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Medicare Update

Brian S. Werfel, Esq.

November 1, 2015

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2013 Medicare Payment Data

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FY 2013 National Data

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

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National Data

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

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National Data

	Description	2013 Paid $	2012 Paid $	% Change
A0425	Ground Mileage	864,339,277	$861,277,845	0.36%
A0426	ALS Non-Emergency	66,422,692	$64,860,566	2.41%
A0427	ALS Emergency	1,615,499,541	$1,630,257,405	- 0.91%
A0428	BLS Non-Emergency	1,182,578,453	$1,178,364,961	0.36%
A0429	BLS Emergency	758,337,761	$753,395,553	0.66%
A0430	Fixed Wing	35,462,990	$33,298,889	6.50%
A0431	Helicopter	201,690,114	$211,489,526	- 4.63%
A0432	Paramedic Intercept	908,676	$894,878	1.54%
A0433	ALS-2	52,420,103	$52,855,918	- 0.82%
A0434	Specialty Care Transport	61,021,808	$60,263,801	1.26%
A0435	Fixed Wing Mileage	18,185,274	$17,090,963	6.40%
A0436	Helicopter Mileage	81,690,492	$84,621,519	- 3.46%
Totals		**4,938,557,181**	**$4,948,671,824**	**- 0.20%**

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National Dialysis

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

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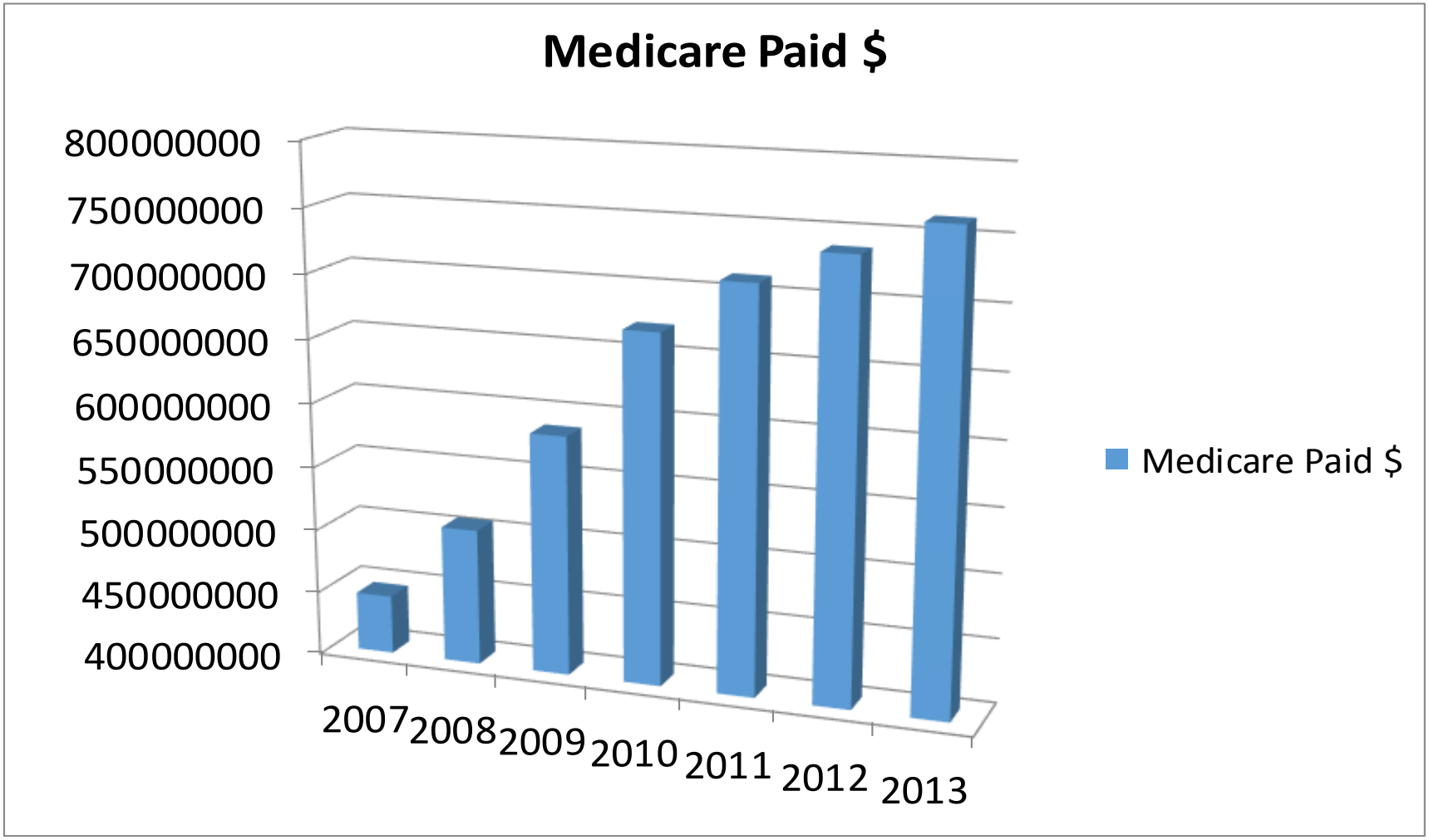
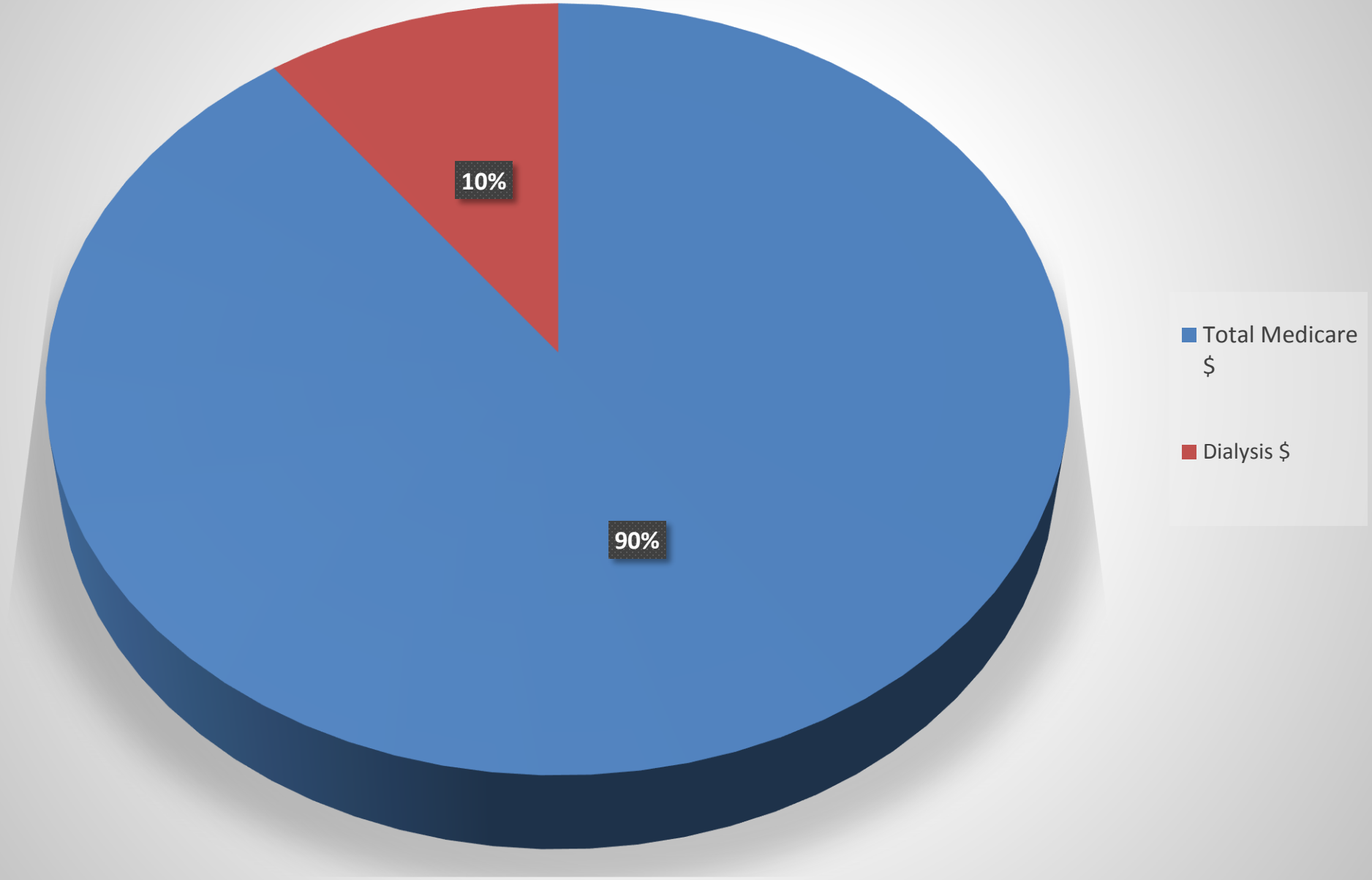
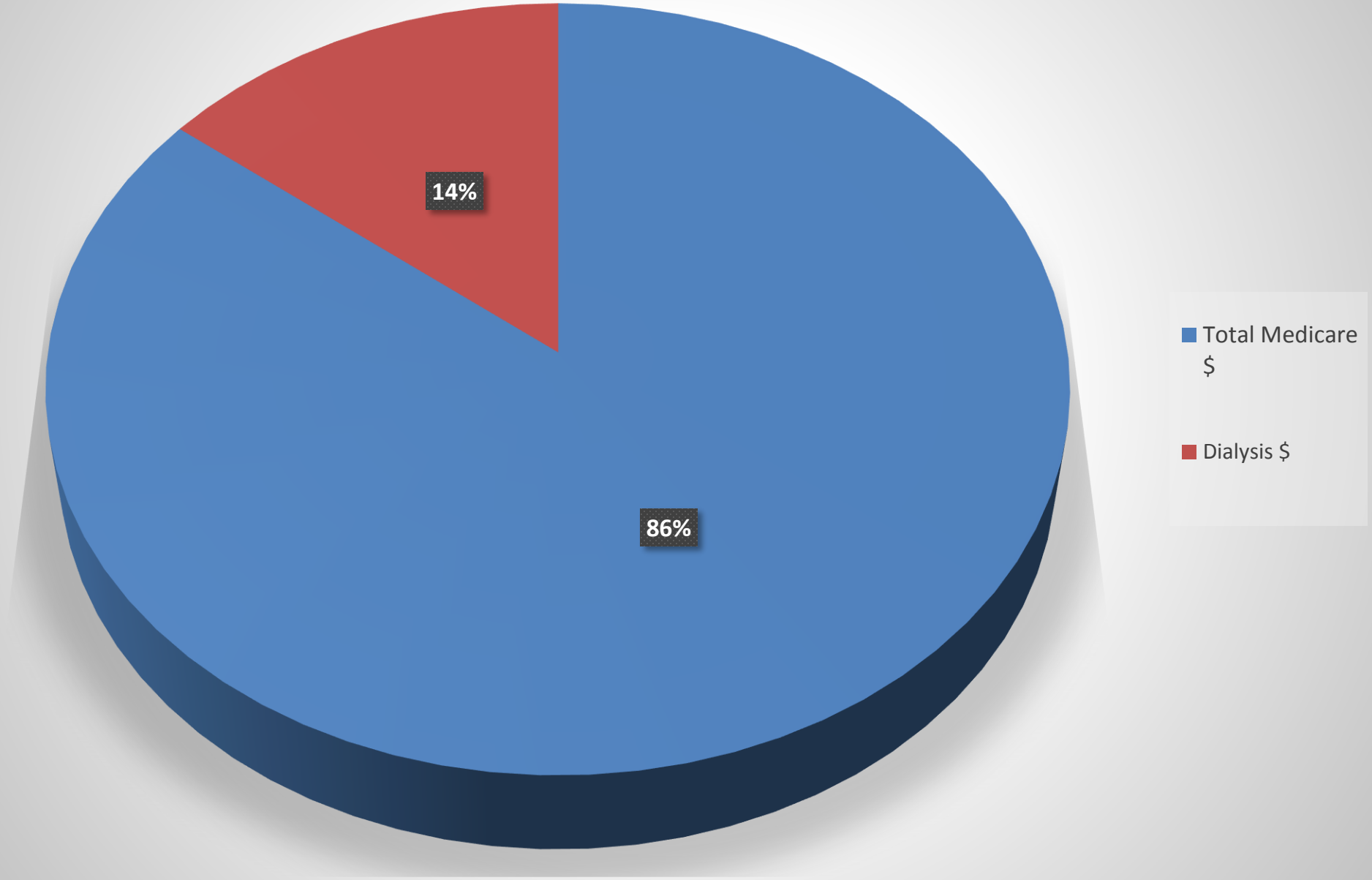


