abdominal pain. And we go out there and we do an ALS assessment, and it is something other than what it was dispatched out to us, and it may end up being a BLS patient. Can you still bill at the ALS level?

Bill Rogers: Not necessarily. Medical necessity still is the most important thing.

(Tim Tacks): OK.

Bill Rogers: Just because you did nail as assessment, doesn't necessarily mean that the claim should be paid in an ALS level.

(Tim Tacks): Yes. The issue with this was it talks about the ALS level response based on medically appropriate dispatch protocols. So, that still is going to be based on the patient's condition at the scene?

Bill Rogers: Yes, the ALS versus BLS, the emergency versus non-emergency is what determines the – is determined by the dispatch method.

(Tim Tacks): OK, thank you.

Bill Rogers: Sure.

Operator: Your next question comes from the line of Nancy Horn from Medical Compliance Services. Your line is open.

Nancy Horn: Yes. I was wondering, the federal register was updated on October 23rd of 2015 and it talks about the MACRA and the prior authorization. And originally, we were told that 11/2017 that all of the states were going to be included in that prior authorization. But, you know, here it is, this is December the 1st and we still haven't gotten any information from our MACs on how that process is supposed to take place.

And this update on October 23rd, 2015 says that the model will end in all states on December 1, 2017. And it doesn't mention the 11, so 2017 where all states come in. So, I'm just trying to figure out where we are in this prior authorization for non-emergency repetitive transports.

Jill Darling: Is (Angela Gaston) on the speaker line?

Nancy Horn: I don't think so. I don't think that the component responsible for that area is on the phone. So if you could provide, Jill, your name and number and –or should you send the e-mail.

Jill Darling: You can just send me an e-mail at jill.darling@cms.hhs.gov and I'll forward it.

Nancy Horn: OK, jill.darling ...

Jill Darling: J-I-L-L dot D-A-R-L-I-N-G@cms.hhs.gov. Yes.

Nancy Horn: OK, thank you very much.

Jill Darling: You're welcome.

Operator: Your next question comes from Nancy Crenshaw from Ambulance Pro Consulting. Your line is open.

Nancy Crenshaw: Hello and thanks for taking the call. My question, we are in a – he did debate amongst another billing company in our area. Our protocol, 911 Protocol for a cardiac arrest dispatch is two units respond to every cardiac arrest. So, according to the guidelines, 10.2.6, The Effect of Beneficiary Death on

Medicare Payment, if I read the chart accordingly, if the pronouncement of death is before dispatch, then of course there's no payment of any kind billable to Medicare. If it's after dispatch but before the ambulance has loaded – the patient is loaded on the ambulance, then you can bill for your response to the BLS rate with a Q.L. modifier, no mileage. But if you pick up the patient, put them in the ambulance and walk them through the hospital, then bill the full ALS2 level type call.

So, we had two units respond to the same patient as cardiac arrest. Pronouncement of death was on the scene. So, my agency billed Medicare that A0428 QL-modifier according to this Chapter 10 guideline. Another billing company on the other agency actually ended up billing Medicare with a BLS emergent rate and mileage because they transported them to the morgue. So, in their mind, they should get credit for that. And it would have been a very exciting exchange in regard to how black and white I think this reads. So, I just kind of wanted to hear it from, you know, Medicare itself on which interpretation of Chapter 10 is accurate.

Female: The interpretation with regards to the response being a BLS response and the claim having to include the QL-modifier because the patient passed after the dispatch but before the patient was transported.

Nancy Crenshaw: Correct. So, I am correct in saying that no mileage should have ever been billed to Medicare, on that other agency. This is not my agency but this other agency billed Medicare a BLS urgent, I can't remember if that's A0429 or which it is, along with mileage simply because they tracked the mileage from the patient to the morgue. And I'm trying to explain that it's not the appropriate way to bill that call or, you know, file that claim. And I just want to make sure that I was understanding that correctly.

Valerie Miller: Based on that information you just stated, you would be correct.

Nancy Crenshaw: Thank you.

Operator: Your next question comes from the line of (Anne Hunt) from Mobile Medical Response. Your line is open.

(Anne Hunt): Hi. I was wondering is a swing bed facility with a CAD credentialing carved out of the SNF Consolidated Billing.

(Bill Ullman): Hi, this is (Bill Ullman). And basically, when we're talking about a critical access hospital which I think is what we're referring to here, that the bundling requirements that that's involved is really not SNF Consolidated Billing but rather hospital bundling. And so, you know, well that's because the swing bed facility really is a hospital even though it's furnishing SNF level services under a swing bed agreement.

