AMERICAN AMBULANCE ASSOCIATION

REPRESENTING EMS IN AMERICA

MEDICARE UPDATE

Brian S. Werfel, Esq.

Texas Ambulance Association

April 12, 2019

2019 AMBULANCE INFLATION FACTOR

2019 Ambulance Inflation Factor

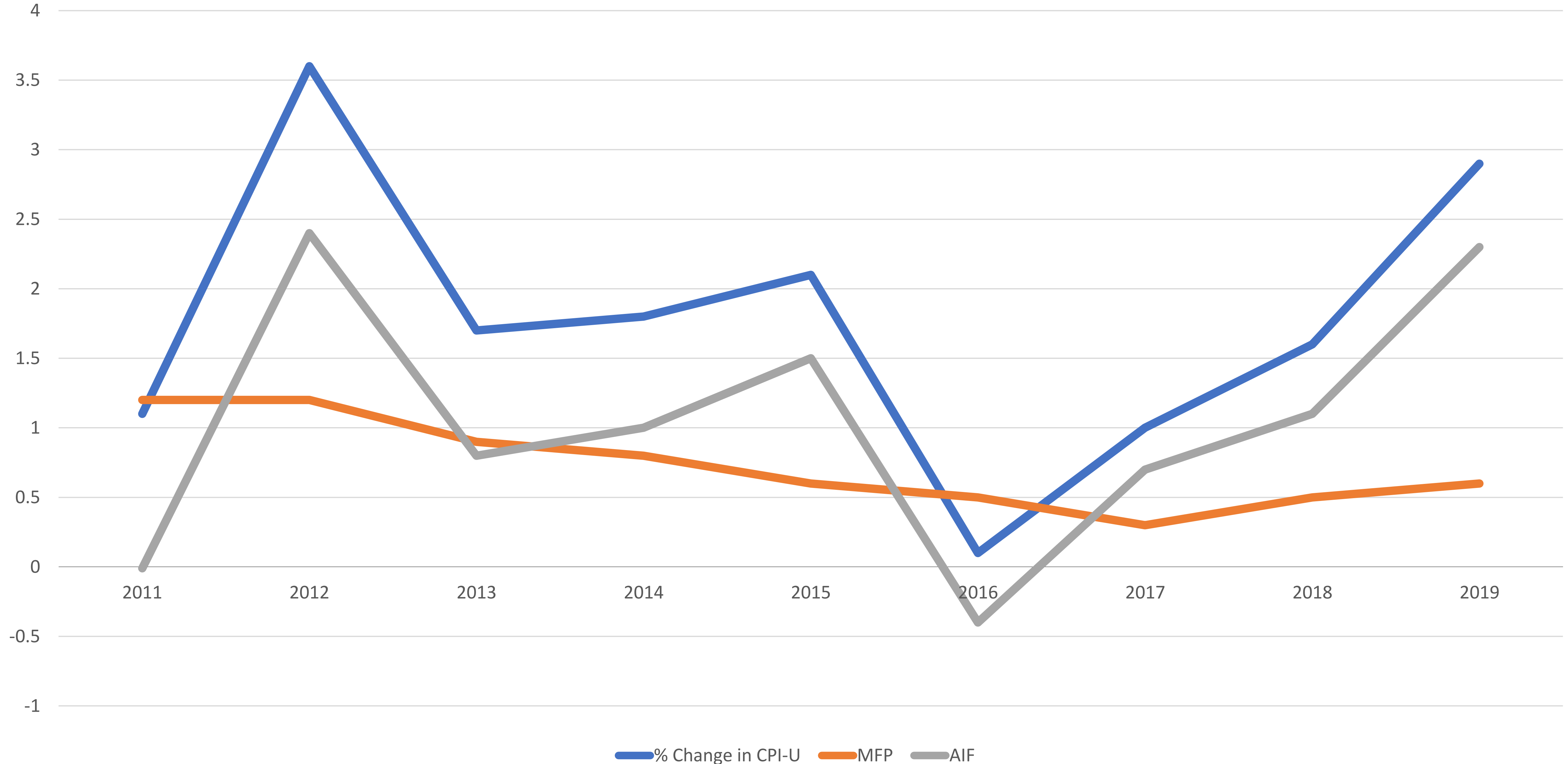
AIF = CPI-U – MFP

CPI-U = 2.9%

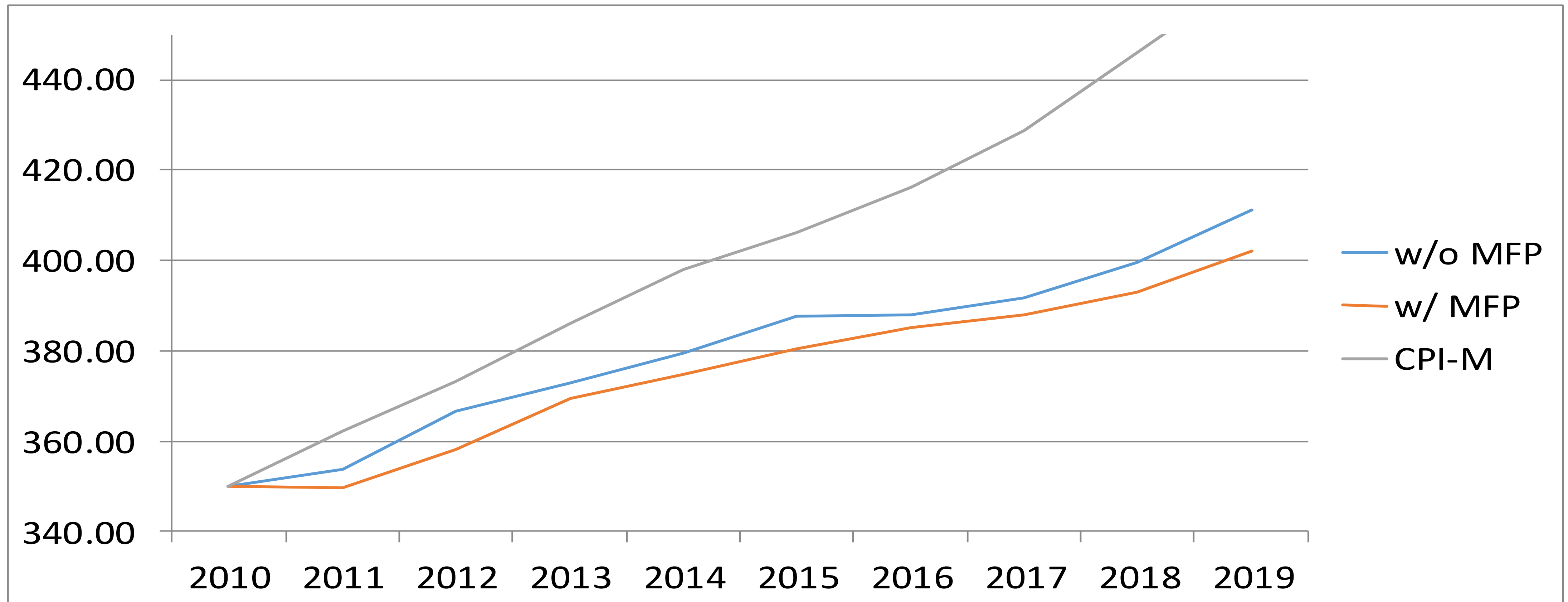
MFP* = 0.6 %

2019 AIF = + 2.3%

Historical Ambulance Inflation Factors



Impact of MFP on Ambulance Rates

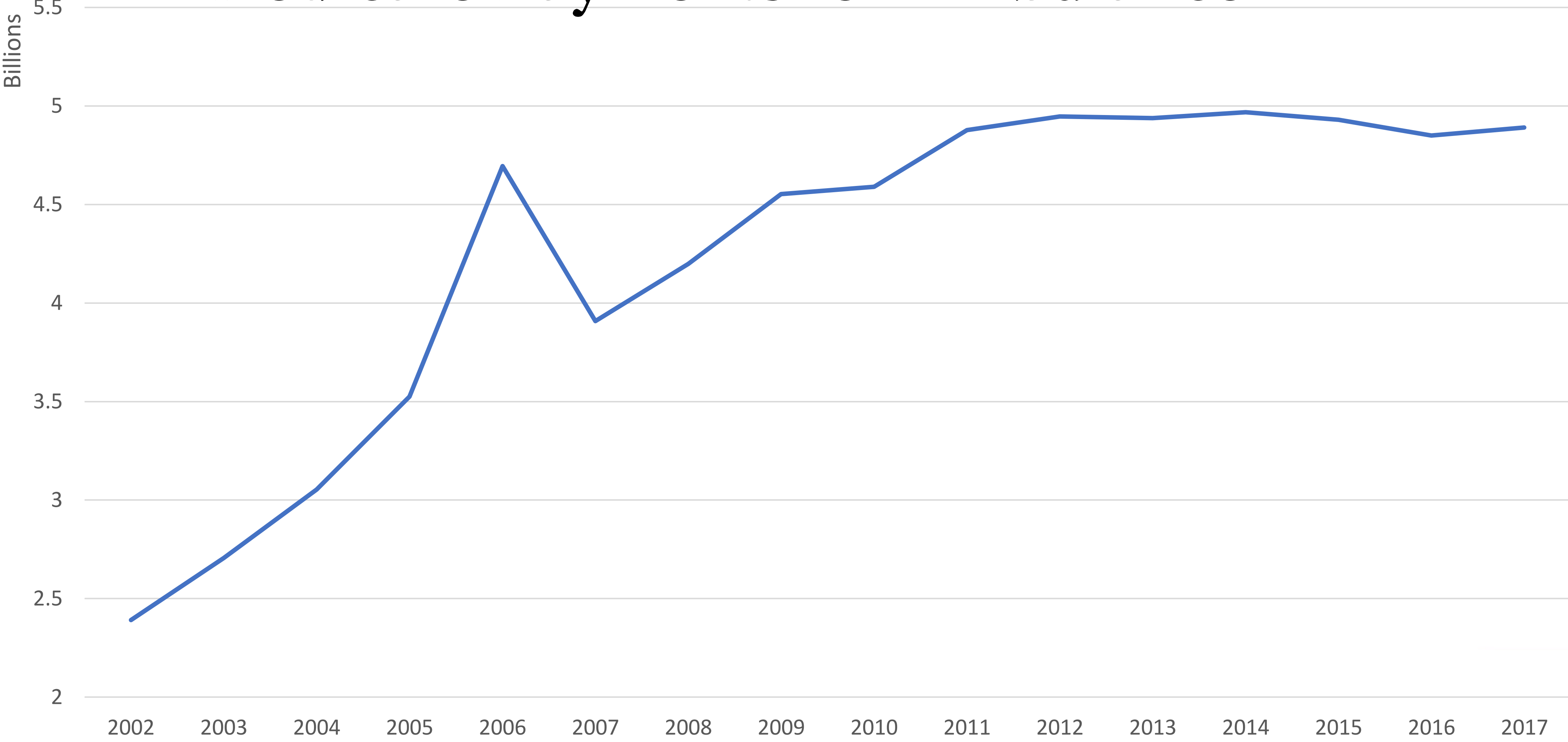


2017 Medicare Payment Data

	Description	2017 Allowed #	2017 Paid $
A0425	Ground Mileage	140,924,217	$874,025,868
A0426	ALS Non-Emergency	361,906	$75,754,103
A0427	ALS Emergency	5,054,129	$1,682,281,478
A0428	BLS Non-Emergency	5,209,535	$881,272,901
A0429	BLS Emergency	2,955,457	$840,890,847
A0430	Fixed Wing	12,821	$42,956,604
A0431	Helicopter	69,327	$252,086,697
A0432	Paramedic Intercept	2,088	$611,680
A0433	ALS-2	111,721	$53,827,778
A0434	Specialty Care Transport	94,106	$55,812,985
A0435	Fixed Wing Mileage	2,548,758	$23,800,695
A0436	Helicopter Mileage	4,272,708	$106,630,584
Totals		161,616,772	$4,889,952,226

	Description	2016 Allowed #	2017 Allowed #	% Change
A0425	Ground Mileage	140,625,619	140,924,217	0.21%
A0426	ALS Non-Emergency	360,477	361,906	0.40%
A0427	ALS Emergency	4,997,698	5,054,129	1.13%
A0428	BLS Non-Emergency	5,353,061	5,209,535	-2.68%
A0429	BLS Emergency	2,966,610	2,955,457	-0.38%
A0430	Fixed Wing	12,508	12,821	2.50%
A0431	Helicopter	68,266	69,327	1.55%
A0432	Paramedic Intercept	2,280	2,088	-8.42%
A0433	ALS-2	112,911	111,721	-1.05%
