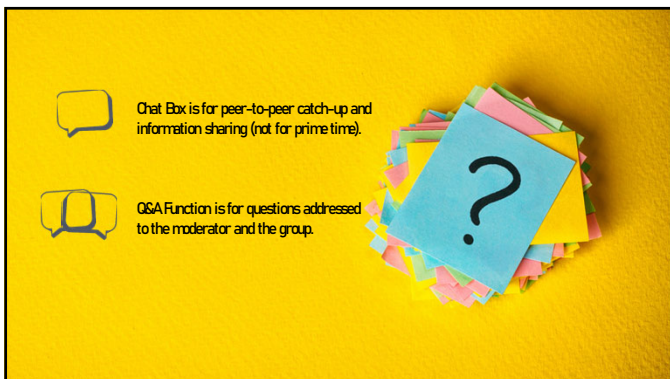





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Disclaimer

This session is intended for informational purposes only and should not be relied upon for legal, financial, or accounting advice. If you require legal, financial, or accounting advice, please seek the assistance of a licensed professional in your jurisdiction.



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Ambulance Cost Data Collection



The dashboard displays four financial statements:

- Balance sheet:** Assets (Total assets: 7,734,826), Liabilities (Total liabilities: 166,630), Equity (Total equity: 74,393).
- Equity statement:** Current year (1,774,276), Previous year (166,630).
- Income statement:** Revenues (12,872,210), Expenses (6,372,535), Net income (6,505,981).
- Cash flow statement:** Operating (12,872,210), Investing (6,372,535), Financing (6,505,981).


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Ambulance Cost Data Collection

Implementation Delay

- On May 18, 2020, CMS announced a one-year delay in the implementation of the Ambulance Cost Data Collection Process
- On December 1, 2020, CMS announced a further one-year delay
- As things stand now, the first Data Collection Period will run from January 1, 2022 to December 31, 2022
 - Apply to Year 1 and Year 2 Participants
 - Cost data must be submitted within 5 months of end of ambulance service's 12-month reporting year




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Ambulance Cost Data Collection

Year 2 Participants

- On December 18, 2020, CMS announced the list of providers selected as Year 2 Participants
- List of Year 2 Participants: <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AmbulanceFeeSchedule/Ground-Ambulance-Services-Data-Collection-System>.




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Revised Ambulance Data Collection Instrument

On July 31, 2020, CMS published a revised version of its Medicare Ground Ambulance Data Collection Instrument

- The revised version contains additional guidance and clarification on how certain data elements within the Instrument should be completed



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Emergency Triage, Treat and Transport (ET3)




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ET3 Model

- ET3 Program went live on January 1, 2021!!




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ET3 Model Billing and Payment Fact Sheet

- In March 2020, CMS issued a Billing and Payment Fact Sheet for Ambulance Suppliers and Providers (Participants) that clarifies how claims for reimbursement will be handled under the ET3 Model
- The guidance also sets forth the billing codes, destination modifiers, and other issues related to claims submissions




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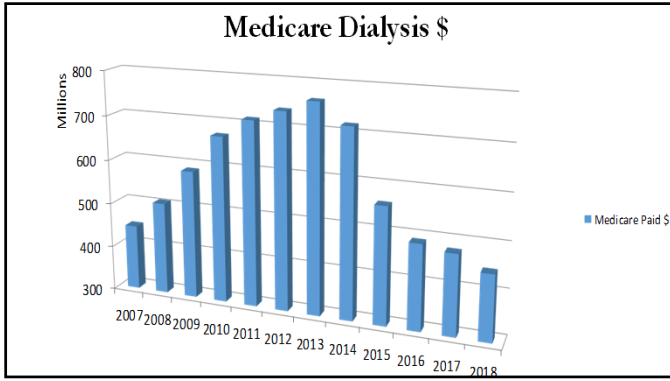
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National Expansion of Prior Authorization Program

