2013 Medicare Payment Data
<table>
<thead>
<tr>
<th></th>
<th>Description</th>
<th>2013 Allowed #</th>
<th>2013 Allowed $</th>
<th>2013 Paid $</th>
</tr>
</thead>
<tbody>
<tr>
<td>A0425</td>
<td>Ground Mileage</td>
<td>140,891,705</td>
<td>1,099,189,084</td>
<td>864,339,277</td>
</tr>
<tr>
<td>A0426</td>
<td>ALS Non-Emergency</td>
<td>325,531</td>
<td>85,189,084</td>
<td>66,422,692</td>
</tr>
<tr>
<td>A0427</td>
<td>ALS Emergency</td>
<td>4,974,507</td>
<td>2,076,931,304</td>
<td>1,615,499,541</td>
</tr>
<tr>
<td>A0428</td>
<td>BLS Non-Emergency</td>
<td>6,833,969</td>
<td>1,509,979,925</td>
<td>1,182,578,453</td>
</tr>
<tr>
<td>A0429</td>
<td>BLS Emergency</td>
<td>2,726,768</td>
<td>976,470,132</td>
<td>758,337,761</td>
</tr>
<tr>
<td>A0430</td>
<td>Fixed Wing</td>
<td>10,820</td>
<td>45,337,204</td>
<td>35,462,990</td>
</tr>
<tr>
<td>A0431</td>
<td>Helicopter</td>
<td>56,200</td>
<td>258,426,685</td>
<td>201,690,114</td>
</tr>
<tr>
<td>A0432</td>
<td>Paramedic Intercept</td>
<td>3,153</td>
<td>1,183,491</td>
<td>908,676</td>
</tr>
<tr>
<td>A0433</td>
<td>ALS-2</td>
<td>111,789</td>
<td>67,358,827</td>
<td>52,420,103</td>
</tr>
<tr>
<td>A0434</td>
<td>Specialty Care Transport</td>
<td>104,605</td>
<td>77,832,279</td>
<td>61,021,808</td>
</tr>
<tr>
<td>A0435</td>
<td>Fixed Wing Mileage</td>
<td>1,972,269</td>
<td>23,203,089</td>
<td>18,185,274</td>
</tr>
<tr>
<td>A0436</td>
<td>Helicopter Mileage</td>
<td>3,309,845</td>
<td>104,479,754</td>
<td>81,690,492</td>
</tr>
<tr>
<td><strong>Totals</strong></td>
<td></td>
<td><strong>161,321,063</strong></td>
<td><strong>6,325,760,889</strong></td>
<td><strong>4,938,557,181</strong></td>
</tr>
</tbody>
</table>
## National Data

<table>
<thead>
<tr>
<th>Description</th>
<th>2013 Allowed #</th>
<th>2012 Allowed #</th>
<th>% Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>A0425 Ground Mileage</td>
<td>140,891,705</td>
<td>139,251,814</td>
<td>1.18%</td>
</tr>
<tr>
<td>A0426 ALS Non-Emergency</td>
<td>325,531</td>
<td>315,322</td>
<td>3.24%</td>
</tr>
<tr>
<td>A0427 ALS Emergency</td>
<td>4,974,507</td>
<td>4,984,105</td>
<td>-0.19%</td>
</tr>
<tr>
<td>A0428 BLS Non-Emergency</td>
<td>6,833,969</td>
<td>6,685,824</td>
<td>2.22%</td>
</tr>
<tr>
<td>A0429 BLS Emergency</td>
<td>2,726,768</td>
<td>2,687,644</td>
<td>1.46%</td>
</tr>
<tr>
<td>A0430 Fixed Wing</td>
<td>10,820</td>
<td>10,074</td>
<td>7.41%</td>
</tr>
<tr>
<td>A0431 Helicopter</td>
<td>56,200</td>
<td>58,308</td>
<td>-3.62%</td>
</tr>
<tr>
<td>A0432 Paramedic Intercept</td>
<td>3,153</td>
<td>3,067</td>
<td>2.80%</td>
</tr>
<tr>
<td>A0433 ALS-2</td>
<td>111,789</td>
<td>111,723</td>
<td>0.06%</td>
</tr>
<tr>
<td>A0434 Specialty Care Transport</td>
<td>104,605</td>
<td>103,315</td>
<td>1.25%</td>
</tr>
<tr>
<td>A0435 Fixed Wing Mileage</td>
<td>1,972,269</td>
<td>1,858,117</td>
<td>6.14%</td>
</tr>
<tr>
<td>A0436 Helicopter Mileage</td>
<td>3,309,845</td>
<td>3,390,550</td>
<td>-2.38%</td>
</tr>
<tr>
<td><strong>Totals</strong></td>
<td><strong>161,321,063</strong></td>
<td><strong>159,459,862</strong></td>
<td><strong>1.17%</strong></td>
</tr>
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</table>
## NATIONAL DATA