A0434	Specialty Care Transport	92,049	94,106	2.23%
A0435	Fixed Wing Mileage	2,452,504	2,548,758	3.92%
A0436	Helicopter Mileage	4,117,745	4,272,708	3.76%

	Description	2016 Paid $	2017 Paid $	% Change
A0425	Ground Mileage	$865,434,392	$874,025,868	0.99%
A0426	ALS Non-Emergency	$75,128,808	$75,754,103	0.83%
A0427	ALS Emergency	$1,650,943,710	$1,682,281,478	1.90%
A0428	BLS Non-Emergency	$899,243,297	$881,272,901	-2.00%
A0429	BLS Emergency	$838,329,863	$840,890,847	0.31%
A0430	Fixed Wing	$41,656,249	$42,956,604	3.12%
A0431	Helicopter	$246,155,888	$252,086,697	2.41%
A0432	Paramedic Intercept	$682,832	$611,680	-10.42%
A0433	ALS-2	$53,891,021	$53,827,778	-0.12%
A0434	Specialty Care Transport	$54,306,374	$55,812,985	2.77%
A0435	Fixed Wing Mileage	$22,806,554	$23,800,695	4.36%
A0436	Helicopter Mileage	$101,940,047	$106,630,584	4.60%

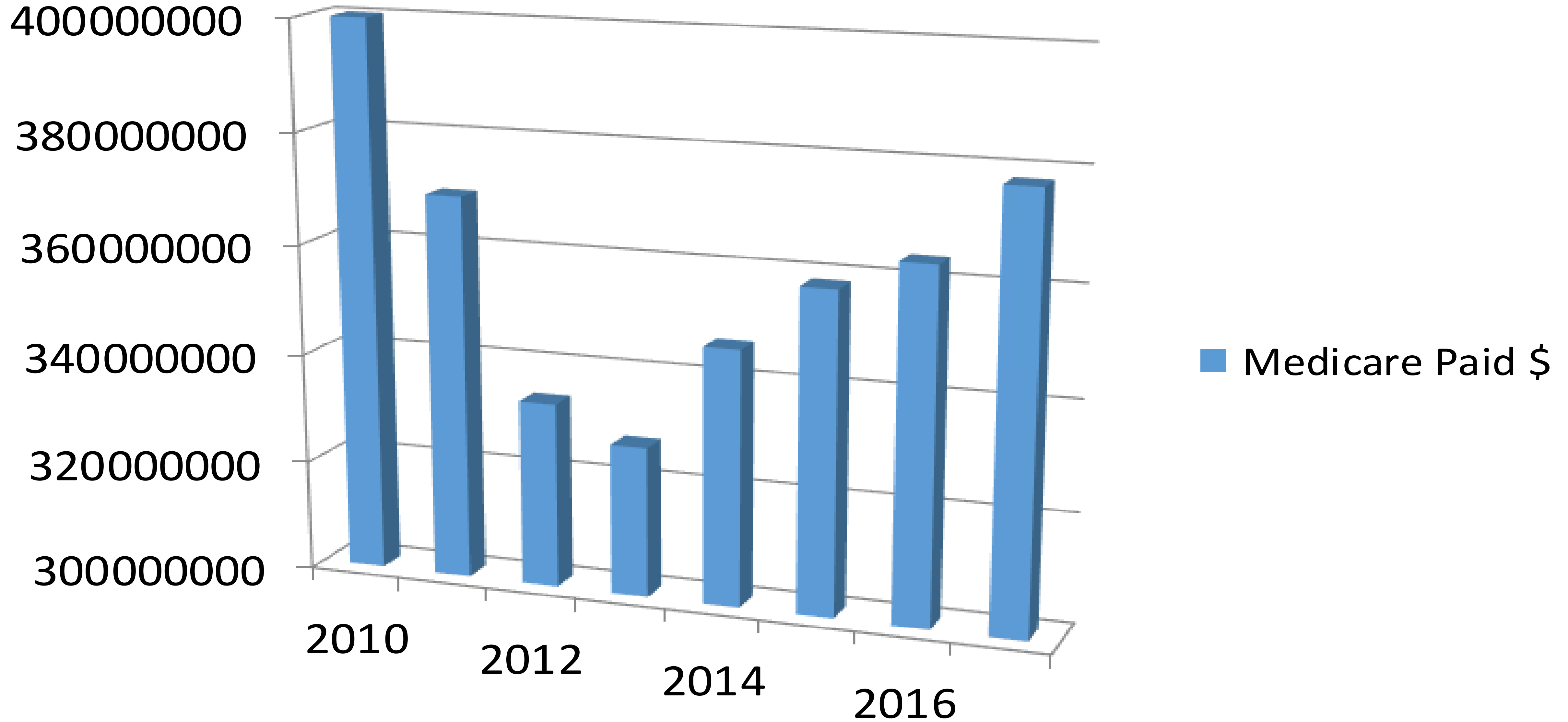

Medicare Payments for Ambulance
Billions
5.5
5
4.5
4
3.5
3
2.5
2
2002
2003
2004
2005
2006
2007
2008
2009
2010
2011
2012
2013
2014
2015
2016
2017
Medicare Payments for Ambulance

Texas Payment Data

	Description	2017 Allowed #	2017 Paid $
A0425	Ground Mileage	12,079,764	$73,245,675
A0426	ALS Non-Emergency	27,667	$5,762,736
A0427	ALS Emergency	383,410	$125,734,965
A0428	BLS Non-Emergency	524,879	$85,689,167
A0429	BLS Emergency	144,443	$39,921,495
A0430	Fixed Wing	1,092	$3,395,302
A0431	Helicopter	6,673	$24,327,542
A0433	ALS-2	11,360	$5,420,744
A0434	Specialty Care Transport	4,613	$2,583,055
A0435	Fixed Wing Mileage	189,974	$1,643,395
A0436	Helicopter Mileage	409,868	$10,151,105