2007 Medicare Paid $



2013 Medicare Paid $



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2016 Medicare Ambulance Fee Schedule

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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

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2016 Inflation Update

AIF = CPI-U – MFP

CPI-U = 0.12%

MFP = 0.6% (2015)

Projected 2016 AIF = - 0.5%

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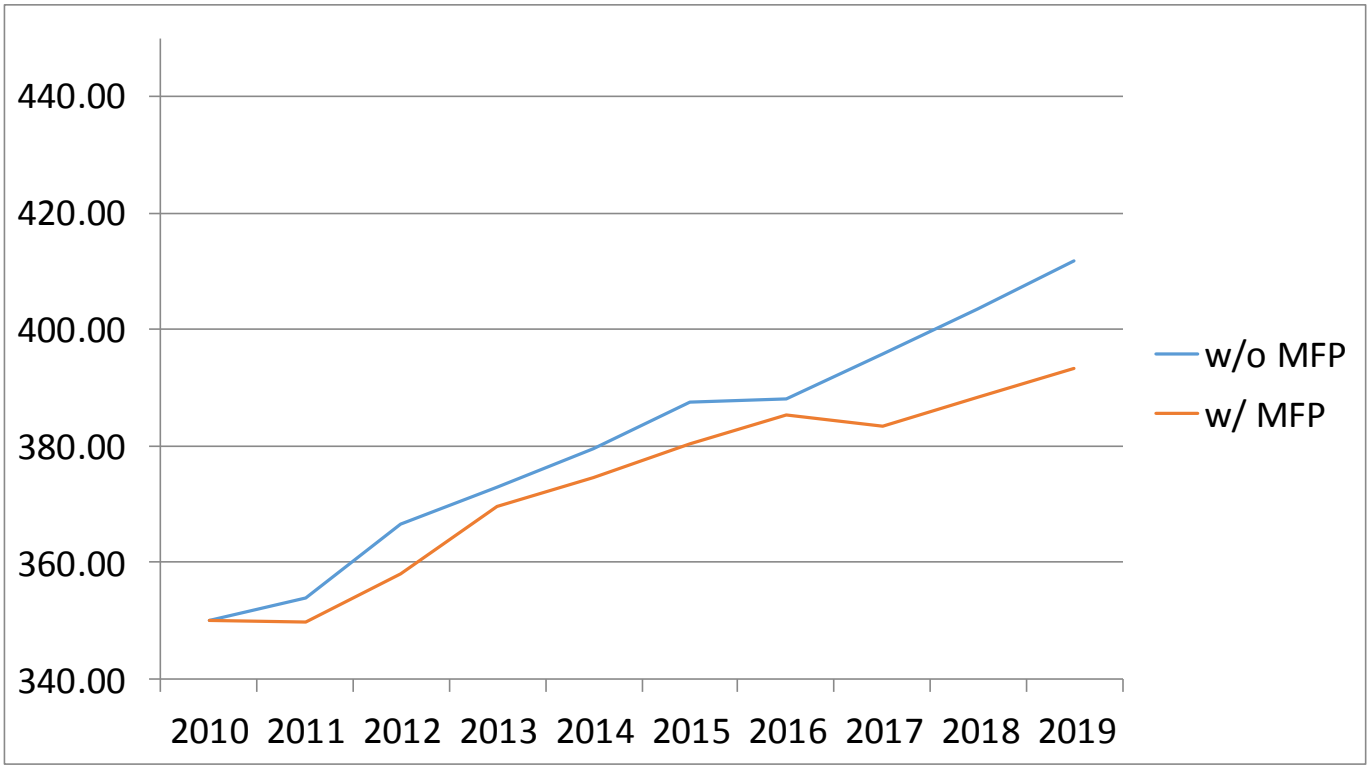
Impact of MFP on Future Updates