So really, what the question is here is whether the Ambulance Services would be bundled according to the hospital bundling rules. And my understanding, from my very limited understanding is that they would because I think that the bundling requirement for hospitals is more comprehensive than the one for SNF and has fewer exceptions. But I think we really might want to confirm that with our hospital staff. So, I'm wondering if maybe you would mind sending that in as an e-mail question.

(Anne Hart): OK, thank you.

(Bill Ullman): Sure.

(Anne Hart): I have another question about the pronouncement. Second part of the first part on the last question, the billing service that just asked the question asked on if they were to bill a 40 – I'm sorry, an A0428, a non-emergent for a pronouncement with a QL-modifier when it was dispatched as an emergent call. Is that correct?

Bill Rogers: This is Bill Rogers. I think if it was dispatched out as an emergent call, obviously, it qualifies for the emergency level of payment. The ALS versus BLS would depend on what the protocol was for your jurisdiction. I would think any jurisdiction that has an ALS level of care available would be dispatching an ALS unit rather than a BLS unit to a suspected cardiac arrest.

Female: Correct. So once the patient is deceased and not transported, then we would go on A0428 with a QL-modifier or an A0429 with a QL-modifier. A call before us stated that she was billing a non-emergent code when we're under

the assumption that it was dispatched emergency, so we are billing an emergency, a BLS code.

Female: You can bill an emergency BLS code but the main distinction is it can't be billed as an ALS transport.

Female: Correct.

(Anne Hunt): OK, thank you very much.

Female: Sure.

Operator: Your next question comes from the line of (Laura Linger) from East Coast Ambulance. Your line is open.

(Laura Linger): Hello. Hi. Question. If a BLS crew is transporting a ventilator patient that's being monitored by the patient's family or nursing facility's respiratory therapist that should be billed as A0428, correct?

Female: Can you send that question to Jill as well? We have to check the coding.

(Laura Linger): OK. And what's the e-mail address? I'm sorry.

Female: J-I-L-L dot D-A-R-L-I-N-G@cms.hhs.gov.

(Laura Linger): Thank you.

Female: You're welcome.

(Laura Linger): Bye-bye.

Operator: Your next question comes from (Bill Bathen) from Ambulance Pro Consultant. Your line is open.

(Clint Bathen): Good afternoon. This is (Clint Bathen) from Ambulance Pro. In our area, it's become the standard for paramedics to work the cardiac arrest on scene, either until they get a response from the patient or until they pronounce the death on scene. So, is Medicare going to work towards changing the policy so that

these ambulance crews who respond to emergent work, you know, full ALS2 level of care on the scene but then pronounce the patient dead, then transport the body not emergently to the morgue? Will the policy be changed at any point that that you perceive so that these crews can get paid for more than just a flat BLS rate with no mileage?

Bill Rogers: I don't think this is written in the law that we couldn't do that but I'm not sure. It's the first time I've encountered the question. But at any rate, you certainly could make the proposal during the proposed rule period of the next ambulance rule. You know how the rule making works, right?

(Clint Bathen): Not too familiar on that one.

Bill Rogers: Yes. So there – every year, we release updated ambulance rule and/or physician rather fee schedule which includes the ambulance rule. And I think we release it November 1st. So, we release a proposed rule before that and it would be a reasonable thing for one of your societies to request that change to the rules about them and.

(Clint Bathen): I appreciate it.

Female: Also ...

(Eric Coulson): If I may, this is (Eric Coulson) in Provider Billing Group. I mean, I think you'd have to make the argument and I don't know how successful you'd be trying to do it that the transportation of the beneficiary who is deceased is a medically necessary service. You know, that's the – I think the crux ...

Bill Rogers: (Eric), I don't think he's talking about transportation. But he's talking about more money for the resuscitation efforts that were made at the scene, if there was something to pay for that.

(Eric Coulson): OK.

(Crosstalk)

Bill Rogers: Yes, that's (inaudible) ultimately wouldn't be transported by the ambulance or at least they're transported. If he was transported, he wouldn't be covered because the patient would be deceased at that point. But the patient wasn't deceased while the resuscitation efforts were being undertaken and it does seem only fair that ...

(Eric Coulson): OK.

Bill Rogers: ... ambulance come to get reimbursed for the cost.

(Clint Bathen): And also, we have a couple of agencies who do more – like who work out with the (ambulance) or whatnot. So, the (name) of the crew response to a scene and works the cardiac arrest for an hour and then pronounce his death. If one of these other services are available, the other service can come in and transport and they'll get to bill for the BLS transport without the mileage, but they're responding paramedic unit doesn't get to bill for anything at all.

Bill Rogers: I'm not sure why that would be the case, but.

Male: Well, if they didn't transport – another service transported, so.

(Clint Bathen): That's kind of an area where a lot of money is being lost on an absolutely medically necessary, you know, skill to provide ...