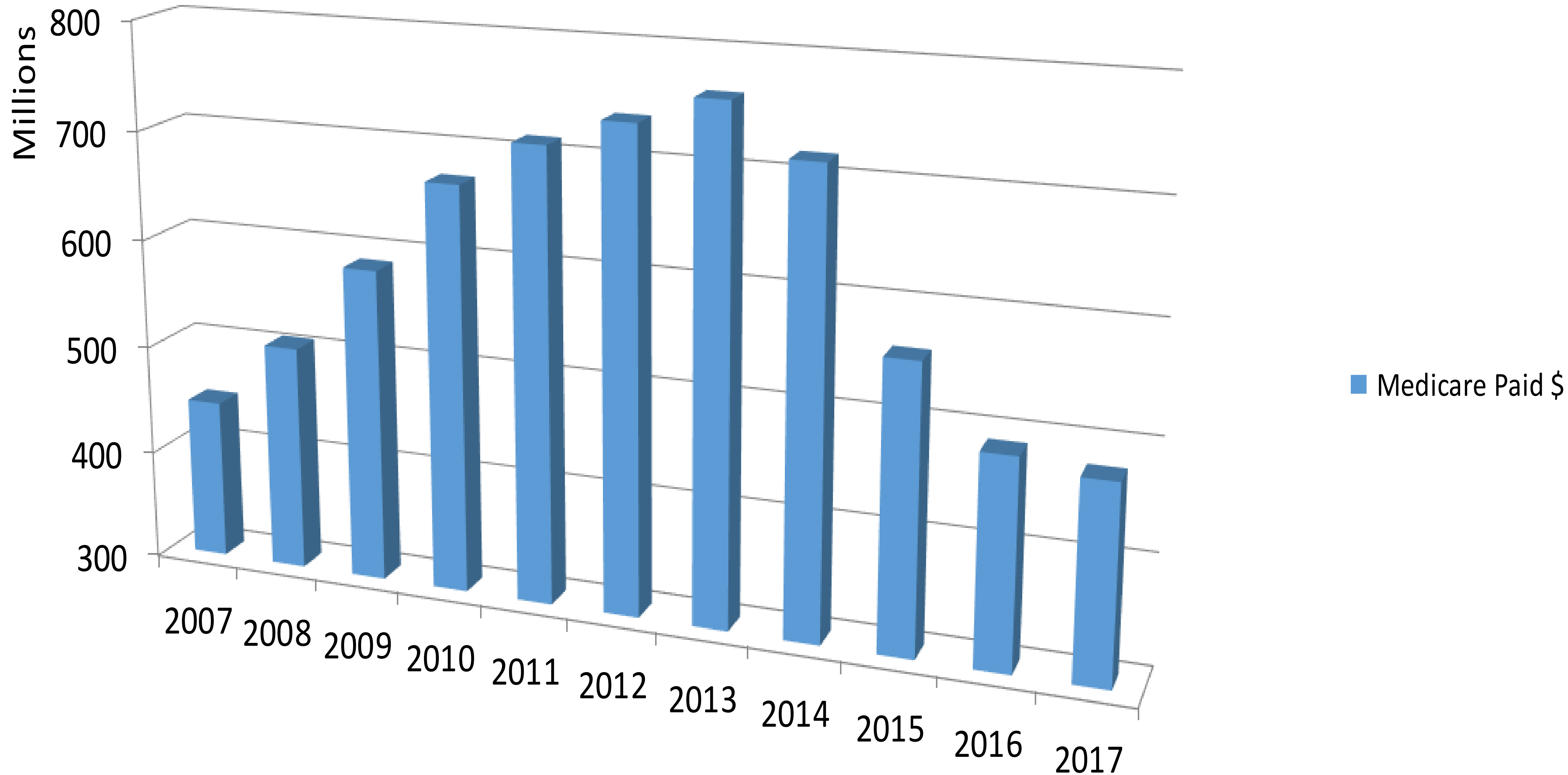
	Description	2016 Allowed #	2017 Allowed #	% Change
A0425	Ground Mileage	11,708,221	12,079,764	3.17%
A0426	ALS Non-Emergency	28,468	27,667	- 2.81%
A0427	ALS Emergency	369,308	383,410	3.82%
A0428	BLS Non-Emergency	510,817	524,879	2.75%
A0429	BLS Emergency	145,311	144,443	- 0.60%
A0430	Fixed Wing	1,035	1,092	5.51%
A0431	Helicopter	6,542	6,673	2.00%
A0433	ALS-2	10,573	11,360	7.44%
A0434	Specialty Care Transport	4,577	4,613	0.79%
A0435	Fixed Wing Mileage	177,013	189,974	7.32%
A0436	Helicopter Mileage	395,205	409,868	3.71%

	Description	2016 Paid $	2017 Paid $	% Change
A0425	Ground Mileage	$70,358,207	$73,245,675	4.10%
A0426	ALS Non-Emergency	$5,874,696	$5,762,736	- 1.91%
A0427	ALS Emergency	$119,829,372	$125,734,965	4.93%
A0428	BLS Non-Emergency	$82,550,740	$85,689,167	3.80%
A0429	BLS Emergency	$39,646,703	$39,921,495	0.69%
A0430	Fixed Wing	$3,191,900	$3,395,302	6.37%
A0431	Helicopter	$23,623,821	$24,327,542	2.98%
A0433	ALS-2	$4,971,390	$5,420,744	9.04%
A0434	Specialty Care Transport	$2,529,383	$2,583,055	2.12%
A0435	Fixed Wing Mileage	$1,519,280	$1,643,395	8.17%
A0436	Helicopter Mileage	$9,745,479	$10,151,105	4.16%

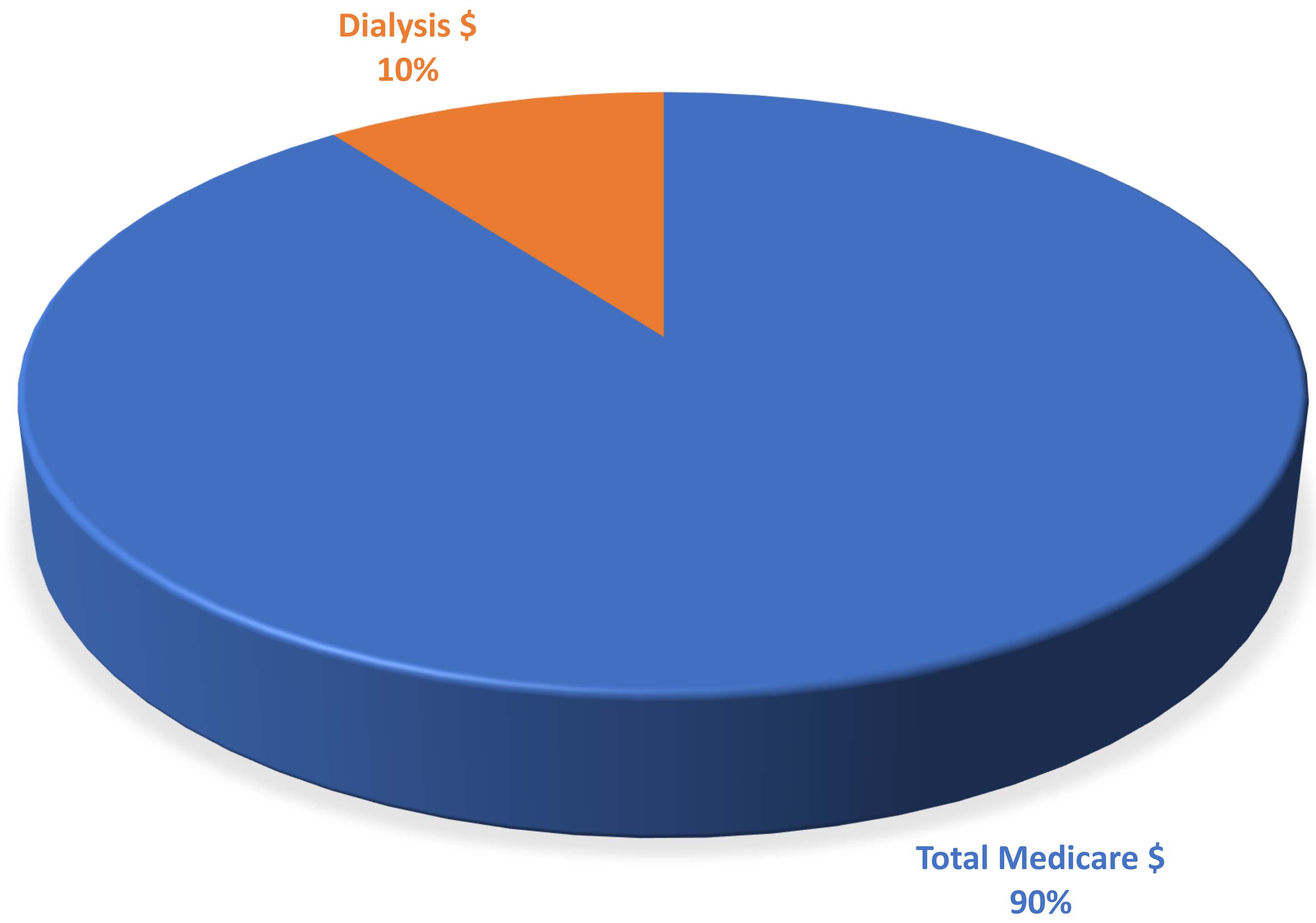

Texas Medicare $
400000000
380000000
360000000
340000000
320000000
300000000
2010
2012
2014
2016
Medicare Paid $

