



Ambulance News

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Technology, Service, Expertise

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Give me a Y!

By: G. Christopher Kelly, Chief Legal Officer
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Well, not really a “Y”, what I’m looking for is a “why”. And it’s not just me that’s looking, more importantly it’s Medicare and it’s arsenal of contractors. After more than a decade of fighting Medicare over ambulance reimbursement issues, and after several recent conversations with Program Integrity Contractors (ZPICs and RACs), I have found that it really does boil down to that one question. Let me show you what I mean:

Increasingly I am seeing Medicare, the nurses who work for these Program Integrity Contractors, and even Administrative Law Judges ask for more than a list of diagnosis on a patient (“patient transported due to history of IDDM, HTN, CVA, CHF”, etc). They also want more than our conclusions (“stretcher/draw sheet/2-man assist required”). They want to know WHY!

*For BLS Non-emergent trips they want to know WHY the patient could not ride in a wheelchair van. A list of diagnosis will not usually suffice to answer that question. And just stating that a stretcher was required is not going to fly. We have to describe how the medical history effects the patient’s physical ability to sit in a wheelchair in a moving vehicle. For example: “Patient required stretcher transport due to history of ESRD, htn, CVA, left BKA.” is not as descriptive as “Patient required stretcher due to inability to sit in a wheelchair due to severe left side paralysis secondary to prior CVA and left BKA prevents pa-

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*Billing Tip of the
Month*

By: Brandie Tibbetts
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Effective as of October 1, 2011, any provider applying for a new Medicare EDI Submitter number must be 5010 compliant. Furthermore, only claims that are 5010 compliant will be accepted.

tient from maintaining sitting position in a moving vehicle.” You might be able to guess from the first general list of conditions what the patient’s limitations are, but trust me, Medicare will not guess. Unless you explain yourself, the claim is subject to denial if reviewed in a pre-pay or post-pay audit.

*For ALS trips they want to know WHY the ALS intervention was necessary. For example, just because your policy states that all falls get a monitor does not mean that Medicare has to pay ALS. To put it another way, your policies do not automatically create an obligation for Medicare to pay a claim. If the patient tripped over her cat, Medicare is going to want to see more than the fall to justify ALS intervention or assessment. Unless you explain why the monitor was necessary (for example “the patient states she believes she blacked out”), then they can downcode the claim from ALS to BLS and take back a large portion of your payment.





*For emergency transports, we occasionally see them want to know WHY an immediate response was necessary. Just because you are the 9-1-1 provider and you responded immediately to the SNF who called you about a patient’s skin tear from the night before does not mean that you needed to respond immediately. Again, unless you explain that the patient’s condition was severe enough to warrant an emergent transport, then the patient’s overall condition might warrant transport by ambulance for treatment, but at the lower BLS Non-emergent rate.


Because there are so many potential WHY’s, and because each one of them could cost you money, it is my suggestion that you answer these WHY’s in your narrative as directly as possible. At the end of each trip report, you should be able to answer these questions without referring to another medical record, without having to rely on your knowledge of the patient outside of the trip report, and without having to guess how their condition effected them or how severe it was.




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Why ask why? Because if you don't, it could prove to be the most costly question you never answered.

G. Christopher Kelly is an attorney who focuses on federal laws and regulations as they relate to the health care industry and specifically to the ambulance industry. Chris lectures and advises EMS service clients across the U.S. This article is not intended to be legal advice, for information regarding any specific overpayment assessment or on how your service can implement a compliance plan and stay on top of these issues, Chris can be reached at chris@emscltd.com or (800) 342-5460. For more information on these OIG reports, detailed articles by Chris can be found courtesy of EMS Magazine at www.emsresponder.com.

EMS and Customer Service: Part 1

By: Jarrett Nykamp, Sales Consultants
EMS Consultants

How many times have you been shopping for something and couldn't find it? Worse yet, how many times have you not been able to find anyone who wanted to help you? Do you find standing at the counter of a hotel waiting to check in frustrating because the second on duty person is "on a break" only to find out that she is sitting just out of sight and could really care less that you have just gotten in after a long and tiring drive?

Now, how about the elderly lady who calls for your service at four o'clock in the morning because she "just doesn't feel well." How do you treat her? How should you treat her? I have always tried to operate off the rule 'do unto others....'. However, just being kind to the little old lady who calls you at four o'clock in the morning isn't enough any more, especially in the increasingly competitive healthcare market. More and more EMS providers are finding themselves in direct competition for their slice of the market-share. What is your service doing to ensure its place in your community? People are rarely glad they have to call an ambulance, but if they do find themselves needing emergency medical services, are they glad it is your service pulling into their driveway?



Attention EMS Consultants' Billing Services clients:

All Medicare enrollment and revalidation requests will be handled on your behalf. Please contact our office if you have any questions or if you receive a request for revalidation.

If you have questions or concerns regarding your 855B Revalidation please feel free to contact our office for a **FREE 855B REVALIDATION GUIDE**

Please remember this is merely a guide and was prepared from the point-of-view of a county owned ambulance service provider. Some answers may vary depending on the set-up of your service.

