



June 2010 Newsletter

Red Flag Rules Delayed AGAIN.

By: Christopher Kelly
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The Federal Trade Commission ("FTC"), the group that brought to us the Red Flag Rules, announced that it is again delaying the enforcement of the Rules, this time the extension goes until December 31, 2010. In that announcement the FTC said that it was delaying enforcement at the request of several members of Congress, while Congress considers legislation that would affect the scope of entities currently covered by the Rules. Does this mean that the Rules may not apply to us if and when they finally do set a firm compliance date? Maybe. Hopefully. But who knows? With Congress involved, it is anybody's guess.

So what are these Red Flag Rules and why do we have them in the first place? Well, identity theft has been an ongoing concern of government agencies over the past ten years. It was, in large part, the driving force behind the HIPAA Security Rule implemented by the Department of Health and Human Services. And now another agency is taking aim at preventing identity theft, and we get to help. The Federal Trade Commission (FTC) has announced the "Red Flag Rules", which are a set of rules designed to help "creditors" prevent identity theft. Traditionally, healthcare providers have not been considered "creditors", since we typically do not charge interest. But, under the new rules, if you defer payment for your services, you will be responsible for watching for these red flags and taking steps to respond to suspected identity theft.

There are basically four elements for the Written Identity Theft Program required by the Rules (I'll just call this your "Program" for short). First you must *identify* any relevant red flags of identity theft. For this, you should take into consideration the risks inherent in your type of business. For healthcare providers such as us, those risks include patients using someone else's insurance policy or name and address. The "red flags" that would alert you to this type of identity theft would be a patient that gives an insurance number but has no insurance card, a complaint from a person whom you have billed that they did not receive the service, or a notice that you have an incorrect address.

Once you have identified what these "red flags" should be, then you have to develop a method to *detect* them. The Rules suggest that this be accomplished by obtaining identifying information about the person that is opening an account with you (for us, that would be our patients). For ambulance providers, obtaining verification of the insurance coverage should also be a key element of your Program.

Next, in the event that you do detect a "red flag" that indicates possible identity theft, you must *respond* to them "appropriately". For example, if you have a complaint from a patient that you have billed them (or their insurance) for services that they did not



receive, then one of your identified red flags has been detected and you must take action. That action may be to write off that account (once you verify that you do in fact have the wrong patient) and/or to contact law enforcement to let them know about the possible identity theft (and theft of your services). It is likely that you have had these situations arise in the past. Use that experience in developing your Program.

Finally, your Program must be *updated* periodically to address changes in the risks of identity theft and your company's history with identity theft in the preceding months. This part of your Program must also require a written report at least annually on the effectiveness of your Program. Given the similarities in this Rule and the HIPAA Security Rule, the best person at your office to put this Program together and write your annual report would likely be your HIPAA Compliance Officer, however the Rules require that the Program be administered by your board of directors or a member of "senior management". Once your written Program is in place, you must then train your staff on at least the first three elements.

Unfortunately, as you can see from this article or a review of the Rules themselves (which can be viewed at <http://www.ftc.gov/opa/2007/10/redflag.shtm>), the Rules do not give us a lot of specific guidance, and much of the suggestions that they do give are relevant to "creditors" in the traditional sense (ones that take a credit application, or at least has the patient fill in an information sheet, before the goods or services are given). What I have given you above is a general outline of the requirements of the Rule, but it is up to you to actually determine what your "red flags" are, how you will detect them and what you should do once you have found an instance of possible identity theft. Then all of that must be put into a written Program and assessed in an annual report. Yes, it is up to you to help prevent identity theft. And you thought all you had to do was save lives!

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What Does Medicare Really Want?

By: R. Steven Everett, Director of Medicare Compliance
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This article follows my previous comments in last month's newsletter. In summary, that article discussed that Medicare wants to know **why** a patient cannot safely be transported by other means.

Scheduled, repetitive non-emergency transports are scrutinized most by Medicare auditors. The rationale for this is obvious: "These transports result in Medicare's largest payout for ambulance transportation!" The "why" question actually becomes: "Why does this patient require ambulance transportation to and from EVERY dialysis treatment?" Although Medicare coverage rules are the same for these transports as other non-emergency transports, I suggest you take your documentation to another level for these trips.

Many dialysis patients have blood pressure issues following dialysis from time to time. This medical history does not support the patient's need for transport to dialysis, or from dialysis on a continuous basis. I like to think that there are three categories of transports of dialysis patients which can be covered by Medicare. Let's look at those:

- On a given day, any dialysis patient may have an acute situation which requires transport on THAT day only. It could be the blood pressure issue following dialysis for instance.
- A dialysis patient may have a less than permanent medical problem which requires transport for a period of time. A good example of that would be a patient with a recent hip fracture with surgical intervention. If that condition alone supports coverage of the transportation, it is reasonable to assume that at some point in the future, transport would not be needed.
- Finally, there are patients with permanent medical conditions who most likely will require transports to and from dialysis on a continuous basis.

For the last category of patients, your answers to the "why" question must be solid. The trip report and the PCS must clearly answer the questions of why the patient can't ambulate, transfer without assistance, or sit up unattended in a car or wheelchair van.

TIP OF THE MONTH: Even if a dialysis patient has been transported for two years, the narrative on each and every trip report must answer the why question. A Medicare auditor may only look at one claim for each patient!



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