Medicare Dialysis Payment Data

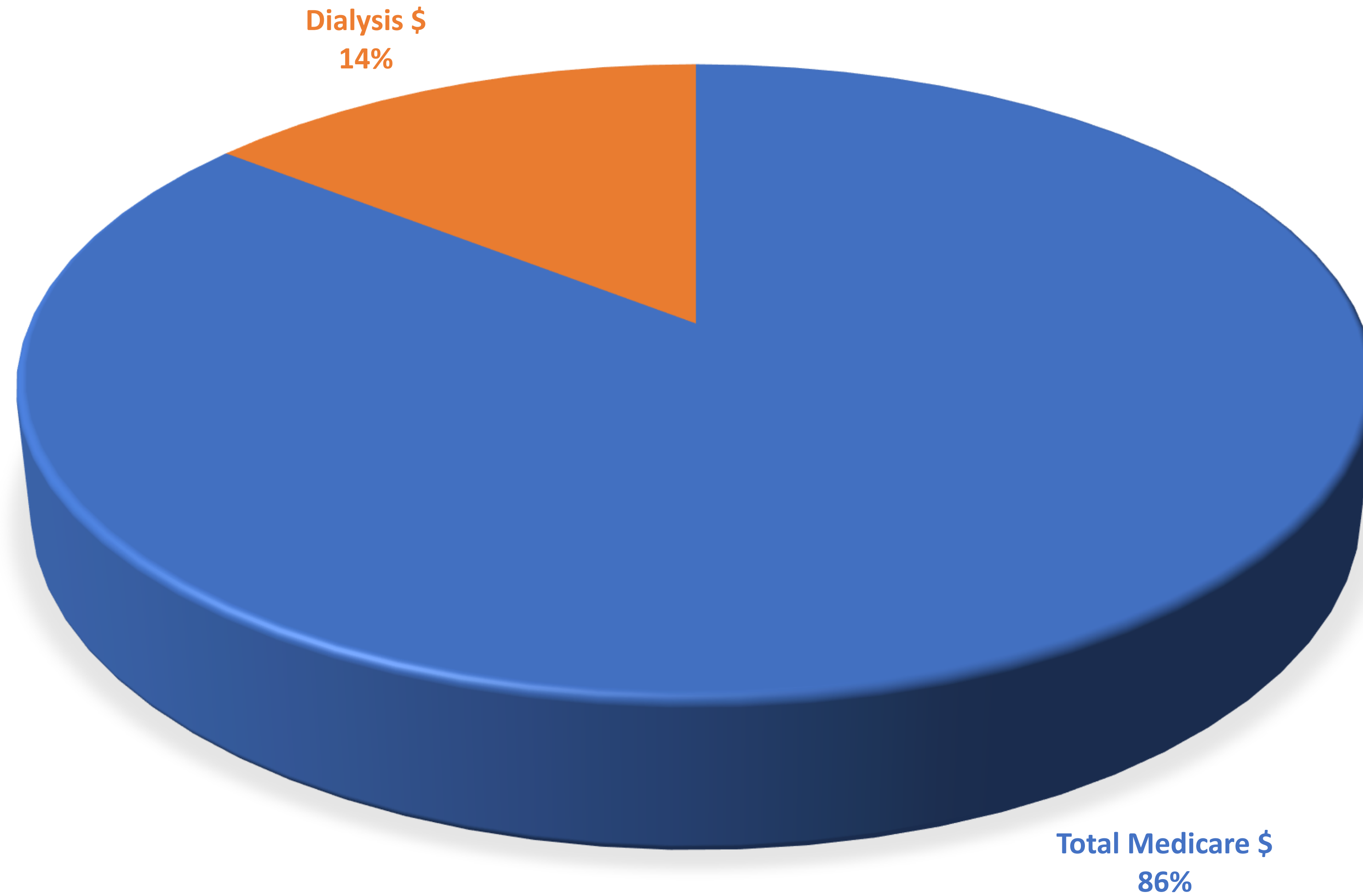
Medicare Dialysis $



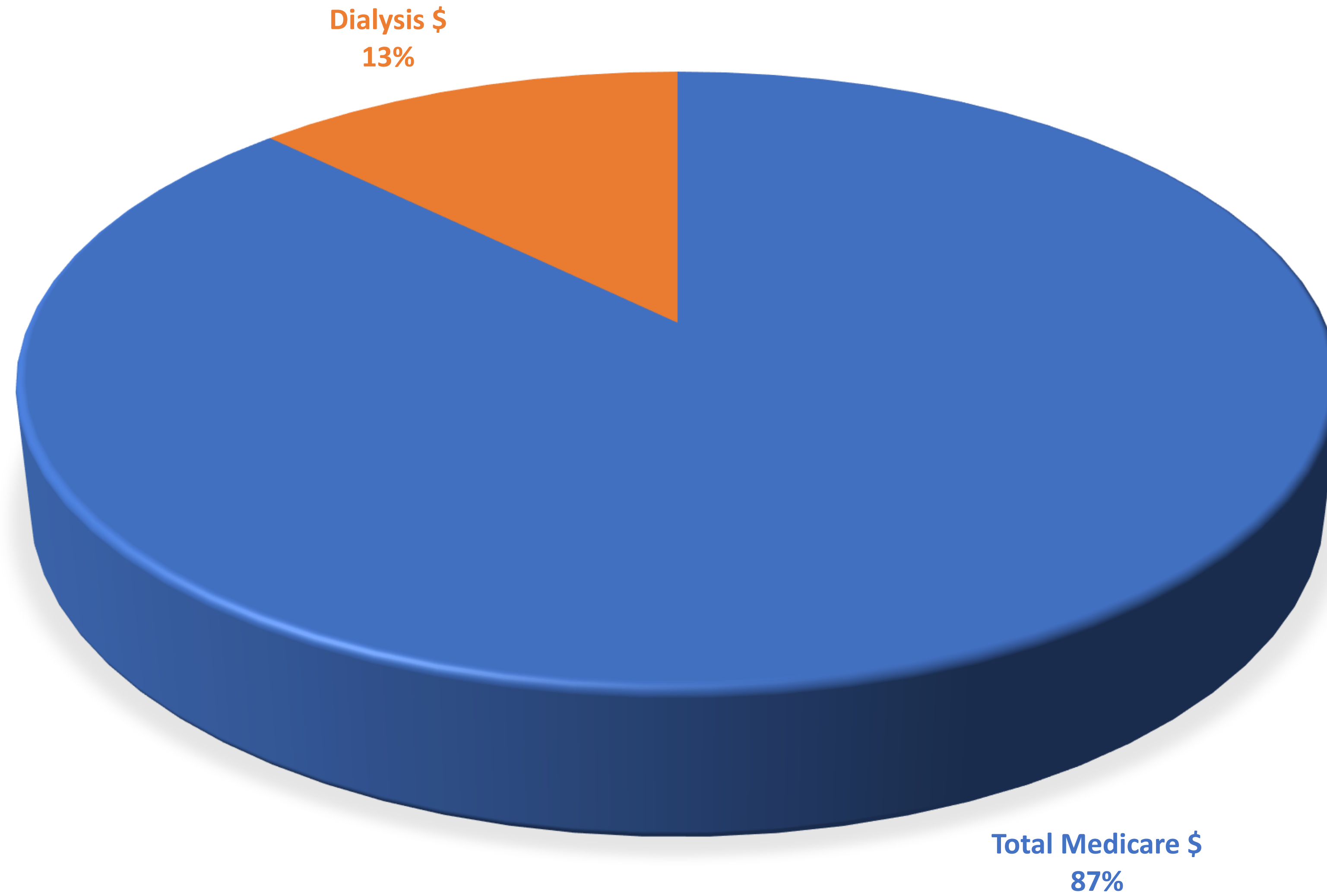
2007 MEDICARE PAID $



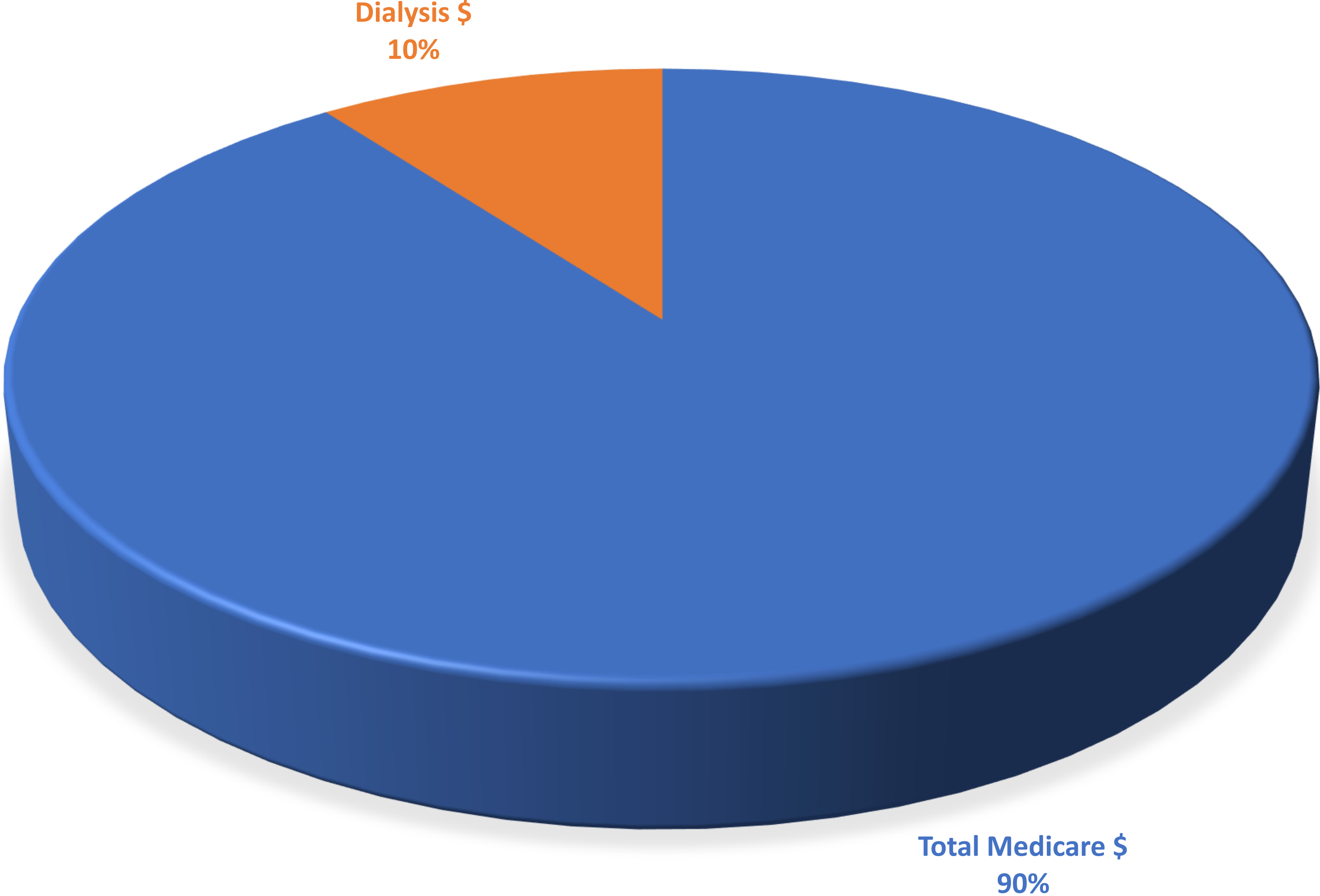
2013 MEDICARE PAID $



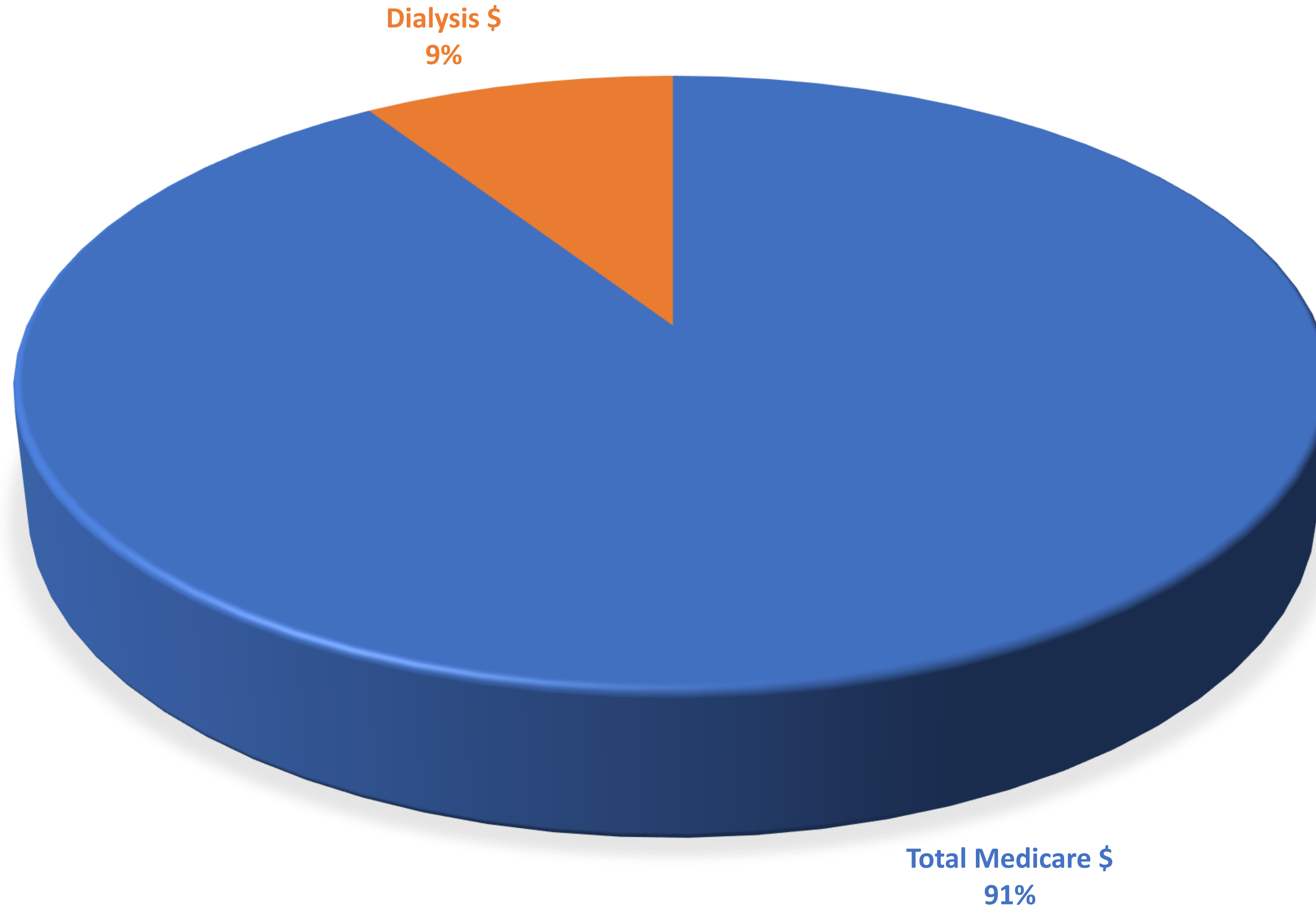
2014 MEDICARE PAID $



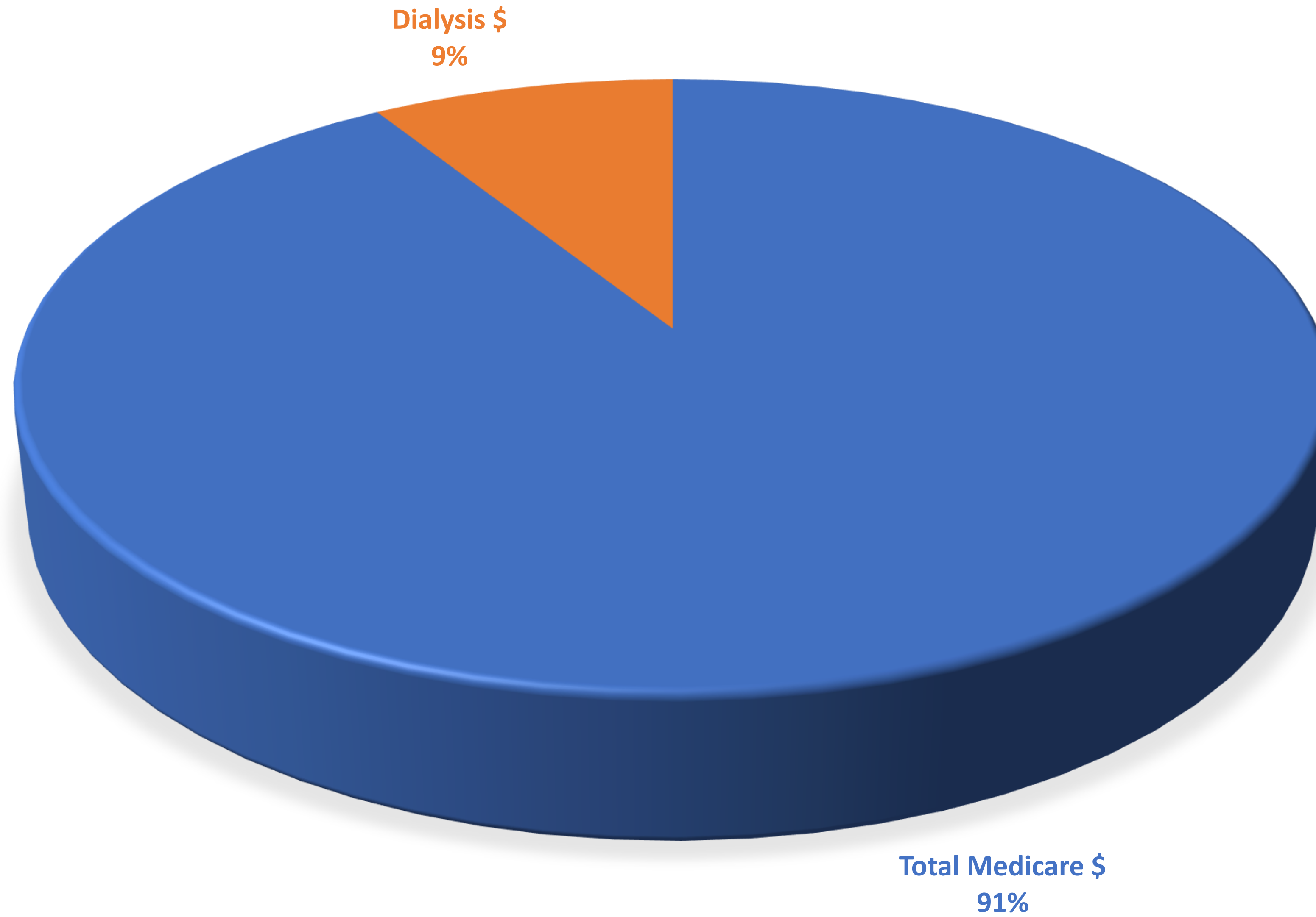
2015 MEDICARE PAID $



2016 MEDICARE PAID $



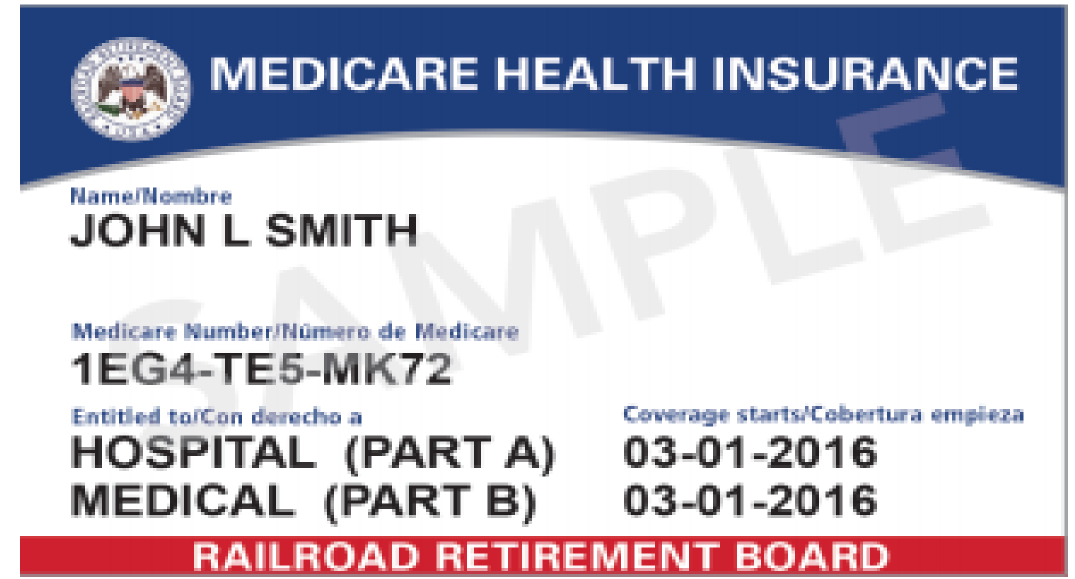
2017 MEDICARE PAID $



ESRD Reduction

- Section 53108 of the Bipartisan Budget Act of 2018
- Effective October 1, 2018, Medicare payments for BLS non-emergency transports to and from dialysis will be subject to a reduction of 23% off the applicable Medicare allowable
  - Previously subject to a 10% reduction

New Medicare ID Cards



SSN Removal Initiative

- The Medicare Access and CHIP Reauthorization Act mandated that CMS take steps to remove the social security number from all Medicare ID cards by April 2019
- CMS has started issuing new Medicare ID Cards to beneficiaries starting in April 2018
  - New cards replace SSN-based Health Insurance Claim Number (HICN)
  - New identifier will be the Medicare Beneficiary Identifier (MBI)

New Medicare Beneficiaries

- CMS stopped issuing SSN-based Medicare ID cards to newly enrolling Medicare beneficiaries in March 2018
- Effective April 2018, all newly enrolling beneficiaries will be issued Medicare ID cards that utilize the MBI

MBI Format

Pos.	1	2	3	4	5	6	7	8	9	10	11
Type	C	A	AN	N	A	AN	N	A	A	N	N

Where:

C – Numeric 1 thru 9

A – Alphabetic Character (A...Z); Excluding (S, L, O, I, B, Z)

N – Numeric 0 thru 9

AN – Either A or N

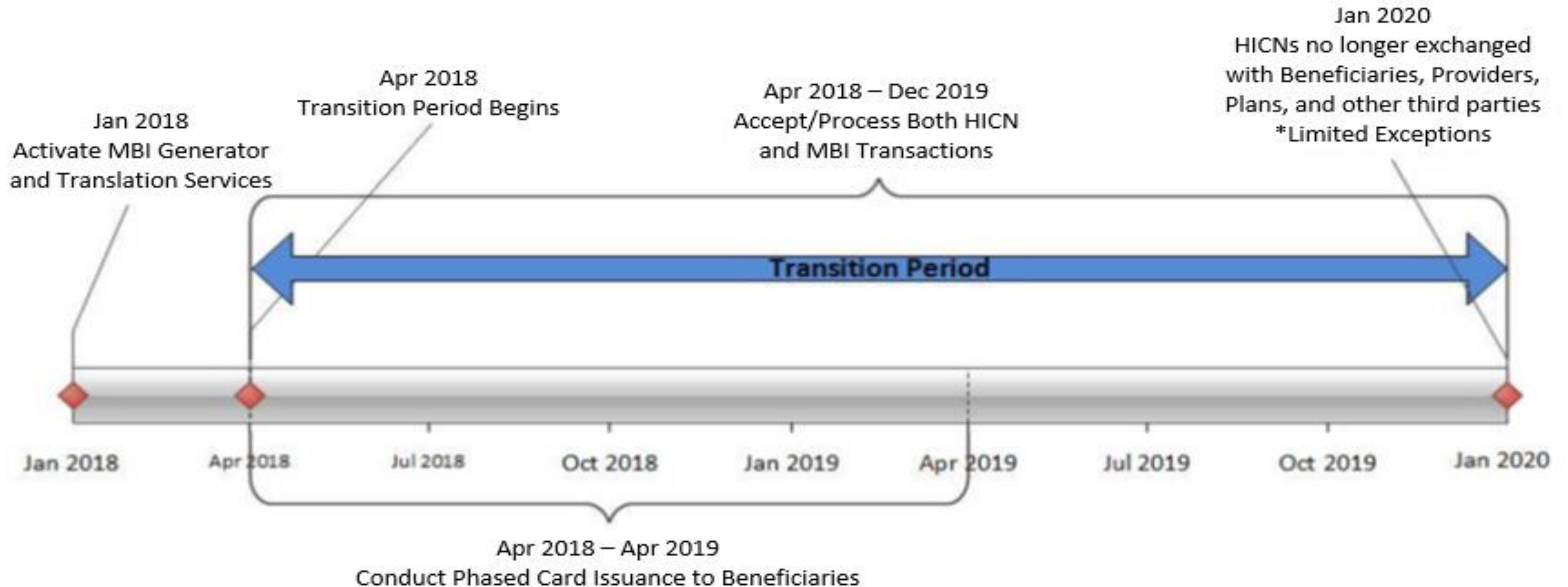
*****NOTE: Alphabetic characters are Upper Case ONLY**

Position 1 – numeric values 1 thru 9
Position 2 – alphabetic values A thru Z (minus S, L, O, I, B, Z)