<table>
<thead>
<tr>
<th>Description</th>
<th>2013 Paid $</th>
<th>2012 Paid $</th>
<th>% Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ground Mileage</td>
<td>864,339,277</td>
<td>$861,277,845</td>
<td>0.36%</td>
</tr>
<tr>
<td>ALS Non-Emergency</td>
<td>66,422,692</td>
<td>$64,860,566</td>
<td>2.41%</td>
</tr>
<tr>
<td>ALS Emergency</td>
<td>1,615,499,541</td>
<td>$1,630,257,405</td>
<td>- 0.91%</td>
</tr>
<tr>
<td>BLS Non-Emergency</td>
<td>1,182,578,453</td>
<td>$1,178,364,961</td>
<td>0.36%</td>
</tr>
<tr>
<td>BLS Emergency</td>
<td>758,337,761</td>
<td>$753,395,553</td>
<td>0.66%</td>
</tr>
<tr>
<td>Fixed Wing</td>
<td>35,462,990</td>
<td>$33,298,889</td>
<td>6.50%</td>
</tr>
<tr>
<td>Helicopter</td>
<td>201,690,114</td>
<td>$211,489,526</td>
<td>- 4.63%</td>
</tr>
<tr>
<td>Paramedic Intercept</td>
<td>908,676</td>
<td>$894,878</td>
<td>1.54%</td>
</tr>
<tr>
<td>ALS-2</td>
<td>52,420,103</td>
<td>$52,855,918</td>
<td>- 0.82%</td>
</tr>
<tr>
<td>Specialty Care Transport</td>
<td>61,021,808</td>
<td>$60,263,801</td>
<td>1.26%</td>
</tr>
<tr>
<td>Fixed Wing Mileage</td>
<td>18,185,274</td>
<td>$17,090,963</td>
<td>6.40%</td>
</tr>
<tr>
<td>Helicopter Mileage</td>
<td>81,690,492</td>
<td>$84,621,519</td>
<td>- 3.46%</td>
</tr>
<tr>
<td>Totals</td>
<td>4,938,557,181</td>
<td>$4,948,671,824</td>
<td>- 0.20%</td>
</tr>
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</table>
# National Dialysis

<table>
<thead>
<tr>
<th>Description</th>
<th>2013 Allowed #</th>
<th>2013 Allowed $</th>
<th>2013 Paid $</th>
</tr>
</thead>
<tbody>
<tr>
<td>A0425 Ground Mileage</td>
<td>24,042,444</td>
<td>$182,660,653</td>
<td>$143,820,280</td>
</tr>
<tr>
<td>A0426 ALS Non-Emergency</td>
<td>9,058</td>
<td>$2,348,337</td>
<td>$1,844,296</td>
</tr>
<tr>
<td>A0427 ALS Emergency</td>
<td>36,644</td>
<td>$15,107,658</td>
<td>$11,824,080</td>
</tr>
<tr>
<td>A0428 BLS Non-Emergency</td>
<td>3,441,190</td>
<td>$753,980,360</td>
<td>$592,925,709</td>
</tr>
<tr>
<td>A0429 BLS Emergency</td>
<td>23,564</td>
<td>$8,407,654</td>
<td>$6,576,810</td>
</tr>
<tr>
<td>A0433 ALS-2</td>
<td>884</td>
<td>$522,505</td>
<td>$409,976</td>
</tr>
<tr>
<td>A0434 Specialty Care Transport</td>
<td>8,048</td>
<td>$6,406,502</td>
<td>$5,049,534</td>
</tr>
<tr>
<td>A0435 Fixed Wing Mileage</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>A0436 Helicopter Mileage</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Totals</strong></td>
<td>27,561,831</td>
<td>$969,433,669</td>
<td>$762,450,685</td>
</tr>
</tbody>
</table>
2007 Medicare Paid $

- Total Medicare $
- Dialysis $
2013 Medicare Paid $
2016 Medicare Ambulance Fee Schedule
Medicare Access and CHIP Reauthorization Act

• Signed by President on April 16, 2015
• Extends temporary adjustments for ground ambulance through December 31, 2017
  – 2% urban
  – 3% rural
  – “Super Rural” bonus

• Expands Prior Authorization Project
  – 2016 – DC, DE, MD, NC, VA, and WV
  – 2017 – All remaining states
2016 Inflation Update

AIF = CPI-U – MFP

CPI-U = 0.12%

MFP = 0.6% (2015)