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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"

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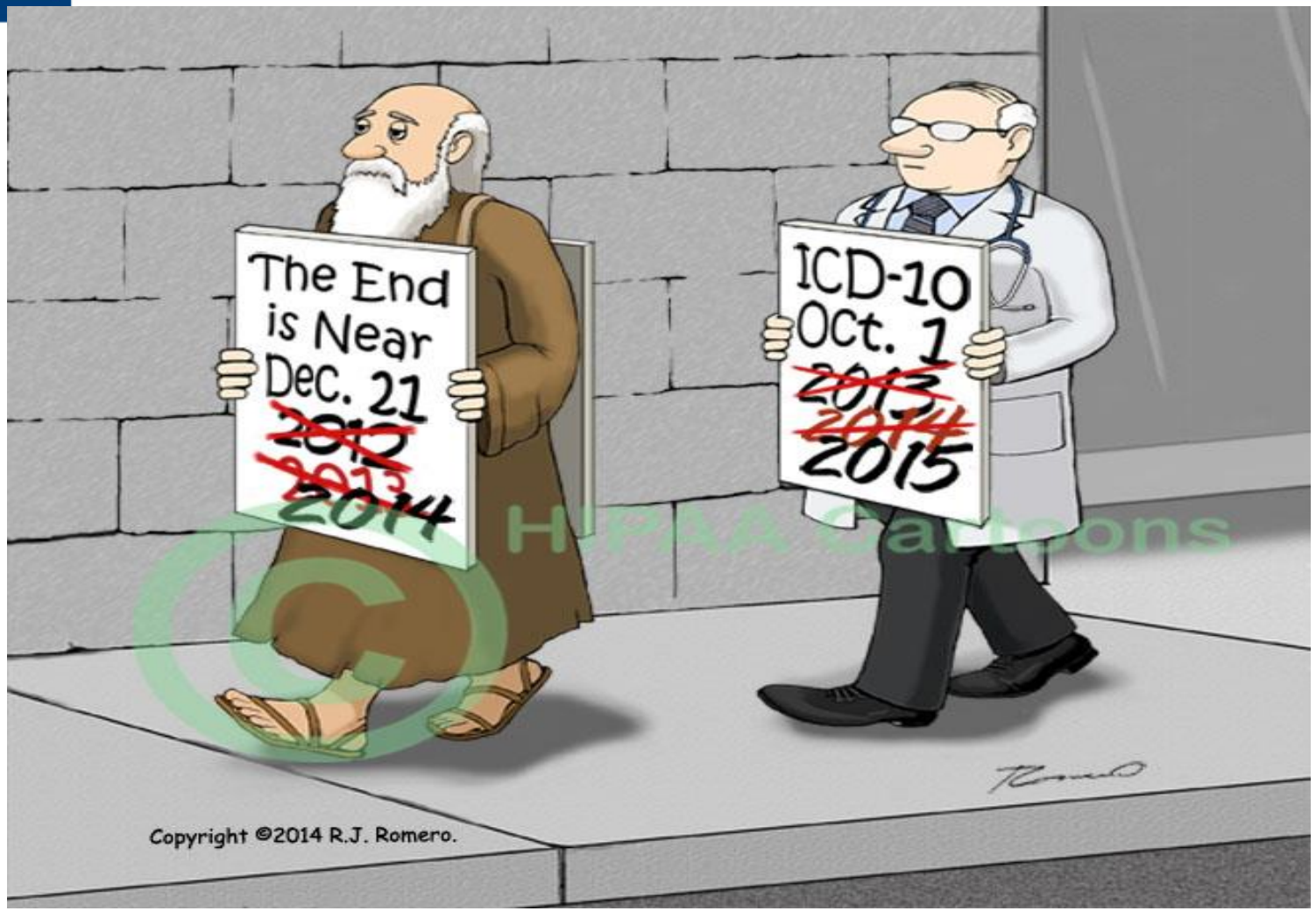

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CMS Notice RE: Condition Codes

- 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

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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
  - 1000+ pages

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Animal Bites,other
*Primary code

870.0 Laceration of skin of eyelid and periocular area	**S01.111A** Laceration without foreign body of right eyelid and periocular area, initial encounter **S01.112A** Laceration without foreign body of left eyelid and periocular area, initial encounter **S01.119A** Laceration without foreign body of unspecified eyelid and periocular area, initial encounter **S01.121A** Laceration with foreign body of right eyelid and periocular area, initial encounter **S01.122A** Laceration with foreign body of left eyelid and periocular area, initial encounter **S01.129A** Laceration with foreign body of unspecified eyelid and periocular area, initial encounter **S01.131A** Puncture wound without foreign body of right eyelid and periocular area, initial encounter **S01.132A** Puncture wound without foreign body of left eyelid and periocular area, initial encounter **S01.139A** Puncture wound without foreign body of unspecified eyelid and periocular area, initial encounter **S01.141A** Puncture wound with foreign body of right eyelid and periocular area, initial encounter **S01.142A** Puncture wound with foreign body of left eyelid and periocular area, initial encounter **S01.149A** Puncture wound with foreign body