Until recently, many EMS providers thought “we got out the door immediately, treated the patient aggressively yet compassionately, and we got them to the hospital quickly. A job well done.” Today, that scenario is a “job half done.” As EMS managers, we have to recognize the importance of our customers as well as our consumers, and take measures to ensure both groups understand that we want them to call our service when they have an emergency. But more importantly, we have to give them reasons to specifically request our service when the need arises.

Does your ambulance service ask for feedback from your customers? I was sitting in a restaurant recently and noticed wedged between the dessert menu holder and the salt and pepper shakers a customer questionnaire. As I usually do, I read over it and took the time to complete the survey. In the service that I managed, we conducted patient follow-up surveys on all emergency calls, but we took it a step further. We wanted to use this follow up tool as more than a “public relations tool”. We developed four questionnaires to be mailed out for specific types of emergencies for which our service was dispatched (chest pain, fall/injury, respiratory, and general illness). After the call was over, our crews, as part of the charting and paperwork routine, placed the complaint-appropriate questionnaire in an envelope

and sent it to the patient's mailing address along with a self-addressed, postage paid envelope for the return. The response our service received was overwhelmingly positive, however we also identified some areas for improvement and were able to make operational and clinical protocol changes based on direct feedback from our customers. We were not only receiving vital information from our customers on our operation, we were reaching out to our customers and



5010 Update

As we get closer to implementing the ANSI X12 5010 changes due January 1, 2012, EMS Consultants, Ltd. will be rolling out a series of EMS Billing software updates to prepare for the migration. Currently, we are generating and testing ANSI X12 5010 claim files with ALL Medicare Carriers, Medicaid Carriers and Clearing Houses that we are affiliated with. To prepare for this transition, it's important that each Provider be aware of the following implications affecting us as Ambulance Service Entities.

- Ensure that your Billing Provider Address (Company Setup) does not contain a P.O. Box. CMS now requires the Billing Provider use a physical address.
- Check Billing Provider Address (Com-

letting them know how much we appreciated the opportunity to serve them.

Another quick and easy customer appreciation tool that we utilized was the 'patient visit.' For each patient that we transported to our local hospital who was admitted, our crews stopped by to visit them the next day. Often times the same crew was working and was able to conduct a visit to a patient whom they had treated the previous day.

These tips are just a few ideas to jump start your understanding of your patient satisfaction and keep the heart beating of your community and your service.

Jarrett Nykamp is a graduate of Wake Forest University with a degree in Business Management in addition to being a 15 year veteran of EMS as a paramedic. Jarrett has numerous years of EMS management experience from positions of local direction of services to building EMS systems in Caribbean countries. Jarrett has orchestrated multiple programs to influence performance improvement within Emergency Medical Services and the crossover to public health. As project manager for numerous projects, state and national, Jarrett successfully instituted grants that made it possible to place 12 Lead ECG's and Waveform Capnography on every ambulance in North Carolina, facilitated the national evaluation of CDC's Field Triage schematic and assisted in the development of a forward thinking set of pediatric protocols within the state of North Carolina. Jarrett currently resides in North Carolina where he is still a major contributor to regulations and forward progress of Emergency Services. Jarrett is a contributing author to Emergency Services-Best Practices Journal and a co-author of Nancy Caroline's 7th Edition - Emergency Care in the Streets-Paramedic Textbook. Jarrett currently uses his experiences and expertise in the field of EMS to provide services as an Operations/Software Consultant for EMS Consultants based in Lagrange, GA.



pany Setup) Zip code contains the correct Zip+4 zip codes for the Address listed.

- Check From/To locations for proper Zip+4 zip codes.
- Use “S” or “SC” for SCENE and “R” or “RES” for RESIDENCE. Other combinations used for Residence and/or Scene will be ignored during extraction.
- Check Diagnosis for proper ICD-9 codes, and that their lengths are a maximum of 5 digits. For example: 487.00 instead of 487.0.
- When extracting ANSI X12 5010 claims, the software will check for proper

855B Update

By: R. Stephen Everett, Director of Medicare Compliance

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This is a further reminder as a follow-up to my previous article regarding provider enrollment:

- Should you make a decision to close your EMS company, you should determine the effective date. Update your 855 to let Medicare know the date on which you will last run your trucks. If you have claims in process with Medicare or in the appeal process, AND, Medicare conducts an onsite visit after your closure date, Medicare will revoke your provider number. You want Medicare to turn off your billing number ONLY for dates of service after you close.
- Should you open a new location and submit the 855 to activate this location for claims, you MUST have someone at that office manning that office, effective with the dates you begin making transports. If you do not, and Medicare makes an onsite visit, you likely will have to start all over with the enrollment process.

For more information, please contact Steven Everett, everethcc@aol.com. Stephen Everett, MBA, MPA, worked for HCFA (now CMS) for 14 years, first with the Office of Program Integrity and later as the Southeast Regional Chief of Medicare Policy. After his career with Medicare, Steve went on to serve as a Medicare Hearing Officer for 16 years. During this time, he heard thousands of ambulance related Medicare appeals involving at least 25,000 ambulance claims. Steve currently works with EMS Consultants as a Medicare Compliance Officer and assists with Medicare/Medicaid overpayment appeals cases.