Projected 2016 AIF = - 0.5%
IMPACT OF MFP ON FUTURE UPDATES
2016 PROPOSED RULE
RE: AMBULANCE FEE SCHEDULE

• July 8, 2015
• Technical changes to reflect extensions of temporary adjustments through December 31, 2017
  • 2% Urban
  • 3% Rural
  • “Super Rural” Bonus
• Proposal to “adopt” recent OMB modifications to Rural-Urban Commuting Area (RUCA)
• Revisions to definitions in regulations for:
  – Ambulance Staffing
  – “Basic Life Support”
CMS NOTICE
RE: CONDITION CODES

• Effective July 27, 2015, CMS has removed the Medical Conditions List (i.e., Condition Codes) from Claims Processing Manual

• List will now appear on the CMS website:

  www.cms.gov/Center/Provider-Type/Ambulance-Services-Center.html
ICD-10 Codes

- Went live **October 1, 2015!!!**
- CMS has released an updated version of the Medicare Condition Code List
  - [https://www.cms.gov/Center/Provider-Type/Ambulances-Services-Center.html](https://www.cms.gov/Center/Provider-Type/Ambulances-Services-Center.html)
  - 1000+ pages
<table>
<thead>
<tr>
<th>870.0 Laceration of skin of eyelid and periocular area</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Animal Bites, other</strong></td>
</tr>
<tr>
<td><strong>Primary code</strong></td>
</tr>
<tr>
<td><strong>S01.111A</strong> Laceration without foreign body of right eyelid and periocular area, initial encounter</td>
</tr>
<tr>
<td><strong>S01.112A</strong> Laceration without foreign body of left eyelid and periocular area, initial encounter</td>
</tr>
<tr>
<td><strong>S01.119A</strong> Laceration without foreign body of unspecified eyelid and periocular area, initial encounter</td>
</tr>
<tr>
<td><strong>S01.121A</strong> Laceration with foreign body of right eyelid and periocular area, initial encounter</td>
</tr>
<tr>
<td><strong>S01.122A</strong> Laceration with foreign body of left eyelid and periocular area, initial encounter</td>
</tr>
<tr>
<td><strong>S01.129A</strong> Laceration with foreign body of unspecified eyelid and periocular area, initial encounter</td>
</tr>
<tr>
<td><strong>S01.131A</strong> Puncture wound without foreign body of right eyelid and periocular area, initial encounter</td>
</tr>
<tr>
<td><strong>S01.132A</strong> Puncture wound without foreign body of left eyelid and periocular area, initial encounter</td>
</tr>
<tr>
<td><strong>S01.139A</strong> Puncture wound without foreign body of unspecified eyelid and periocular area, initial encounter</td>
</tr>
<tr>
<td><strong>S01.141A</strong> Puncture wound with foreign body of right eyelid and periocular area, initial encounter</td>
</tr>
<tr>
<td><strong>S01.142A</strong> Puncture wound with foreign body of left eyelid and periocular area, initial encounter</td>
</tr>
<tr>
<td><strong>S01.149A</strong> Puncture wound with foreign body</td>
</tr>
</tbody>
</table>
Crushed by alligator?

There's a code for that!
(ICD-10) W5803XA
Stabbed while Crocheting (ICD10) -Y93D1

Don’t bother me while I crochet.

Knitting accident?

There’s a code for that! (ICD-9) E012.0

www.medicalbillersandcoders.com
What Else is New?
February 16, 2012, CMS issued a proposed rule designed to implement new ACA regarding return of overpayment

—“60 day” rule

February 17, 2015, CMS published a notice in the Federal Register extending for another year the time for it to finalize that rule
On February 10, 2015, H.R. 822 was introduced in the House of Representatives

- Rep. Pete Sessions (R-TX)
- Rep. Gregory Meeks (D-NY)
- Rep. Todd Young (R-IN)
- Rep. Bill Johnson (R-OH)

Legislation would provide for:
- 20% increase in Year 1 to Medicare’s rates for air ambulance
- 5% increases in Years 2 – 4
- Require air medical providers to report basic operational costs
Patient Signature Requirement

• July 11, 2014
• Transmittal 2984

• CMS removed the requirement that you must capture the address of anyone signing on the patient’s behalf

• The AAA had requested this change over 2 years ago
MEDICARE REVALIDATION

• CMS is continuing its efforts to require all existing Medicare providers and suppliers to “revalidate” their Medicare enrollment information
  – Original target date: March 2013
  – Extension: March 2015
  – 2014 Enrollment Fee: $553

• Medicare contractors given discretion on when to revalidate various provider groups

• Failure to revalidate can result in 1 year ban on participation in Medicare!!