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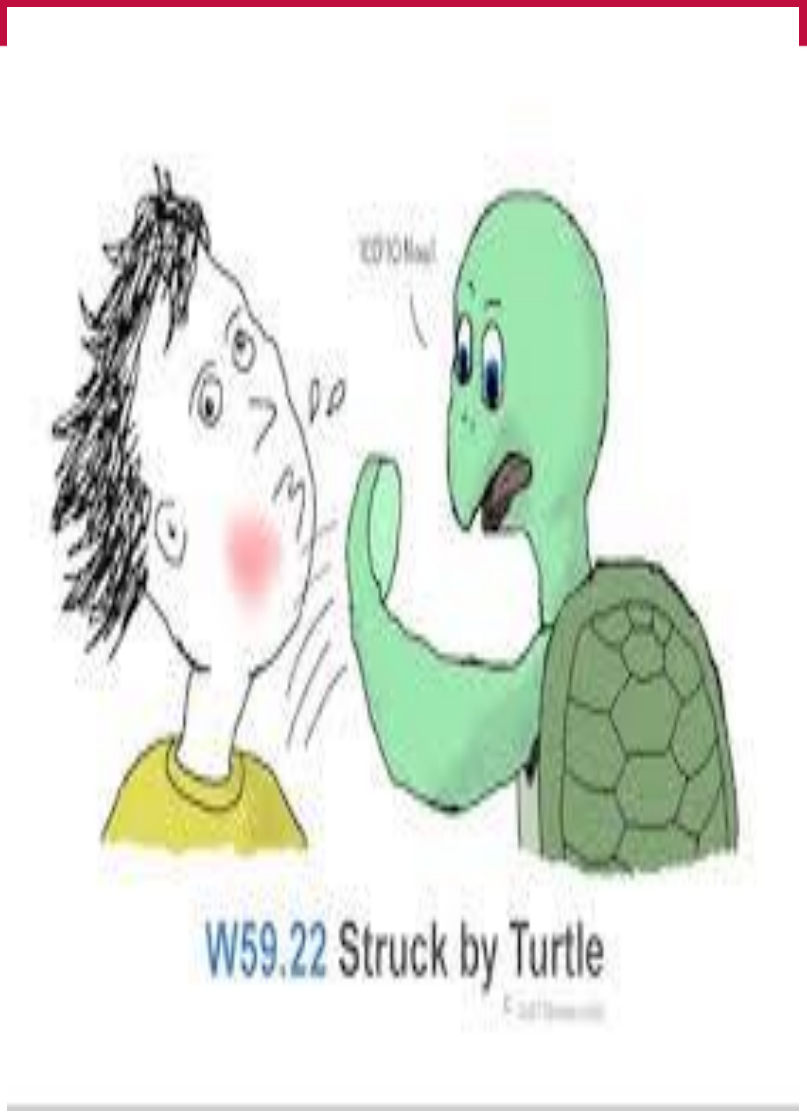


SPACECRAFT CRASH
INJURING OCCUPANT
KNOW THE CODE: V95.41XA


Burn due to water-skis on fire?
There's a code for that!
ICD-10 V91.07XA
INTELICODE


Stabbed while Crocheting
(ICD10) -Y93D1
Don't
bother me
while I crochet.
www.medicalbillersandcoders.com
Call Now 888 357 3226


Knitting accident?
There's a code for that!
(ICD-9) E012.0
INTELICODES


Murdered Snowman?
There's a code for that!
(ICD-10) Y02.8xxA
INTELICODE


Afraid of the Easter Bunny?
There's a code for that!
(ICD-10) F40.218
INTELICODE

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What Else is New?

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CMS Rule on Overpayments

- 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

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AIR AMBULANCE LEGISLATION

- 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

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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

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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**

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MEDICARE ACCESS AND CHIP REAUTHORIZATION ACT

- 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

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MEDICARE ENROLLMENT APPLICATION

Clinics/Group Practices
and Certain Other Suppliers

CMS-855B

DECEMBER 5, 2014
FINAL RULE

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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

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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

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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

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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

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NEW FROM THE OIG

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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

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Table 4: Questionable Billing Among Ambulance Suppliers, First Half of 2012

Measure of Questionable Billing	Median Among All Suppliers	Suppliers That Had Questionable Billing	
		Threshold	Number of Suppliers
No Medicare Service at the Origin or Destination	0 transports	3%	2,038
Excessive Mileage for Urban Transports	10 miles	34 miles	642
High Number of Transports per Beneficiary[1]	4 transports	21 transports	533
Compromised Beneficiary Number	1%	7%	358
Inappropriate or Unlikely Transport Level	<1%	3%	268
Beneficiary Sharing[1, 2]	1.2 suppliers	2.3 suppliers	168
Transports to or From PHPs	0 transports	<<1%[3]	127

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.

Source: OIG analysis of Part B data for Medicare ambulance services, 2013.

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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

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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"

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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

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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

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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

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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

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The Latest From the SCOTUS

King v. Burwell

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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

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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
0
THUNDERDOME
1. WE ARE ALWAYS FIGHT
2. FIND YOUR OWN OPPONENT
3. SIGN UP TO FIGHT
4. START AND STOP WHEN TOLD
5. FIGHT LAST AS LONG AS WE SAY
DON'T BITCH

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SCOTUS Decision

- 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

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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

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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 provides so that care and services are available' to Medicaid recipients just as they are to the general population"

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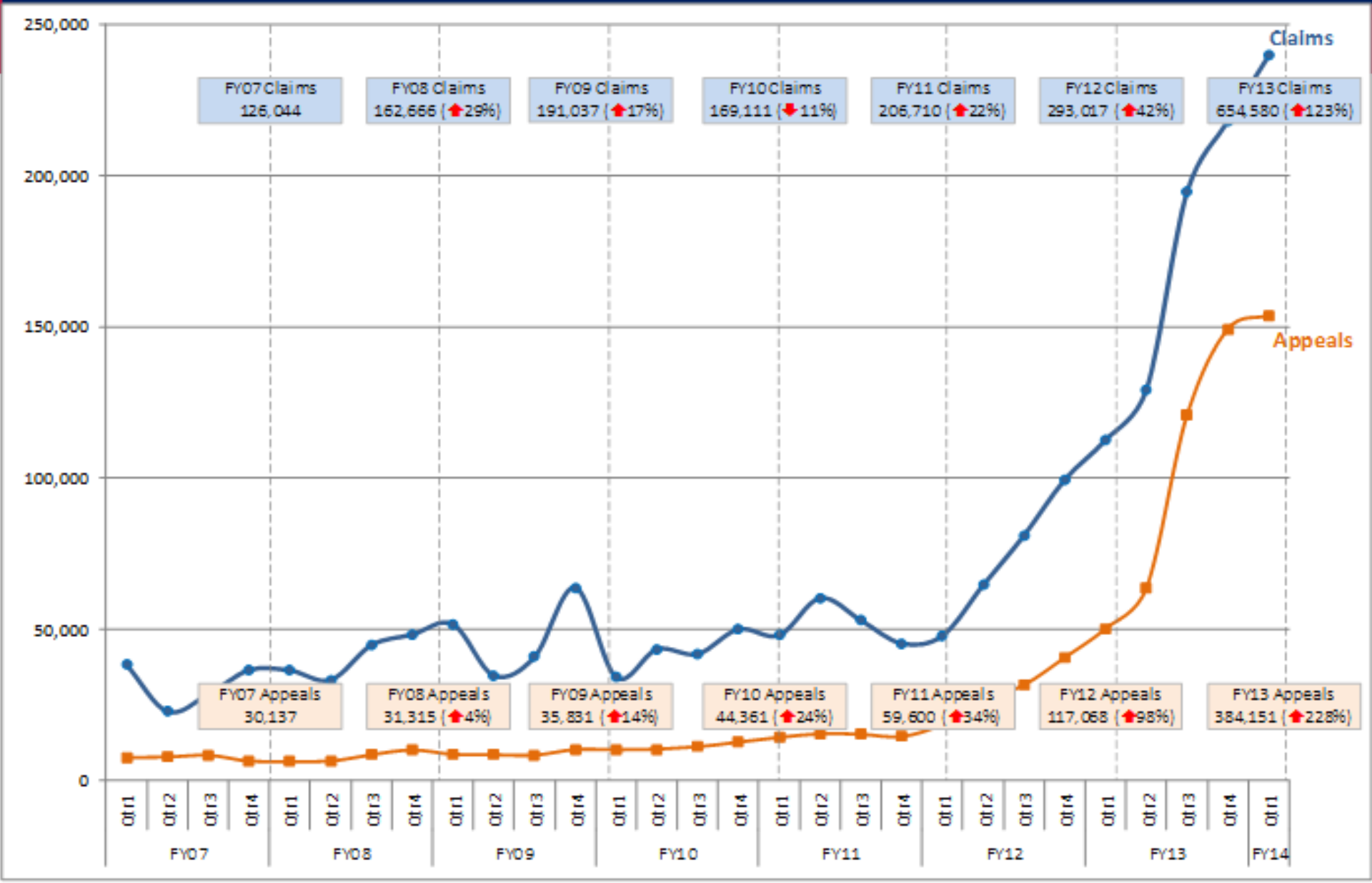
Medicare Appeals Process

Quarterly Receipts



epresents cases with Request for Hearing Date in listed year

Excludes reopened and combined appeals

Y14 receipts may be incomplete due to data entry backlog. Receipts complete as of January 2014.