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placement and existence of a Primary Chief Complaint in each invoice. An invoice with a missing Chief Complaint will be skipped during extraction.

- Ambulance Service Pick-up and Drop-off locations will now be reported in the claim file, as required by CMS. Each From/To location, except a Residence or Scene will require a valid address.

ANSI X12 5010 claims submitted will cause the following:

- 999 (Formerly 997) Acknowledgment for Healthcare will be generated.
- 277CA Healthcare Claim Acknowledgment will be generated. This is a report to show which claims Accepted and which claims Rejected and

Provider Enrollment Revalidation

By: Kelli Cassarino
EMS Consultants

Recently, providers have received letters from their Medicare Administrative Contractor (“MAC”) requesting that they revalidate their 855b enrollment application for Medicare. The revalidation process can be scary if you are unfamiliar with this task. We first saw these changes back in February, but there have been several questions on why they are now implementing these changes. Here are the facts.

Why are they doing it?

In February 2011 CMS published new guidelines designed to reduce fraud and abuse of the Medicare system. Through the Patient Protection and Affordable Care Act, Section 6401 all Medicare suppliers and providers who enrolled in Medicare prior to March 25, 2011 will be required to revalidate their 855B



application by March 2015. Each MAC will review these new and existing Medicare providers and place them in one of three categories.

- For “limited risk” providers and suppliers, the Medicare contractor must (1) verify that the provider or supplier meets all applicable Federal regulations and State requirements; (2) conduct license verifications; and (3) conduct pre-enrollment and post-enrollment database checks to ensure that the provider or supplier continues compliance with the applicable enrollment criteria.
- For “moderate risk” providers and suppliers, the Medicare contractor also must conduct unscheduled and unannounced



why.

- 835 Healthcare Claims Payment Advice/Remittance will be generated based on the 277CA.

Migration from the ANSI 4010 to ANSI 5010 Production will be done in phases over the next few weeks. This is to prepare us so there are no payment interruptions, as some carriers have stated there will be no requests for interim payments honored.

We are simultaneously in the process of implementing software to read the 999, 277CA and adjustments to the 835's are under review at this time. Email notifications from EMS Consultants, Ltd. regarding software updates will notify you of specific information as we transition.

-Scott Kapaona
Lead Software Developer

on-site visits.

- For "high risk" providers and suppliers, the Medicare contractor also must perform finger-print based criminal background checks and fingerprinting for individuals who maintain a five percent (5%) or greater direct or indirect ownership interest.

How are they doing it?

The MAC's will be sending notification to all providers requesting that they revalidate their 855 within sixty (60) days of the letter date. Do not complete your revalidation until you have received a letter requesting that you do so. Medicare will request providers to revalidate their enrollment every five years. Also included with these changes is a \$505.00 charge for all "institutional providers" who complete an 855A, 855B (except physician and non-physician practitioner organizations), or CMS-855S forms or associated Internet-based PECOS enrollment application. Ambulance providers will be required to pay the \$505.00 each time you revalidate.

Completing Revalidation

There are two ways providers can handle completing this revalidation, through PECOS or submission of a paper 855B application. **BE SURE TO KEEP A COPY OF YOUR REVALIDATION AND SUPPORTING DOCUMENTATION ON FILE FOR YOUR RECORDS!**

- Using the PECOS system has proven to be the most efficient way to complete the process. The PECOS system can be accessed by visiting <https://pecos.cms.hhs.gov>. Once you have completed you revalidation print, sign, date and mail the certification statement along with the supporting documentation. Providers only have 15 days to submit the original copy and supporting documentation. All information currently on file with Medicare can be viewed through the system.



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- If you choose to submit a paper version of the 855 revalidation be sure to download the most recent version from the CMS website. You have 60 days from the date listed on the revalidation request letter to submit your original signed revalidation that includes all supporting documents.

Here are a few important Items to remember when completing and submitting your revalidation:

- Providers' legal business name should match what is reported to IRS (Internal Revenue System). If you are operating under a "doing business as name" be sure to list it as well.
- Be sure to include an email address for the contact person listed on the application. Medicare will send notification on the status of your revalidation to the email address listed.
- Dates listed throughout the document (i.e. change/add/delete dates and signature dates) should be consistent throughout the entire 855.
- Be sure to include your current Medicare Identification Number and National Provider Identifier in the appropriate fields.
- Social security numbers, dates of birth, and states of birth are required for all delegated and authorized officials. Some states (i.e. Texas) require the submission of copies of drivers' licenses for all officials listed on the 855b. Be sure to read your letter carefully to see what is required.
- If the provider stores patient files at a destination that does not share the same physical address as the providers' location, list both the physical location for the service and the off-site location where the files are stored.
- **FAILURE TO COMPLETE YOUR REVALIDATION WILL RESULT IN A SUSPENSION OF MEDICARE PAYMENTS!**

If you have questions regarding this issue please feel free to contact Kelli at KCassarino@emscld.com

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