• List of all providers that have been asked to revalidate, arranged by calendar quarter
  – [http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/Revalidationshtml](http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/Revalidationshtml)
Section 501 requires the HHS Secretary to “establish a cost-effective procedures to ensure that a Social Security account number (or derivative thereof) is not displayed, coded, or embedded” on Medicare ID cards by April 2019

- Impacts 54 million current Medicare beneficiaries
- 4 years
- $320 million allocated
DECEMBER 5, 2014
FINAL RULE

MEDICARE ENROLLMENT APPLICATION
Clinics/Group Practices and Certain Other Suppliers

CMS-855B
Effective Date of Billing Privileges

• Effective February 3, 2015, effective date of a new provider’s billing privileges will be the later of:
  – Date enrollment application was filed, or
  – Date you started providing Medicare services at that practice location

• Exceptions:
  – 30 days in situations where circumstances beyond the provider’s control precluding filing enrollment application in advance of providing services
  – 90 days in federally-declared disaster areas
LIMITATION ON USE OF CORRECTIVE ACTION PLANS

• Effective February 3, 2015, Corrective Action Plans (CAPs) will no longer be available for revocations of billing privileges based on:
  – Exclusion from the Medicare program, or exclusion of owner or managing employee of provider
  – Felony conviction of provider, supplier, or owner
  – Providing false or misleading information on its enrollment application
  – The failure to disclose a practice location
  – Evidence that the provider is no longer operational at a practice location

• Providers or suppliers revoked for any of these reasons will be limited to appealing the revocation of their billing privileges
TRANSMITTAL 499

* Issued December 27, 2013
* Defined a “practice location” for ambulance suppliers to be:
  - Each site at which any vehicles are garaged
  - Each site from which personnel are dispatched
  - Its base of operations

**Note:** CMS indicated that an ambulance supplier may only have a single base of operations
Revocation of Billing Privileges

• Effective February 3, 2015, CMS will have the authority to revoke the billing privileges of any provider or supplier that engages in a pattern of billing for services that do not meet Medicare requirements.

• Factors CMS would consider:
  – The percentage of claims denied
  – The reason for the denials
  – Whether the provider has a history of “final adverse actions”
  – The length of time over which the pattern has continued
  – The length of time the provider has been enrolled in Medicare
  – Any other circumstances CMS deems relevant
New From the OIG
OIG Report on Questionable Billing Practices

• September 29, 2015
• OIG identified $24.2 million in payments that did not meet Medicare requirements
  – Transports to non-covered destinations
  – “Unlikely combinations” of base rate and destination
• OIG identified $30.2 million in payments where beneficiary did not receive Medicare services at either the origin or destination
### Table 4: Questionable Billing Among Ambulance Suppliers, First Half of 2012

<table>
<thead>
<tr>
<th>Measure of Questionable Billing</th>
<th>Median Among All Suppliers</th>
<th>Suppliers That Had Questionable Billing</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Threshold</td>
</tr>
<tr>
<td>No Medicare Service at the Origin or Destination</td>
<td>0 transports</td>
<td>3%</td>
</tr>
<tr>
<td>Excessive Mileage for Urban Transports</td>
<td>10 miles</td>
<td>34 miles</td>
</tr>
<tr>
<td>High Number of Transports per Beneficiary&lt;sup&gt;1&lt;/sup&gt;</td>
<td>4 transports</td>
<td>21 transports</td>
</tr>
<tr>
<td>Compromised Beneficiary Number</td>
<td>1%</td>
<td>7%</td>
</tr>
<tr>
<td>Inappropriate or Unlikely Transport Level</td>
<td>&lt;1%</td>
<td>3%</td>
</tr>
<tr>
<td>Beneficiary Sharing&lt;sup&gt;1, 2&lt;/sup&gt;</td>
<td>1.2 suppliers</td>
<td>2.3 suppliers</td>
</tr>
<tr>
<td>Transports to or From PHPs</td>
<td>0 transports</td>
<td>&lt;&lt;1%&lt;sup&gt;3&lt;/sup&gt;</td>
</tr>
</tbody>
</table>

Note: We identified suppliers that had questionable billing and calculated median levels for each measure among all suppliers to which the measures applied. For example, the measure “excessive mileage for urban transports” applies to suppliers with urban transports. Appendix B provides a detailed description of how each measure was calculated.

1 Among suppliers that provide dialysis-related transports.
2 As represented by the number of suppliers per beneficiary.
3 <<1% means that the number would round to 0, but is above 0.