Run Date: July 7, 201

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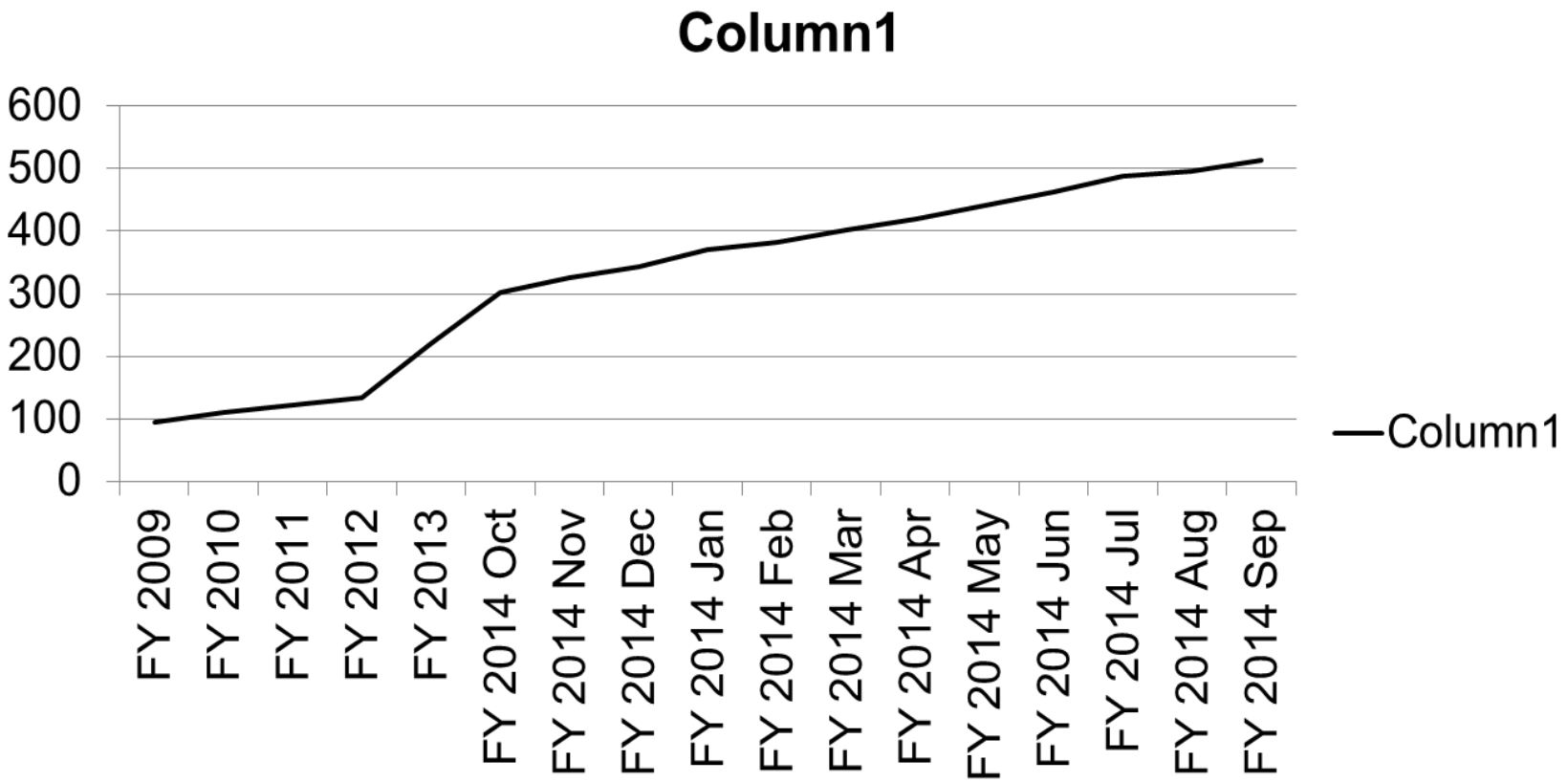
ALJ Avg. Processing Times



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ALJ Decisions

	FY 2012	FY 2013	FY 2014 (Through Aug)
Fully Favorable	53.2%	44.3%	36.5%
Partially Favorable	6.4%	5.2%	2.8%
Unfavorable	27.9%	25.5%	29.8%
Dismissed	12.5%	25.0%	30.9%

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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

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ALJ Settlement Conferences

- 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

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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

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Recent Trends In Fraud & Abuse

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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

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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

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City of Dallas to Pay $2.47 Million to Resolve Allegations That it Caused Improper Medicare and Medicaid Ambulance Claims - Google Chrome

www.justice.gov/usao/txn/PressRel11/dallas_ambulance_settle_pr.html

Apps | Online ICD9/ICD9C... | FDsys - Browse Fede... | HIPAA Regs | FDsys - Browse Cod... | IOM 100-02, Chap. 10 | IOM, 100-04, Chap 15 | (J12) LCD L32252 - A... | Medicare Payments ... | Obamacare Pricing

U.S. Department of Justice

United States Attorney James T. Jacks
Northern District of Texas

FOR IMMEDIATE RELEASE
TUESDAY, JUNE 7, 2011
http://www.usdoj.gov/usao/txn/

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.

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"Operation Broken Trust" Northern District of Texas - Google Chrome

www.justice.gov/usao/txn/PressRel11/ambulance_all_settle_pr.html

Apps | Online ICD9/ICD9C... | FDsys - Browse Fede... | HIPAA Regs | FDsys - Browse Cod... | IOM 100-02, Chap. 10 | IOM, 100-04, Chap 15 | (J12) LCD L32252 - A... | Medicare Payments ... | Obamacare Pricing | "Operation Broken T...

U.S. Department of Justice

United States Attorney James T. Jacks
Northern District of Texas

FOR IMMEDIATE RELEASE
TUESDAY, AUGUST 23, 2011
http://www.usdoj.gov/usao/txn/

MEDIA INQUIRIES: KATHY COLVIN

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 "upcoded" 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