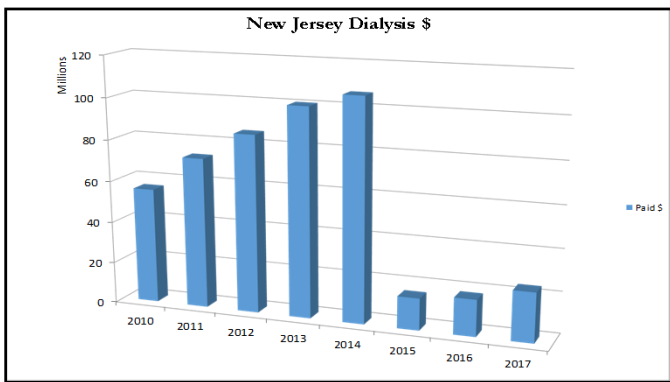
- On September 22, 2020, CMS announced that it would be expanding its Prior Authorization Model for Repetitive, Scheduled Non-Emergency Ambulance Transportation to the entire country
 - Program will follow "same design as current model"
- Timeline:
 - The program will continue uninterrupted in the 8 states and the District of Columbia where it is currently in effect
 - CMS will likely phase the program into additional states on a rolling basis
 - Minimum of 60 days prior notice before the program starts in any new state



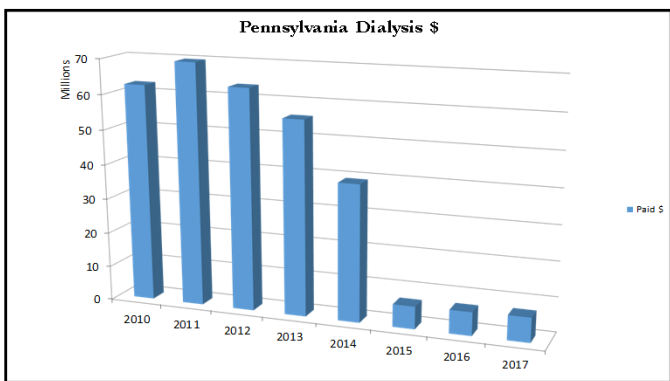
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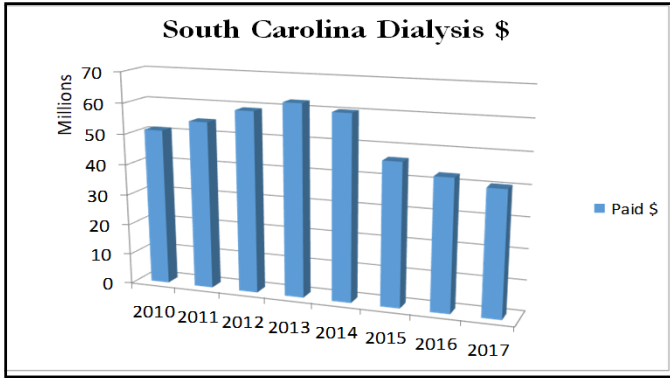
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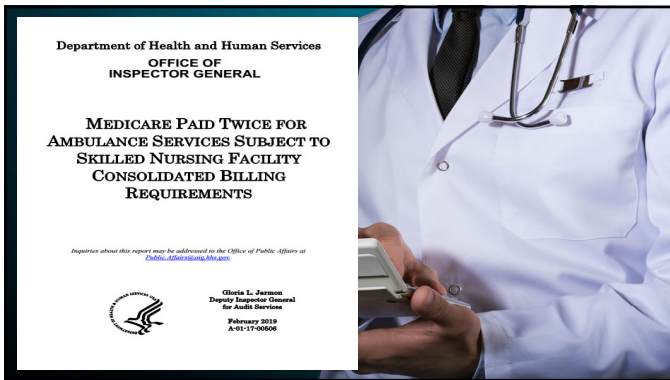
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For 78 of the 100 beneficiary days we sampled, Medicare made Part B payments that were incorrect

On the basis of our sample results....Medicare made a total of \$19.9 million in Part B overpayments

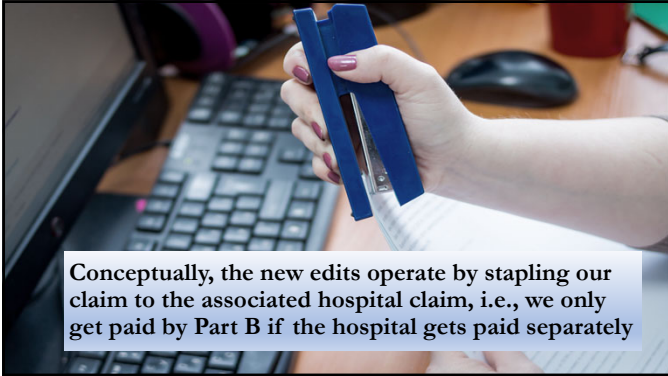
Medicare Paid Twice for Ambulance Services Subject to Skilled Nursing Facility Consolidated Billing Requirements