Investigations re: “Unlikely Emergencies”

• The DC Office of the OIG is actively investigating ambulance providers around the country for “unlikely emergencies”
  – i.e., claims billed for an emergency base rate where the destination was a residence or nursing home
PROPOSED RULE re: CMPs

• May 12, 2014 Proposed Rule
• Expands OIG’s authority to impose civil monetary penalties for certain misconduct
  – $15,000 per day for failure to grant timely access to records in connection with an audit or investigation
  – $10,000 per day for each day an overpayment is not returned following the 60th day after it has been “identified”
PROPOSED RULE RE: EXCLUSIONS

• May 9, 2014 Proposed Rule
• Revises OIG’s exclusion authority to incorporate ACA changes
  – Would give OIG right to exclude individuals convicted for obstructing an audit or investigation
  – Expands OIG’s authority to exclude individuals for failing to supply certain payment data to CMS
  – Would give OIG right to exclude individuals that knowingly make false statements in connection with the submission of an enrollment application
Proposed Rule re: AKS Safe Harbors

- Safe Harbor for Cost-Sharing Waivers for Emergency Ambulance Services:
  - Governmental ambulance provider or supplier
  - Qualified provider or supplier of “emergency ambulance services”
    - Would not apply to governmental ambulance services that provide *exclusively* non-emergent transportation
  - Waiver of coinsurance and deductibles must not constitute the provision of “free services”
  - Waiver must be offered on a uniform basis, without regard to patient-specific factors
  - Waiver must not be claimed as “bad debt” or otherwise shifted onto Medicare, Medicaid, other payers, or the beneficiary
PROPOSED RULE RE: AKS SAFE HARBORS

• Safe Harbor for Free or Discounted Local Transportation
  – Provided by an “Eligible Entity”
  – Free or local transportation must not be determined in a manner related to past or anticipated volume, or the value of Federal health care program business
  – Free or local transportation cannot take the form of air, luxury or ambulance transportation
  – Free or local transportation must not be marketed or advertised, and no marketing or advertising can occur during the transport
  – Transport must be limited to:
    • Established patients and family members or others assisting patient
    • Within the local area
      – i.e., within 25 miles of the facility
Proposed Rule re: AKS Safe Harbors

- Exception to Prohibition on Inducements to Beneficiaries in Cases of Financial Hardship
  - Item or service must not be advertised
  - Item or service cannot be tied to the provision of other items or services reimbursable, in whole or in part, by a Federal health care program
  - There must be a reasonable connection between the item or service and the medical care of the individual
  - There must be a good faith determination of financial hardship on the part of the patient
The Latest From the SCOTUS
King v. Burwell
SCOTUS Challenge to Insurance Premiums

• On March 4, 2015, the SCOTUS heard oral arguments in a case challenging the authority of the IRS to offer tax credits to individuals purchasing insurance through the exchanges operated by the federal government.

• Decision potentially impacts:
  – 37 states
  – 6.5 million individuals
    • 87% of which qualified for subsidies averaging $105 a month in 2015
POSSIBLE OUTCOMES

1. SCOTUS upholds authority of IRS to offer tax subsidies to all Americans

2. SCOTUS rejects tax credits for individuals that purchased insurance through a federally-run exchange, but stays its ruling to give Congress time to act

3. SCOTUS rejects tax credits for individuals that purchased insurance through a federally-run exchange, effective immediately

4. SCOTUS rejects tax credits retroactive to January 1, 2014, and orders IRS to recoup all monies previously paid to individuals....
DAYS SINCE LAST INJURY

THUNDERDOME

1. WE ARE ALWAYS FIGHT
2. FIND YOUR OWN OPPONENT
3. SIGN UP TO FIGHT
4. START AND STOP WHEN TOLD
5. FIGHTS LAST AS LONG AS WE SAY

DON'T BITCH
On June 15, 2015, the SCOTUS held 6-3 that tax credits may be offered to anyone purchasing health insurance through a state health exchange, regardless of whether the exchange is run by the state or the federal government.
ARMSTRONG V. EXCEPTIONAL CHILD CARE

• 2 home health agencies had challenged the methodology used by the State of Idaho to set *Medicaid* reimbursement rates.

• On March 31, 2015, SCOTUS ruled (5-4) in favor of the state, holding that the law does not authorize a private right of action to challenge Medicaid reimbursement rates.
Armstrong v. Exceptional Child Care

• Scalia (for the majority):

“[N]either the Constitution nor federal law authorizes doctors and other health-care providers to go to court to enforce the law’s directive that reimbursement rates set by states be ‘sufficient to enlist enough providers so that care and services are available’ to Medicaid recipients just as they are to the general population”
Medicare Appeals Process
ALJ Avg. Processing Times

Column1

FY 2009
FY 2010
FY 2011
FY 2012
FY 2013
FY 2014 Oct
FY 2014 Nov
FY 2014 Dec
FY 2014 Jan
FY 2014 Feb
FY 2014 Mar
FY 2014 Apr
FY 2014 May
FY 2014 Jun
FY 2014 Jul
FY 2014 Aug
FY 2014 Sep
# ALJ Decisions