Part B Payment

- 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

Provider	Specialty / Facility type	City	State / Country	Total Medicare payments ▼
+ ACADIAN AMBULANCE SERVICE, INC.	Ambulance Service Supplier	LAFAYETTE	LA.	$59,727,485.19
+ ROCKY MOUNTAIN HOLDINGS LLC	Ambulance Service Supplier	MERIDIANVILLE	ALA.	$42,894,582.64
+ SUPERIOR AIR-GROUND AMBULANCE SERVICE, INC	Ambulance Service Supplier	ELMHURST	ILL.	$28,875,084.95
+ NEW YORK CITY HEALTH AND HOSPITALS CORP.	Ambulance Service Supplier	BROOKLYN	N.Y.	$26,172,201.32
+ AMERICAN AMBULETTE & AMBULANCE SERVICE, INC	Ambulance Service Supplier	PORTSMOUTH	OHIO	$25,575,204.36
+ AMERICAN MEDICAL RESPONSE OF CONNECTICUT INCORPORATED	Ambulance Service Supplier	NEW HAVEN	CONN.	$19,677,399.72
+ AMERICAN MEDICAL RESPONSE OF MASSACHUSETTS INC	Ambulance Service Supplier	NATICK	MASS.	$19,385,977.15
+ COUNTY OF PINELLAS BOARD OF COUNTY COMMISSIONERS	Ambulance Service Supplier	LARGO	FLA.	$16,621,078.49
+ LOS ANGELES CITY FIRE DEPARTMENT	Ambulance Service Supplier	LOS ANGELES	CALIF.	$16,608,734.97
+ MEDICAL TRANSPORT, LLC	Ambulance Service	VIRGINIA BEACH	VA.	$16,379,950.36

AMERICAN AMBULETTE & AMBULANCE SERVICE, INC

2012 2013

Ambulance Service Supplier
729 6TH STREET D/B/A LIFE | PORTSMOUTH, OHIO

$14,051,114
Change 2012-13: **-45.06%**

Procedure	Number performed	Number of Medicare patients	Average Medicare reimbursement per procedure	Total Medicare payments for procedure ▾
Ambulance service, basic life support, non-emergency transport, (bls) *Equipment and services* CODE: A0428-F	41,337	9,519	$161.41	**$6,672,205**
Ground mileage, per statute mile *Equipment and services* CODE: A0425-F	635,388	14,885	$6.36	**$4,041,068**
Ambulance service, advanced life support, emergency transport, level 1 (als1-emergency) *Equipment and services* CODE: A0427-F	4,632	3,875	$307.65	**$1,425,035**
Ambulance service, basic life support, emergency transport (bls-emergency) *Equipment and services* CODE: A0429-F	5,398	4,209	$257.28	**$1,388,797**
Ambulance service, advanced life support, non-emergency transport, level 1 (als 1) *Equipment and services* CODE: A0426-F	1,410	1,128	$191.71	**$270,311**
Specialty care transport				

[redacted]

$314,854.42

Total Medicare payments in 2012

Provider's Services in Detail

Services for which [redacted] was reimbursed by Medicare:

Procedure	Number performed	Number of Medicare patients	Average Medicare reimbursement per procedure	Total Medicare payments for procedure ▼
ALS1-emergency *Equipment and services* CODE: A0427-F	475	301	$381.68	$181,298.00
Ground mileage *Equipment and services* CODE: A0425-F	14,394	390	$6.54	$94,136.76
Als 1 *Equipment and services* CODE: A0426-F	162	148	$243.78	$39,492.36

Showing 1 to 3 of 3 entries

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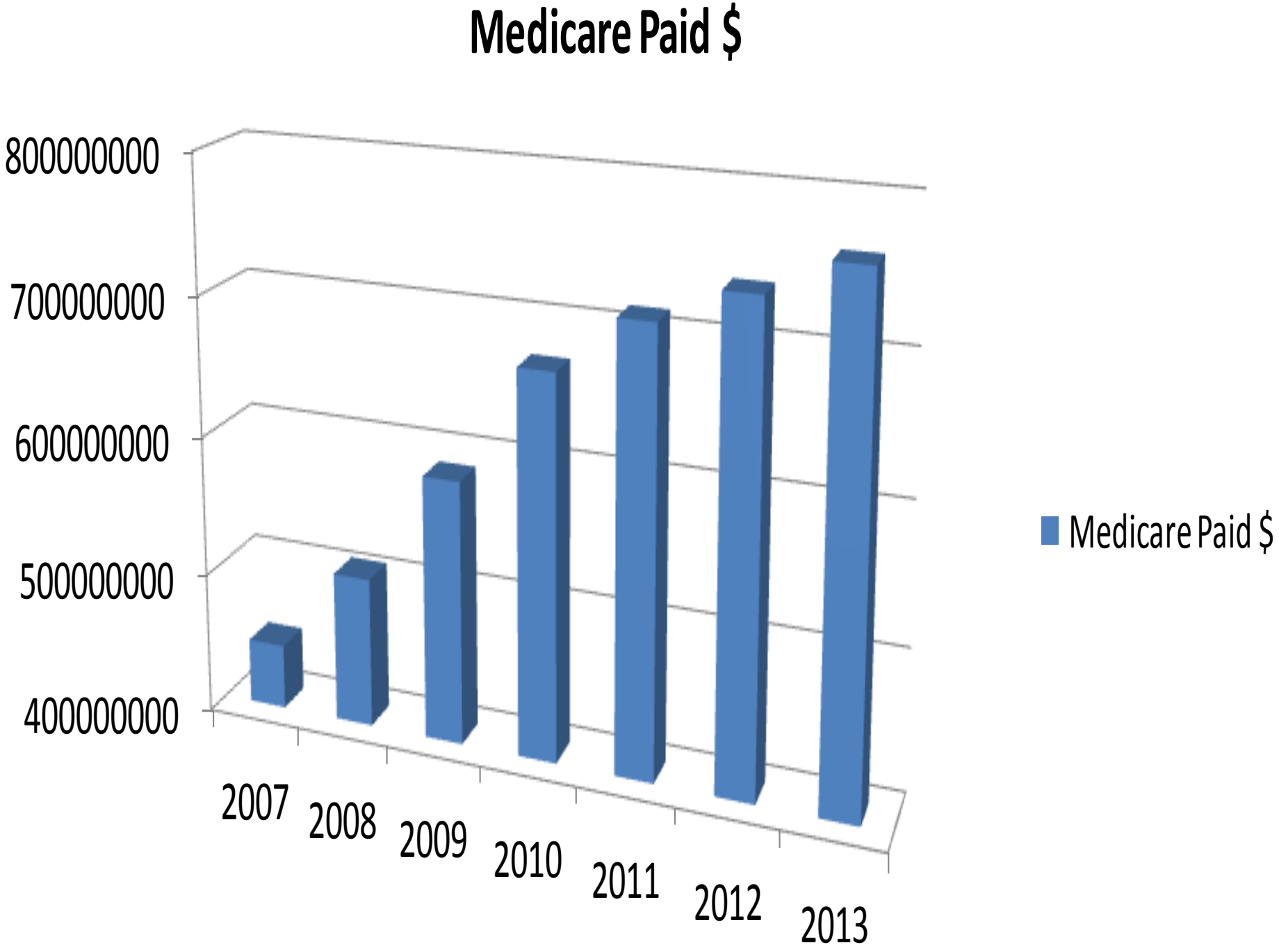
Why is Dialysis Different?