Position 3 – alpha-numeric values 0 thru 9 and A thru Z (minus S, L, O, I, B, Z)
Position 4 – numeric values 0 thru 9
Position 5 – alphabetic values A thru Z (minus S, L, O, I, B, Z)
Position 6 – alpha-numeric values 0 thru 9 and A thru Z (minus S, L, O, I, B, Z)
Position 7 – numeric values 0 thru 9
Position 8 – alphabetic values A thru Z (minus S, L, O, I, B, Z)
Position 9 – alphabetic values A thru Z (minus S, L, O, I, B, Z)
Position 10 – numeric values 0 thru 9
Position 11 – numeric values 0 thru 9

Medicare Beneficiary Identifier

CMS wants you to know that there will be no combinations of numbers or strings that could be considered "inappropriate" or "offensive"

MBI Generation and Transition Period



Transition Period

- CMS indicated that the transition period to the new MBI# will run from April 1, 2018 through December 31, 2019
  - During this period, claims can be submitted with either the HIC# or the MBI#
  - Batches can be submitted with claims using either identifier
    - i.e., you do not have to use the same identifier on each claim in a batch

Transition Period

- During the transition period, CMS will return on the remittance advice the same beneficiary identifier to you that you submitted on the claim submission
  - If you submit a HIC#, the remittance advice will return the HIC#
  - If you submit an MBI#, the remittance advice will return the MBI#

Transition Period

- Effective October 1, 2018, when a valid HIC# is submitted on a FFS Medicare claim, the remittance advice will be returned with both the HICN and the MBI#
  - The MBI will be in the same place you currently get information on a "changed HICN"
    - 835 Loop 2100
    - Segment NM1 (Corrected Patient/Insured Name)
    - Field NM109 (Identification Code)

Eligibility Transactions