<table>
<thead>
<tr>
<th></th>
<th>FY 2012</th>
<th>FY 2013</th>
<th>FY 2014 (Through Aug)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fully Favorable</td>
<td>53.2%</td>
<td>44.3%</td>
<td>36.5%</td>
</tr>
<tr>
<td>Partially Favorable</td>
<td>6.4%</td>
<td>5.2%</td>
<td>2.8%</td>
</tr>
<tr>
<td>Unfavorable</td>
<td>27.9%</td>
<td>25.5%</td>
<td>29.8%</td>
</tr>
<tr>
<td>Dismissed</td>
<td>12.5%</td>
<td>25.0%</td>
<td>30.9%</td>
</tr>
</tbody>
</table>
ALJ PILOT PROJECT – SETTLEMENT OFFER

• CMS is offering to pay hospitals 68¢ on the dollar for all claims currently in the appeals process
  – 836,840 appeals of RAC determinations in FY 2013
    • 18.1% overturned on appeal

• AHA estimates that nearly $1.5 billion in claims are eligible for this settlement offer
OMHA recently contacted an ambulance company in Texas to see whether the ambulance company was willing to participate in a settlement conference to resolve 2010-2012 claims for dialysis patients.
Audit and Appeal Fairness, Integrity and Reforms in Medicare Act

- Senate Finance Committee
  - Increase funding to OMHA
  - Increase “Amount in Controversy” (AIC) requirement for ALJs to equal AIC for federal district court ($1,460)
    - Create Medicare “Magistrates” to review cases below AIC threshold
  - Permit ALJs and Magistrates to issue decisions from the record, without the need for actual hearings
  - Create process for expedited judicial review
  - Require HHS to determine if specialization of ALJs by provider type would lead to more consistent decisions
  - Require annual reports on outcomes of ALJ decisions
Recent Trends In Fraud & Abuse
Hospital Settlement
re: Non-Emergency Ambulance

• 9 hospitals in Jacksonville (FL) area have agreed to pay a total of $6.25 million to resolve allegations related to the improper use of ambulances for hospital discharges
  – 1 of 2 ambulance companies implicated has also settled

• Allegations were that the hospitals were knowingly ordering ambulances to discharge patients that could go safely by other means
  – Financial benefit was to ambulance companies
  – Intangible benefits to hospitals
Ambulance Settlement

re: Kickbacks

• 5 ambulance companies in Southern California have agreed to pay a total of more than $11.5 million to resolve allegations related to potential kickbacks

  – Allegation was that ambulance companies engaged in “swapping” schemes to provide deeply discounted ambulance services to hospitals and nursing homes in exchange for referrals
FOR IMMEDIATE RELEASE
TUESDAY, JUNE 7, 2011
http://www.usdoj.gov/usao/bnx/

MEDIA INQUIRIES: KATHY COLVIN

CITY OF DALLAS TO PAY $2.47 MILLION TO RESOLVE ALLEGATIONS THAT IT CAUSED IMPROPER MEDICARE AND MEDICAID AMBULANCE CLAIMS

DALLAS — The City of Dallas has agreed to pay the U.S. and Texas $2.47 million and enter into certain compliance obligations to resolve allegations that it violated the civil False Claims Act and Texas Medicaid Fraud Prevention Act, announced U.S. Attorney James T. Jacks of the Northern District of Texas. The U.S. and Texas contend Dallas caused “upcoded” claims to be submitted to Medicare and Medicaid for city-dispatched 911 ambulance transports between 2006 and 2010. Dallas fully cooperated with the investigation, and by settling did not admit any wrong-doing or liability.
FOR IMMEDIATE RELEASE
TUESDAY, AUGUST 23, 2011
http://www.usdoj.gov/usao/txn/

GOVERNMENT RECOVERS MORE THAN $1.6 MILLION FROM
ELEVEN CITIES TO RESOLVE ALLEGATIONS THEY
CAUSED IMPROPER MEDICARE AND MEDICAID AMBULANCE CLAIMS

DALLAS — The Texas cities of Plano, Frisco, Richardson, Mesquite, Celina, DeSoto, Corpus Christi, Cedar Hill, Rowlett, North Richland Hills and University Park (collectively “Cities”) have agreed to pay the U.S. and Texas the collective amount of $1.69 million to resolve allegations they violated the civil False Claims Act and Texas Medicaid Fraud Prevention Act, announced U.S. Attorney James T. Jacks of the Northern District of Texas. The U.S. and Texas contend all the Cities caused “uncoded” claims to be submitted to Medicare and Medicaid for city-dispatched 911 ambulance transports between 2006 and 2010. All the Cities fully cooperated with the investigation, and by settling, did not admit any wrongdoing or liability.