Medicare Paid $
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OIG Report on Utilization

- **Between 2002 – 2011:**
  - **269% increase in dialysis transports**
    - 85% increase in number of ESRD patients transported by ambulance

AMERICAN AMBULANCE ASSOCIATION

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**

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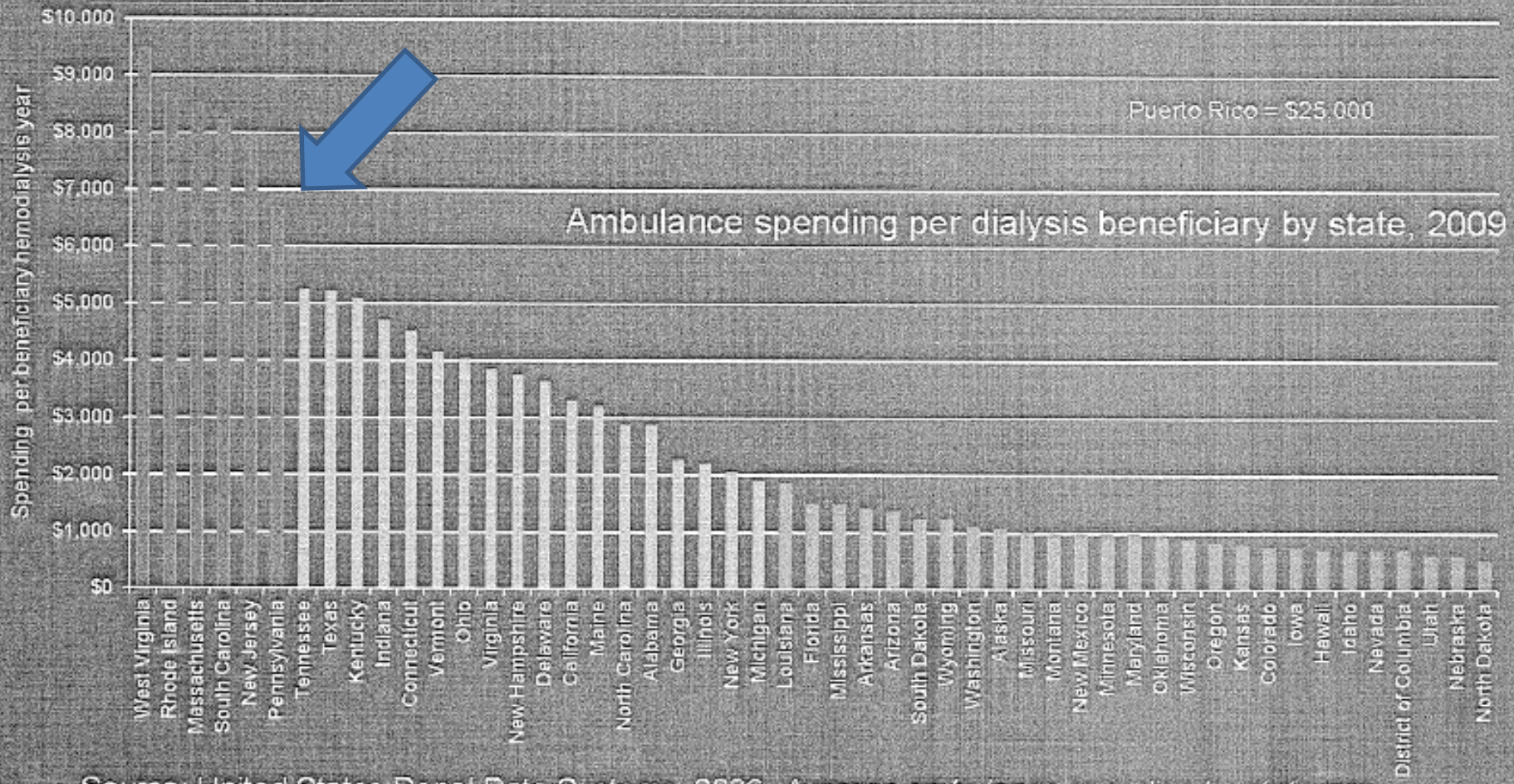
2013 MEDPAC REPORT

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



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

MEDPAC

Data are preliminary and subject to change

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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

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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

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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

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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**

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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."

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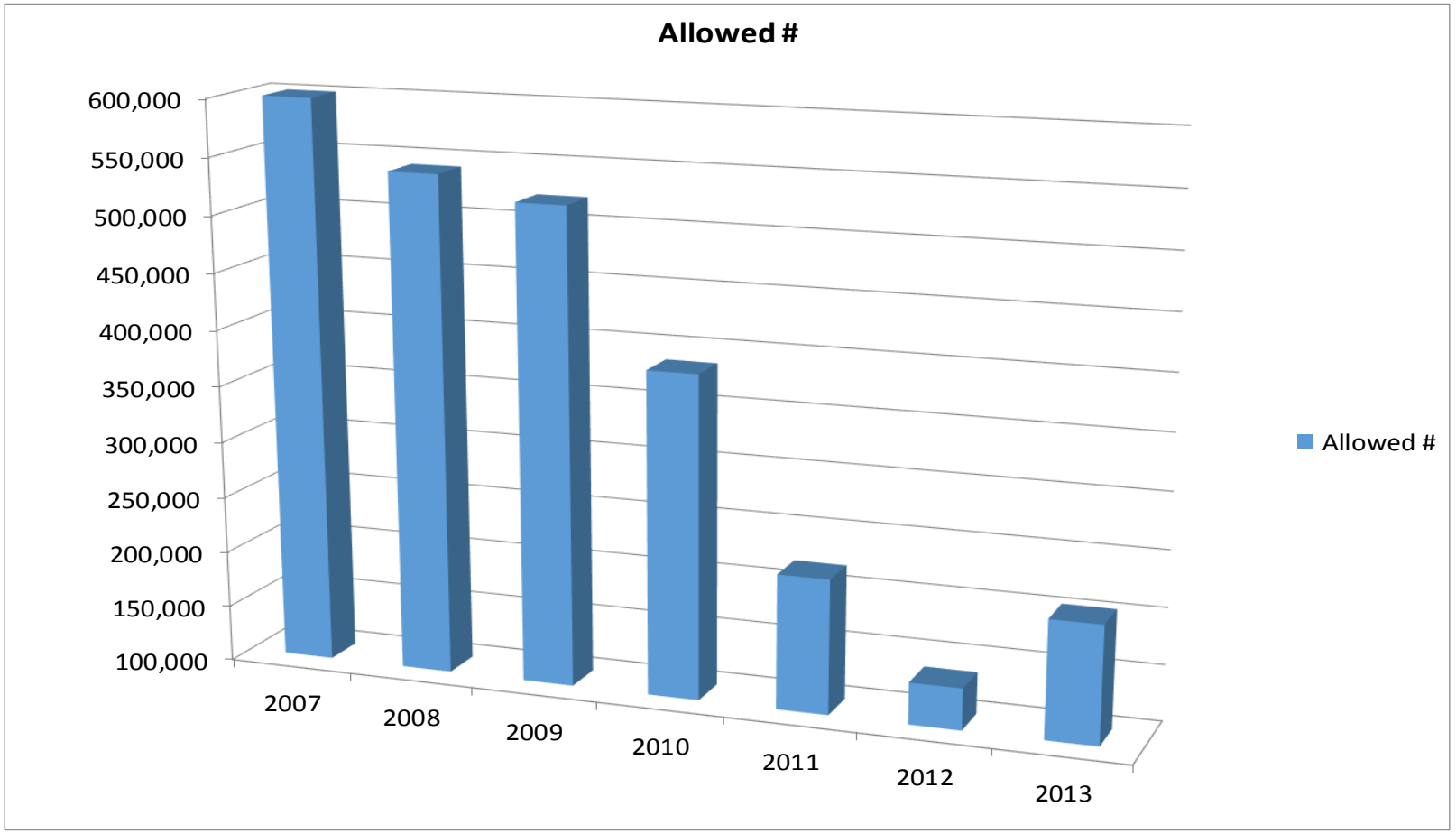
TEXAS DIALYSIS



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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."