- Effective June 2018, health care providers may look up a beneficiary's MBI through the MAC-based eligibility portal
  - Will require the patient's full name, SSN, and date of birth

MBI Utilization

- In a March 14, 2019 MLNConnects notice, CMS indicated that, for the week ended March 1, 2019, 67% of Medicare fee-for-service claims were submitted with a valid MBI

WHAT ELSE IS NEW?

New SNF Consolidated Billing Edits

- On November 2, 2019, CMS issued Transmittal 2176
  - Implemented a new set of Common Working File (CWF) edits to identify ambulance transports that should be bundled to the skilled nursing facility under the SNF Consolidated Billing Regime
  - Edits took effect **April 1, 2019**

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

MEDICARE PAID TWICE FOR AMBULANCE SERVICES SUBJECT TO SKILLED NURSING FACILITY CONSOLIDATED BILLING REQUIREMENTS

Inquiries about this report may be addressed to the Office of Public Affairs at Public.Affairs@oig.hhs.gov.

Gloria L. Jarmon
Deputy Inspector General
for Audit Services

February 2019
A-01-17-00506

Medicare Paid Twice for Ambulance Services Subject to Skilled Nursing Facility Consolidated Billing Requirements

What OIG Found

Medicare made Part B payments to ambulance suppliers for transportation services that were also included in Medicare Part A payments to SNFs as part of consolidated billing requirements. For 78 of the 100 beneficiary days we sampled, Medicare made Part B payments that were incorrect. Medicare overpaid the ambulance suppliers because the Common Working File (CWF) edits were not designed to prevent or detect Part B overpayments for all transportation subject to consolidated billing. In addition, ambulance suppliers did not have the necessary controls to prevent incorrect billing to Medicare Part B.