(Off-Mic)

Bill Rogers: Service, yes, yes. Well, are you a member of the American Ambulance Association or something like that?

(Clint Bathen): I am not but we have folks who are.

Bill Rogers: Yes, that would be a very reasonable question to bring up with them.

(Clint Bathen): All right, I appreciate it.

Bill Rogers: Sure.

Operator: Your next question comes from the line of (Beth Doubt) from WhidbeyHealth Medical. Your line is open.

(Beth Doubt): Hi. I don't know if you can answer this question over the phone or if you'd prefer an e-mail on it. But I'm trying to understand the locality issue a little bit and the nearest appropriate facility. We are on an island. We have a bridge and a ferry that allows us to leave the island. And what I'm up against is that sometimes patients ask to be transported to a hospital off-island, which means they would either go by bridge or ferry. And I am trying to figure out if that's really the most appropriate facility given on island, we already have a hospital. Can you guys answer that?

Bill Rogers: That drags. I think it's in the eyes of the beholder but the MACs make these decisions all the time. If it's – if the medical problem is a problem that the local hospital obviously is not appropriate for like a major trauma, if the local hospital doesn't – isn't staffed for that or a major burn, then that local hospital may not be the nearest appropriate facility. But for the vast majority of emergencies, the local hospital is the appropriate nearest facility. And the patient's preference isn't an issue at least as far as what's appropriate, what's not appropriate.

(Beth Doubt): OK. And is it fair for me to say, because this – because the ambulance is owned by the public district hospital that's also local. So, is it fair then for us to say to the patient, if you want to go there for convenience, then there is off-island, then I can charge them for that additional mileage.

Bill Rogers: Yes, there's an ABN process for that ...

(Crosstalk)

(Beth Doubt): Yes, we've got ...

Bill Rogers: Right.

(Beth Doubt): Yes. So, we're OK with that and that makes sense. Now, what about – because see the concern – and to dialogue on this in it. The concern is sometimes that if a person wants to go that extra mile to that extra hospital, we

don't know that the bridge hasn't had an accident or that they can even get off-island. So to me, and this is my judgment. To me, I'm thinking – most often, it's better to bring the patient to our hospital, then if we decide we can't take care of them or they really want to go to their doctor, then we transport them after they've been seen in the emergency room because of EMTALA laws and everything. Would you agree?

Bill Rogers: I think there's some potential liability for ambulance crew that decides to pass a "medically appropriate facility for another medically appropriate facility". If something were to happen during the added time in the ambulance because of the extended transport and, you know, I wouldn't be surprised if a plaintiff's attorney could find some sunlight there.

(Beth Doubt): OK.

Bill Rogers: But I'm not lawyer.

(Beth Doubt): All right.

Bill Rogers: But yes, I think you're probably barking up the right tree.

(Beth Doubt): OK, thank you. Appreciate it.

Operator: Again, if you would like to ask a question, press star, one.

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

Nancy Crenshaw: Hello. Yes, I'm sorry. I'm circling back around my original question because a couple of folks back asked the question very specifically. If you were dispatched, 911 cardiac arrest in an emergent situation and on the scene and the patient is pronounced dead on the scene, that I'm under the understanding the highest code you can code is an A0428 with Q.L. But I just a heard a lady earlier say no, that it was OK to code the A0429 which is BLS emergency transport. But that is not what I was understanding in reading the guidelines, the providers' suppliers BLS base rate, not mileage, but it does not define the BLS emergent or not emergent base rate.

So, are you telling me we can use an A0429 with a Q.L.?

Female: Yes, you can. It depends on how the call was dispatched.

Nancy Crenshaw: Wonderful, I did not know that. That is wonderful, yes. But even though you've transported them somewhere if their pronounced mileage is not an option to bill, correct?

Female: Correct.

Nancy Crenshaw: OK, wonderful. That does change a lot in our world. Thank you.

Operator: There are no further questions in queue at this time. I'll turn the call back over to the presenters.

(Off-Mic)

Jill Darling: Dr. Rogers, any closing remarks?

Bill Rogers: No, thank you all. It's been a great pleasure working with you. And if you're in New Orleans, give me a call.

Jill Darling: All right. Well, thanks everyone. Thank you, Dr. Rogers and Valerie and to all of our speakers. The next Ambulance Open Door Forum is scheduled for March 16th, 2017. But always note that the date is subject to change. So, thanks again everyone. Have a great day.

Operator: Thank you for participating in today's Ambulance Open Door Forum conference call. This call will be available for replay beginning at 9:00 a.m. eastern time, December 5th, 2016 through the midnight on December 7th. The conference I.D. number for replay is 44947739. The number to dial for the replay is 855-859-2056.

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

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