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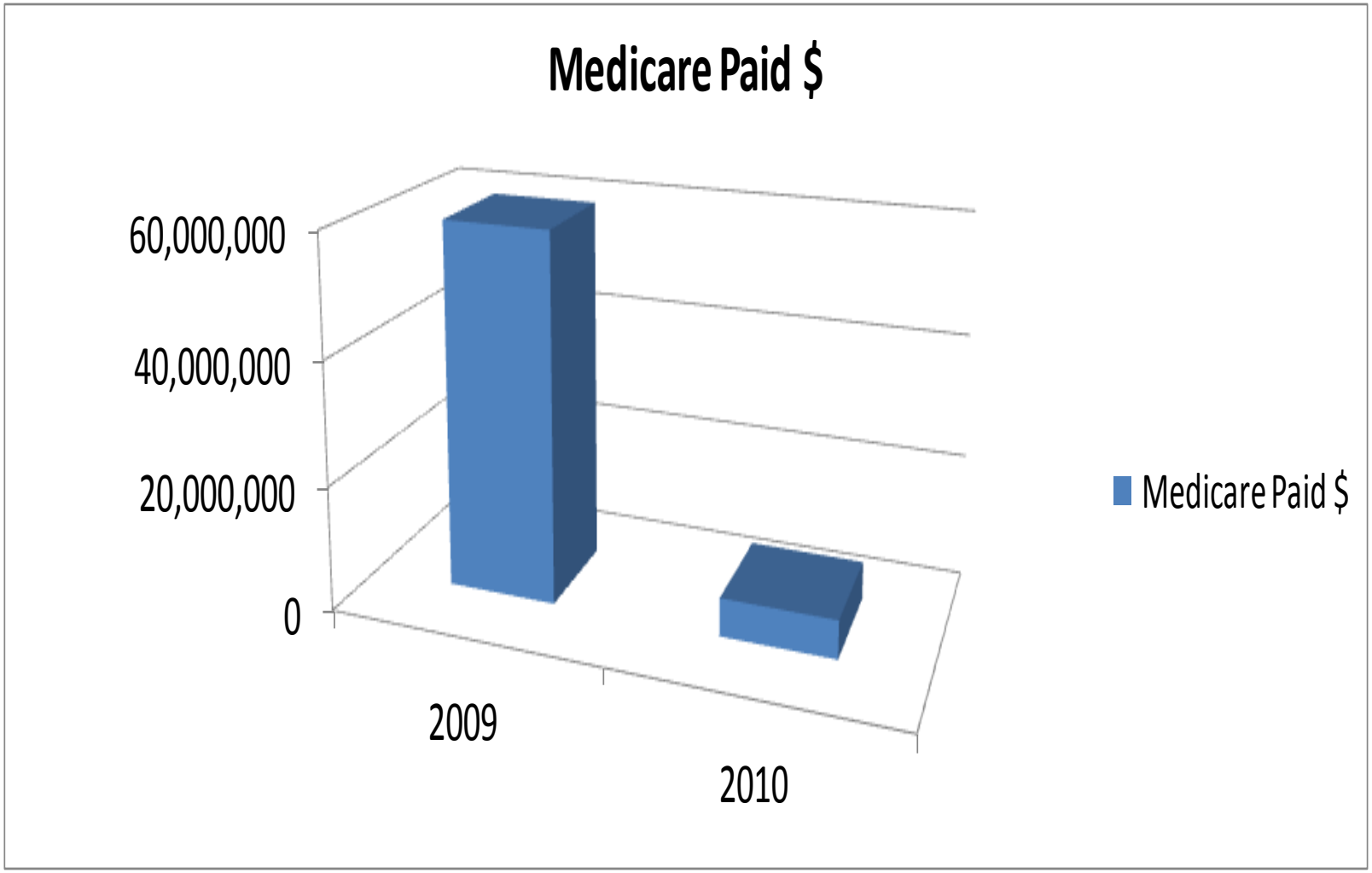
Puerto Rico – Dialysis



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Prior Authorization Demonstration Project

- 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

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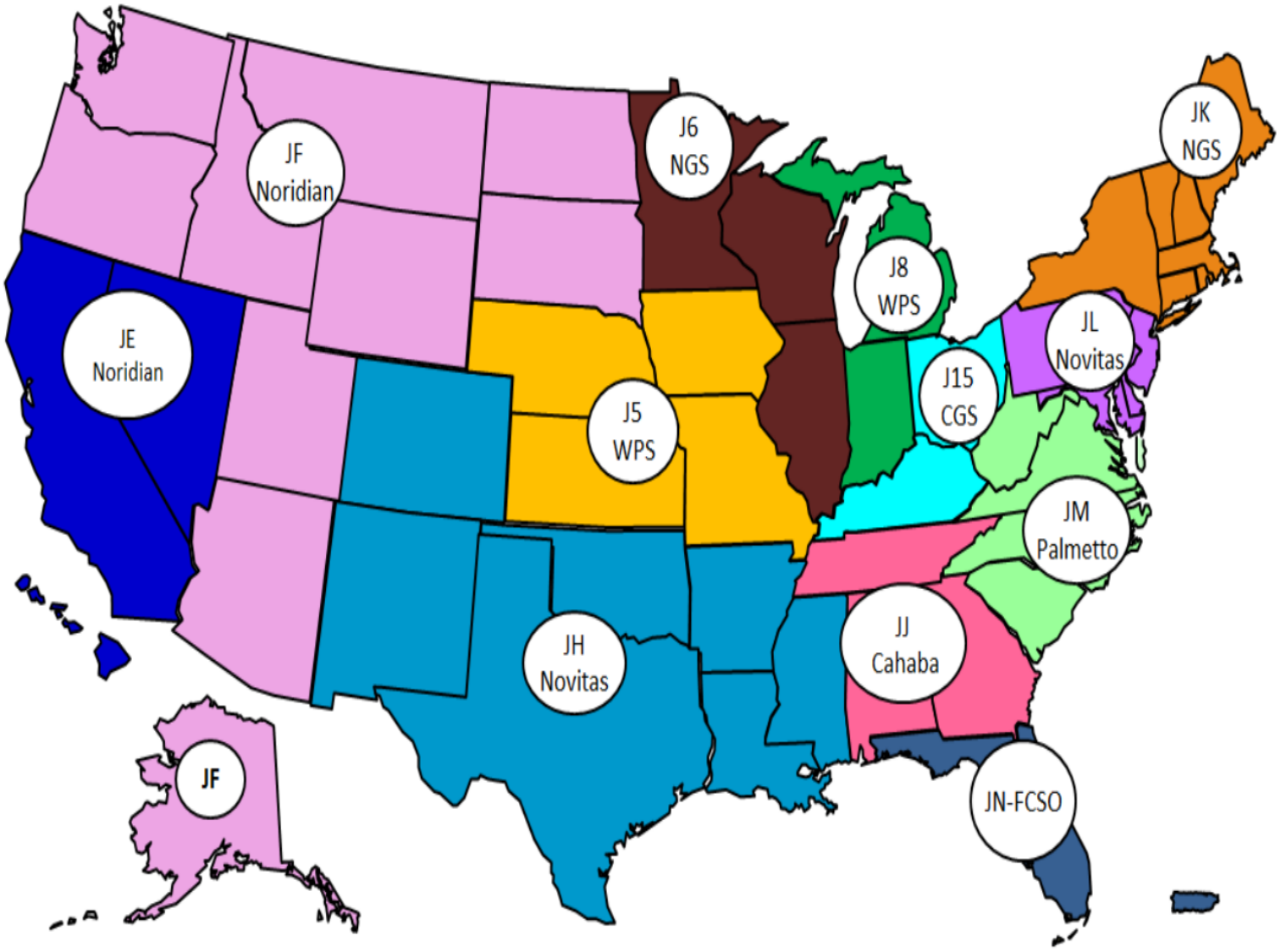
EXPANSION OF PRIOR AUTHORIZATION PROGRAM

- 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)



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Brian Werfel, Esq.
A.A.A. Medicare Consultant
631-265-5650
bwerfel@aol.com