On the basis of our sample results, we estimated that Medicare made a total of $19.9 million in Part B overpayments to ambulance suppliers for transportation services for beneficiaries in Part A SNF stays. In addition, we estimated that beneficiaries incurred an estimated $5.2 million in coinsurance and deductible liabilities related to these incorrect payments.

OIG Report Methodology

- OIG reviewed $25.3 million in Medicare Part B payments to ambulance suppliers for beneficiaries that were in a Part A SNF stay between July 1, 2014 and June 30, 2016
- 58,006 "beneficiary days" that included at least one claim line for ambulance transportation
  - 100 beneficiary days selected for review sample
- Sampled beneficiary days were reviewed to determine whether the HCPCS or CPT codes on the associated hospital outpatient claim indicated that the hospital outpatient service was bundled to the SNF

Key Finding

The OIG determined that 78 of the 100 beneficiary days they sampled contained a Medicare overpayment, because the ambulance supplier transported the beneficiary to receive services that did not suspend or end their SNF resident status and which were not related to maintenance dialysis

OIG's Recommendation

"We recommend that CMS redesign the CWF edits to prevent Part B overpayments to ambulance suppliers for transportation services provided to beneficiaries in Part A SNF stays."

New Edit Mechanics

- Effective April 1, 2019, ambulance claims for beneficiaries within a Part A SNF stay will be **denied** to the extent they are:
  1. Submitted prior to the submission of the associated hospital claim; or
  2. Submitted after the submission of the associated hospital claim, unless the hospital claim contains at least one HCPCS or CPT code on the list of excluded codes

CMS Clarification

"The instruction in business requirement 10955.5 is intended modify CWF IUR 7275 to identify previously rejected/denied ambulance claims upon receipt of an outpatient hospital claim containing an excluded service and to remind MACs and SSMs that claims returned for CWF IUR 7275 should continue to be systematically adjusted by the SSMs as they are today.

Therefore, ***no action should be required for ambulance suppliers*** *to reprocess their claims once the hospital claim containing the excluded service is received."*

RISK

LOW
MEDIUM
HIGH
VERY HIGH
EXTREME

CMS PCS TEMPLATE

- On July 20, 2018, CMS released a template PCS form
- CMS indicated that the template was designed to assist physician's, non-physician practitioners (NPP), licensed social workers, case managers, and discharge planners in completing the PCS for ***repetitive, scheduled non-emergency ambulance transportation***
- Use of this template is ***voluntary***

CMS PCS TEMPLATE

DRAFT

Use of this template is voluntary / optional

Non-Emergency Ambulance Transportation Order / Physician Certification Statement (PCS) Template

Patient Information:

Last name: ______________________ First name: ______________________ MI: ____

DOB (MM/DD/YYYY):____________ Gender: __ M __ F __ Other Medicare ID:____________

Certifying physician / practitioner information: (if different from person signing below)

*Last name:*____________________ *First name:*________________ *MI:*___ *Suffix:*____

*NPI:*____________________ Place of employment:______________________

Address:____

City:__________________________ State:______ Zip:___________

Telephone number and extension: (___)_____-_______ x ________

Direct address:____

*Date of order, if different from signature date (MM/DD/YYYY):*____________

Start date:________________ End date:______________ Round trip: ___ Yes ___ No

Transport from ____ Home, or ____________________ To:__________________

Number of transports requested in a 60-day period:______

Procedure Code:______________ *Modifier 1:*__________ *Modifier 2:*__________

Purpose of transport [service(s) that cannot be provided in the current setting]:

___ Dialysis ____ Wound care ___ Radiation therapy ___ Chemotherapy ___ O&P services

___ Imaging ____ Other, describe:______________________________

Reason(s) that non-emergency ground transport by ambulance is required. Supporting documentation for any checked item must be maintained in the patient's medical record. Check all that apply:

Mobility

___ Bed confined (all three criteria must be met):

1) Unable to ambulate,
2) Unable to get out of bed without assistance,
3) Unable to safely sit in a chair or wheelchair

___ Unable to maintain erect sitting position in a chair for time needed to transport, due to moderate muscular weakness and de-conditioning

___ Risk of falling off wheelchair or stretcher while in motion (not related to obesity)

CMS PCS TEMPLATE

___ IV medications/fluids required during transport

___ Restraints (physical or chemical) anticipated or used during transport

Mental

___ Danger to self or others

___ Confused, combative, lethargic, comatose

Other

___ Other, *describe:* ______________________________

____

I certify that the information contained above represents an accurate assessment of the patient's medical condition on the date(s) of service.

Physician, allowed NPP, LSW, case manager, or discharge planner signature, name, date signed and NPI:

Signature: ______________________________

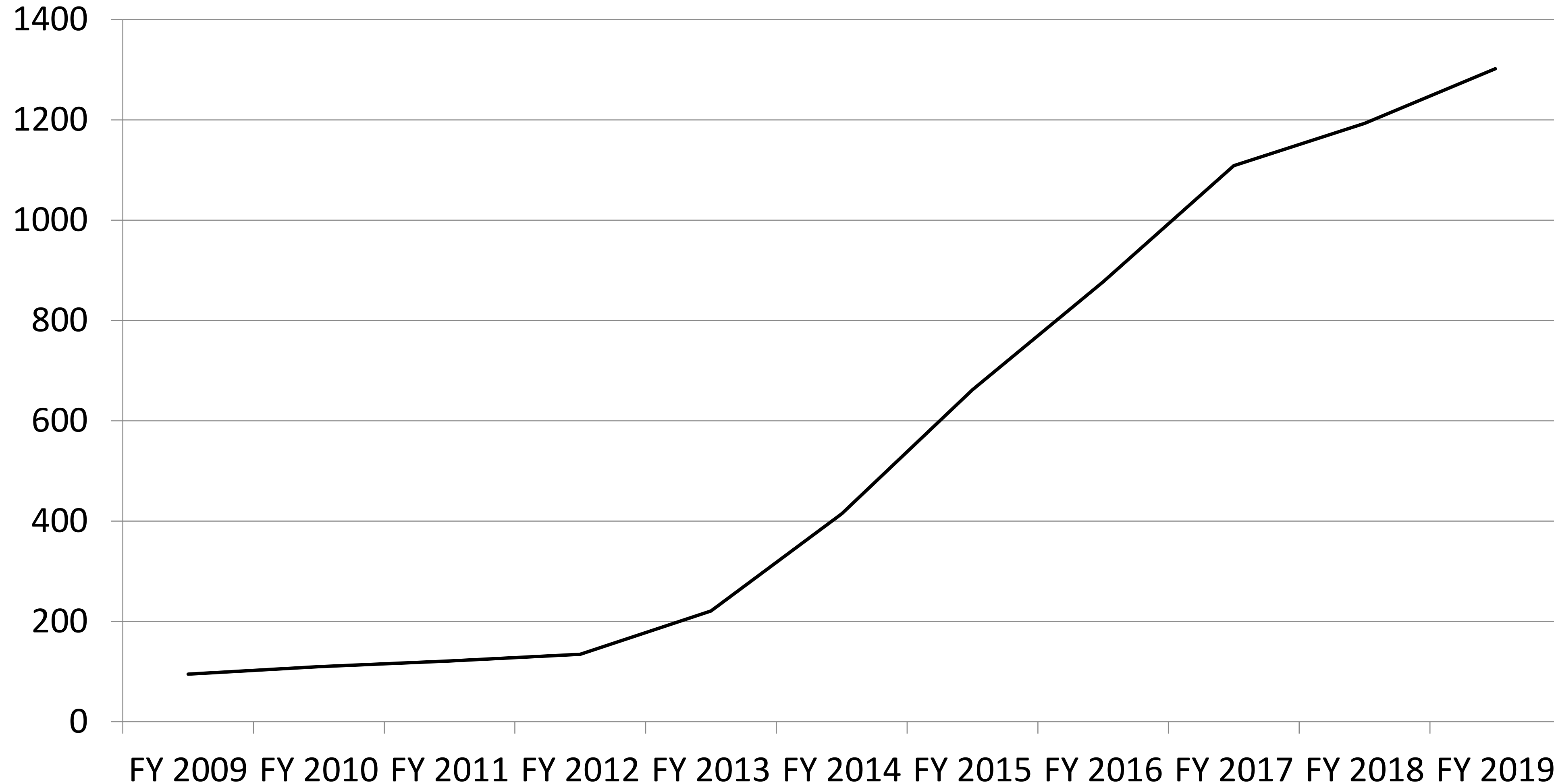
Name (Printed): ______________________________

Date (MM/DD/YYYY): ______________ NPI: ______________

Medicare
Revalidation
APPLY

Medicare Appeals Process

ALJ AVERAGE PROCESSING TIMES



ALJ DECISIONS – CLAIM RESULTS

	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017	FY 2018	FY 2019
Fully Favorable	53.2%	44.3%	36.7%	33.6%	25.6%	17.2%	17.3%	14.4%
Partially Favorable	6.4%	5.2%	2.8%	3.1%	2.0%	1.0%	1.1%	1.4%
Unfavorable	27.9%	25.5%	30.1%	37.5%	44.5%	24.9%	20.9%	21.3%
Dismissed	12.5%	25.0%	30.4%	25.8%	27.9%	56.9%	60.7%	62.9%