Ambulance services generally are coded either as basic life support level or advanced life support (ALS). ALS transports are reimbursed at a higher rate by both Medicare and Medicaid. The U.S. and Texas contend the Cities’ billing contractor coded 911-dispatched transports at the ALS level, which indicates an ALS service was furnished and/or the patient’s condition necessitated an ALS intervention. The U.S. and Texas
On June 1, 2015, CMS released the CY 2013 Medicare Provider Utilization File

- Sortable database of FFS payments by individual physician, ambulance supplier and other health care suppliers
  - [http://projects.wsj.com/medicarebilling/?mod=medicarein](http://projects.wsj.com/medicarebilling/?mod=medicarein)
<table>
<thead>
<tr>
<th>Provider</th>
<th>Specialty / Facility type</th>
<th>City</th>
<th>State / Country</th>
<th>Total Medicare payments</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACadian Ambulance Service, Inc.</td>
<td>Ambulance Service Supplier</td>
<td>LAFAYETTE</td>
<td>LA.</td>
<td>$59,727,485.19</td>
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<tr>
<td>Rocky Mountain Holdings LLC</td>
<td>Ambulance Service Supplier</td>
<td>MERIDIANVILLE</td>
<td>ALA.</td>
<td>$42,894,582.64</td>
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<td>Superior Air-Ground Ambulance Service, Inc</td>
<td>Ambulance Service Supplier</td>
<td>ELMHURST</td>
<td>ILL.</td>
<td>$28,875,084.95</td>
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<tr>
<td>New York City Health and Hospitals Corp.</td>
<td>Ambulance Service Supplier</td>
<td>BROOKLYN</td>
<td>N.Y.</td>
<td>$26,172,201.32</td>
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<tr>
<td>American Ambulette &amp; Ambulance Service, Inc</td>
<td>Ambulance Service Supplier</td>
<td>PORTSMOUTH</td>
<td>OHIO</td>
<td>$25,575,204.36</td>
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<tr>
<td>American Medical Response of Connecticut Incorporated</td>
<td>Ambulance Service Supplier</td>
<td>NEW HAVEN</td>
<td>CONN.</td>
<td>$19,677,399.72</td>
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<td>American Medical Response of Massachusetts Inc</td>
<td>Ambulance Service Supplier</td>
<td>NATICK</td>
<td>MASS.</td>
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<td>County of Pinellas Board of County Commissioners</td>
<td>Ambulance Service Supplier</td>
<td>LARGO</td>
<td>FLA.</td>
<td>$16,621,078.49</td>
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<td>Los Angeles City Fire Department</td>
<td>Ambulance Service Supplier</td>
<td>LOS ANGELES</td>
<td>CALIF.</td>
<td>$16,608,734.97</td>
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<tr>
<td>Medical Transport, LLC</td>
<td>Ambulance Service Supplier</td>
<td>VIRGINIA BEACH</td>
<td>VA.</td>
<td>$16,379,950.36</td>
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</table>
## American Ambulette & Ambulance Service, Inc

**Ambulance Service Supplier**  
729 6th Street D/B/A Life | Portsmouth, Ohio

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Number performed</th>
<th>Number of Medicare patients</th>
<th>Average Medicare reimbursement per procedure</th>
<th>Total Medicare payments for procedure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ambulance service, basic life support, non-emergency transport, (bls)</td>
<td>41,337</td>
<td>9,519</td>
<td>$161.41</td>
<td>$6,672,205</td>
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<tr>
<td>Equipment and services CODE: A0425-F</td>
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<td></td>
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<tr>
<td>Ground mileage, per statute mile</td>
<td>635,388</td>
<td>14,885</td>
<td>$6.36</td>
<td>$4,041,068</td>
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<tr>
<td>Equipment and services CODE: A0425-F</td>
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<tr>
<td>Ambulance service, advanced life support, emergency transport, level 1 (als1-emergency)</td>
<td>4,632</td>
<td>3,875</td>
<td>$307.65</td>
<td>$1,425,035</td>
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<td>Equipment and services CODE: A0427-F</td>
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<tr>
<td>Ambulance service, basic life support, emergency transport (bls-emergency)</td>
<td>5,398</td>
<td>4,209</td>
<td>$257.28</td>
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<tr>
<td>Ambulance service, advanced life support, non-emergency transport, level 1 (als1)</td>
<td>1,410</td>
<td>1,128</td>
<td>$191.71</td>
<td>$270,311</td>
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<td>Equipment and services CODE: A0426-F</td>
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</tbody>
</table>
## Provider's Services in Detail

Services for which Medicare was reimbursed by Medicare:

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Number performed</th>
<th>Number of Medicare patients</th>
<th>Average Medicare reimbursement per procedure</th>
<th>Total Medicare payments for procedure</th>
</tr>
</thead>
<tbody>
<tr>
<td>ALSI-emergency</td>
<td>475</td>
<td>301</td>
<td>$381.68</td>
<td>$181,298.00</td>
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<td>Equipment and services CODE: A0427-F</td>
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</tr>
<tr>
<td>Ground mileage</td>
<td>14,394</td>
<td>390</td>
<td>$6.54</td>
<td>$94,136.76</td>
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<td>Equipment and services CODE: A0425-F</td>
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<tr>
<td>Als 1</td>
<td>162</td>
<td>148</td>
<td>$243.78</td>
<td>$39,492.36</td>
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</tr>
</tbody>
</table>