AHA V. BURWELL

- In 2014, the American Hospital Association filed suit in the Federal District Court for the District of Columbia against the Department of Health and Human Services. The AHA sought a *writ of mandamus* that would compel HHS to abide by the timeline for ALJ decisions set forth in the Medicare regulations
- The district court ruled in the AHA's favor in December 2016. The district court ordered that CMS reduce the ALJ backlog on the following timeframe:
  - 30% reduction by end of CY 2017
  - 60% reduction by end of CY 2018
  - 90% reduction by end of CY 2019
  - 100% reduction by end of CY 2020

AHA V. BURWELL

- The district court also required quarterly status reports on CMS' efforts to reduce the ALJ backlog
- CMS filed its first quarterly status report in March 2017, indicating that:
  - 667,326 appeals were pending as of March 5, 2017
  - CMS projected an increase in the number of pending appeals for each fiscal year through FY 2021
  - CMS projected the backlog would reach 1 million pending appeals by FY 2021

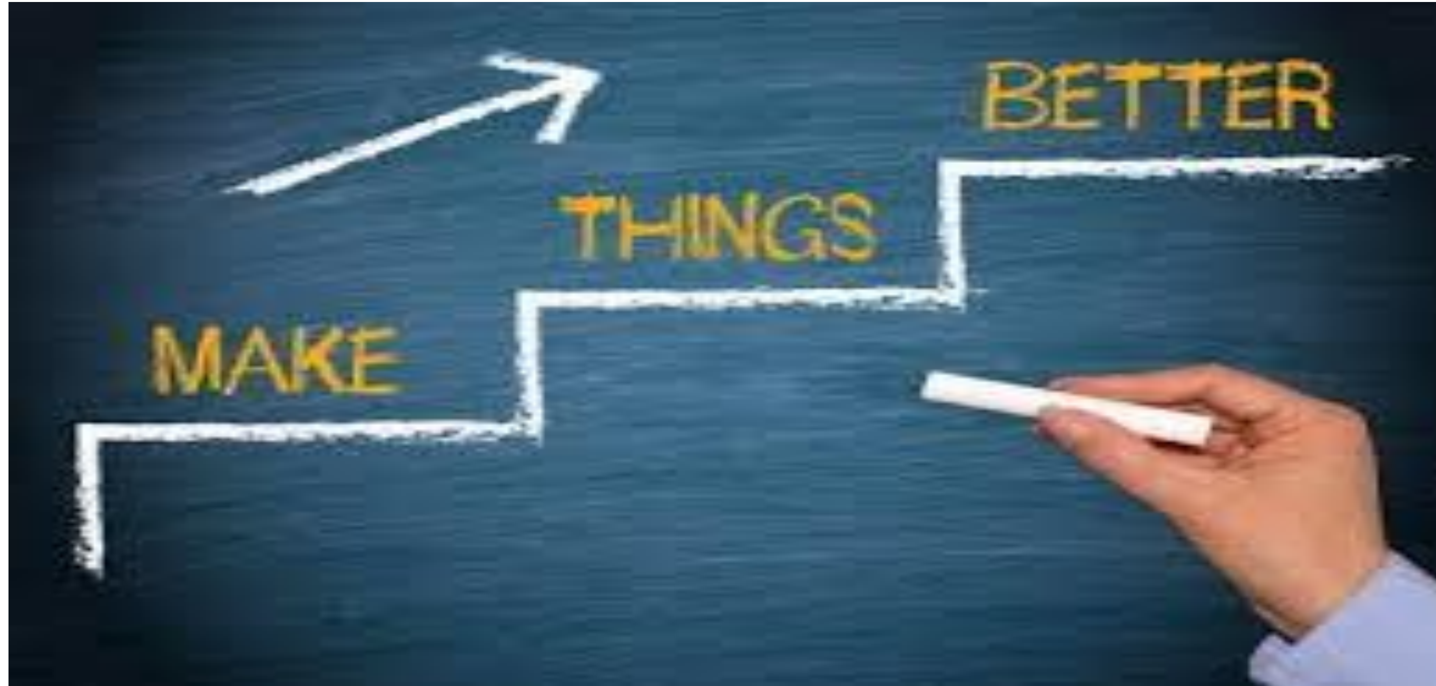
AHA V. BURWELL

- CMS appealed to the Court of Appeals for the D.C. Circuit
- On August 11, 2017, the Court of Appeals remanded the case back to the district court for further proceedings
  - Key issue was whether HHS had the ability to lawfully comply with the court order to reduce the ALJ backlog
- On March 22, 2018, the district court issued a stay through June 22, 2018
  - AHA was required to submit specific proposals for how to lawfully alleviate the ALJ backlog, accounting for existing CMS resources
    - i.e., the AHA's proposals needed to be based in reality!!

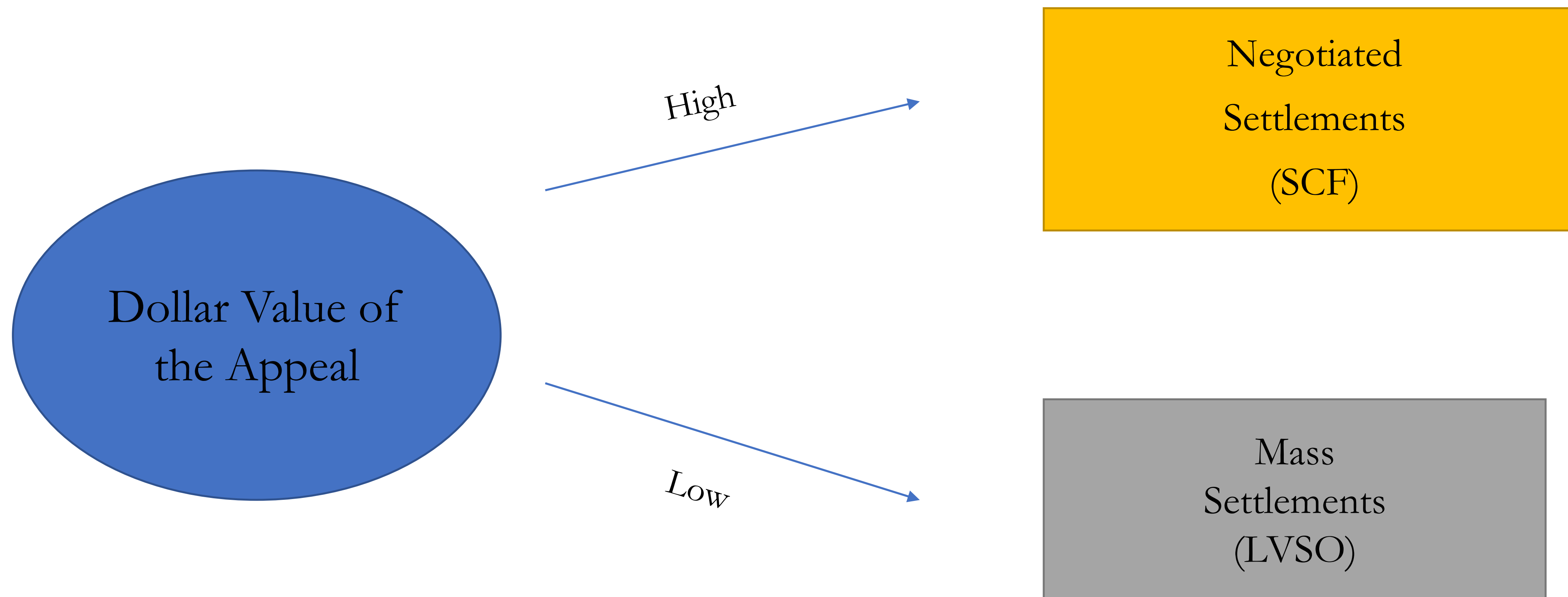
AHA's SUGGESTIONS

- On June 22, 2018, the AHA submitted its proposals for how CMS could reduce the current ALJ backlog. The AHA submitted 9 proposals:
  1. Implementation of a financial penalty on RACs with high overturn rates at the ALJ level
  2. CMS should shift the review of hospital claims from the RACs to the Quality Improvement Organizations (QIOs)
  3. CMS should be required to either settle outstanding inpatient rehabilitation claims, or file a notice with the court explaining why it is unwilling to settle
  4. CMS should make good-faith settlement offers as part of the Settlement Conference Facilitation Program
  5. CMS should reduce the interest charged on funds not recouped from providers while appeals are pending
  6. CMS should allow providers and suppliers to "rebill" claims for up to 6 months
  7. CMS should toll the time limits for filing 340B appeals
  8. CMS should continue its current efforts to reduce the backlog
  9. CMS should continue to submit status reports to the court every 90 days

CMS ALJ Initiatives



Conceptual Strategy



“LVSO” OPTION

- “Low Volume Settlement Option”
- Eligible to providers and suppliers with less than 500 claims pending appeals at ALJ or Medicare Appeals Council as of November 3, 2017
  - Total billed amount must be less than $9,000 “per appeal”
- CMS will agree to settle appeals at 62% of the net allowed amount

SETTLEMENT FACILITATION PROGRAM

- Expanded May 2018
- Eligibility requirements:
  - Appeal of a QIC decision
  - No beneficiary liability
  - Request for an ALJ hearing must have been filed prior to November 3, 2017
  - At least 25 claims at issue or at least one appeal must have more than $9,000 in billed charges
    - Billed amount of each claim must be $1 million or less
    - If an extrapolation is used, extrapolated amount must be $1 million or less

THANK YOU

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