Showing 1 to 3 of 3 entries

Previous 1 Next
Why is Dialysis Different?
Medicare Paid

2007 2008 2009 2010 2011 2012 2013

Medicare Paid $
OIG Report on Utilization

• Between 2002 – 2011:
  – 269% increase in dialysis transports
  • 85% increase in number of ESRD patients transported by ambulance
OIG REPORT ON UTILIZATION

• Between 2002 – 2011:
  – 69% increase in Part B ambulance transports
  – 34% increase in number of beneficiaries requiring ambulance transport
  – 26% increase in number of ambulance suppliers
    • ~ 100% increase in number of BLS-NE suppliers
  – 829% increase in transports to partial hospitalization programs
Key Findings:

• Number of ambulance providers has grown steadily since 2007

• Ambulance volume increased by 10% from 2007 to 2011
  • Most of increase in volume was from increase in BLS-NE
  • Dialysis in particular
  • Increase centered in urban areas
Rapid increase in dialysis-related transports and inappropriate billing for non-emergency transports

Ambulance spending per dialysis beneficiary by state, 2009

Source: United States Renal Data Systems, 2009. Average ambulance spending by state per beneficiary hemodialysis year

Data are preliminary and subject to change
City of Brotherly Love

- Since 2011, an ongoing Medicare Task Force in the Philadelphia metropolitan area has investigated 8 ambulance companies in connection with billing improprieties related to the transportation of dialysis patients
  - 30 arrests
  - 22 convictions
    - Total of more than 60 years in prison terms
TEMPORARY MORATORIUM ON NEW ENROLLMENTS

• On July 26, 2012, CMS announced a temporary moratorium on enrollment of new ground ambulance suppliers in Houston and surrounding counties
• Response to wide-spread fraud and abuse
• Key findings:
  – 26 counties in US with more than 200,000 Medicare beneficiaries
    • On average, there is less than 1 ambulance supplier for every 10,000 Medicare beneficiaries in these counties
    • 9.5 ambulance supplier per 10,000 Medicare beneficiaries in Harris County, Texas (Houston)
    • 275 active ambulance suppliers in Harris County
      – Two-thirds have not been billing continuously since 2008
TEMPORARY MORATORIUM ON NEW ENROLLMENTS

• On February 4, 2014, CMS announced that it was extending the moratorium on new ambulance enrollments in Houston metropolitan area for another 6 months
  – Through December 31, 2015

• New temporary moratorium on enrollment of new ambulance suppliers for Philadelphia metropolitan area
  – Further extended through December 31, 2015
Future of Dialysis

- Future Congressional Action
  - Further reductions to Fee Schedule Payments
    - Nothing currently proposed for 2014
  - Cap on number of covered ambulance trips
    - Per patient per year
    - Similar to physical therapy caps
  - Possible expansion of dialysis payment bundle
  - “Safe harbors” to induce dialysis facilities to transport their own patients

- Increase in Enforcement Activity
Case Study: Texas Dialysis

“In 2007, Medicare paid $38 million per year to Texas ambulance suppliers related to excess services per beneficiary, compared to services per beneficiary in the remainder of the U.S. Audit findings…show that much of the excess is not justifiable based on the patients’ conditions.”
Texas Dialysis

![Bar graph showing allowed numbers from 2007 to 2013. The allowed numbers decrease from 2007 to 2013.]

- 2007: 600,000
- 2008: 550,000
- 2009: 500,000
- 2010: 450,000
- 2011: 400,000
- 2012: 350,000
- 2013: 300,000
Case Study: Puerto Rico

“FCSO quickly identified an extreme data anomaly related to non-emergency ambulance services provided in Puerto Rico and the U.S. Virgin Islands. More specifically, our analysis of paid claims data for procedure code A0428 – ambulance service, basic life support, non-emergency transport (BLS), revealed that utilization in Puerto Rico for this procedure code was over 1,000 percent higher than the rest of the United States.”
Puerto Rico – Dialysis

Medicare Paid $ 

- 2009: $60,000,000
- 2010: $0

Medicare Paid $
On May 22, 2014, CMS announced that it was implementing a prior authorization process for dialysis transports in 3 states:

- New Jersey
- Pennsylvania
- South Carolina

Prior authorization required for claims to be paid:

- Alternative is 100% prepayment review
Expansion of Prior Authorization Program

- Medicare Access and CHIP Reauthorization Act
  - Pub. Law (114-10)
  - April 16, 2015

- Expands Prior Authorization Project to:
  - DC, DE, MD, NC, VA, WV (2016)
  - All Remaining States (2017)