What OIG Found

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

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

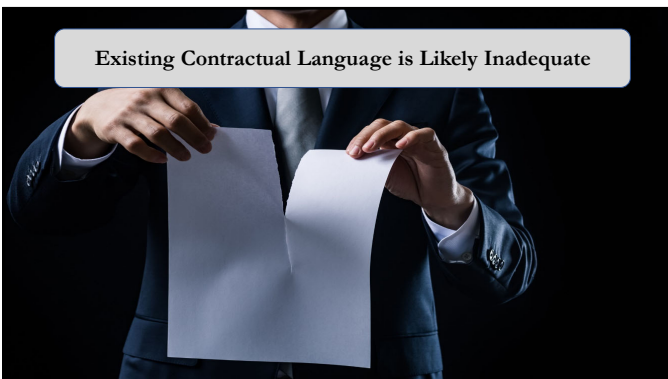
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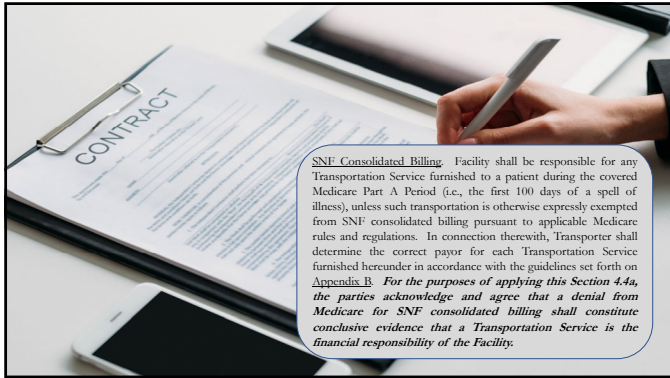
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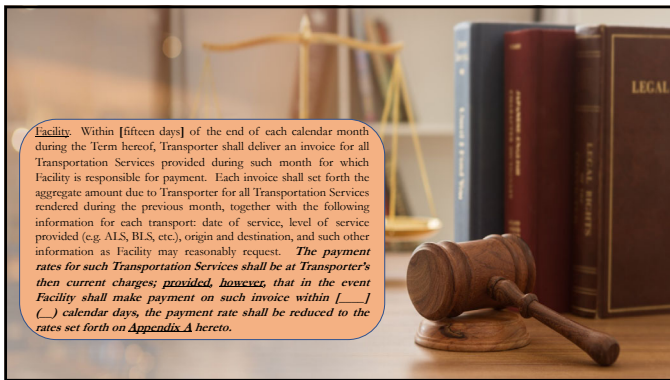
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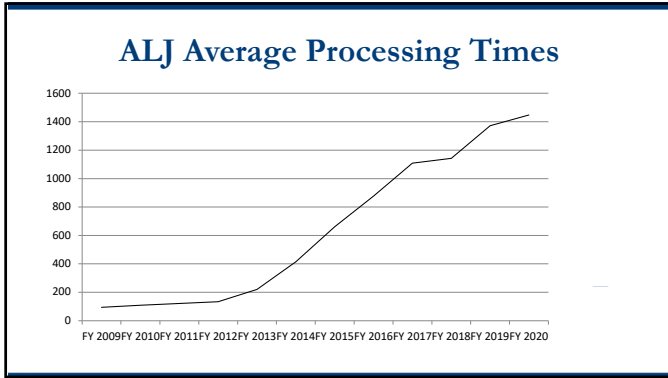
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SCF Express

- Effective June 2018, CMS began offering an expedited Settlement Conference Facilitation Process
- To qualify for SCF Express, you must:
 - Have pending appeals with billed amounts totaling less than \$100K (or an extrapolation of less than \$100K)
 - If you have appeals totaling less than \$10K, you will only be eligible for SCF Express
- In lieu of participating in a settlement conference, SCF Express participants will be offered a settlement amount from CMS
 - Settlement amount will be based on preliminary data available to CMS, including ALJ overturn rates, the type of claims or services, etc.



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PCS Changes

In the November Physician Fee Schedule Final Rule for Calendar Year 2020, CMS made some significant changes to the Medicare PCS requirement

- These are largely “cosmetic,” i.e., they do not impact when a PCS is required, or who may sign the PCS form in certain situations
- “PCS” v. “NPCS” form

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PCS Form v. NPCS Form

CMS created a formal distinction between certification statements signed by physicians and certification statements signed by other individuals

- Certification statements signed by physicians will hereinafter be referred to as “Physician Certification Statements” or “PCS forms”
- Certification statements signed by other licensures/job titles will hereinafter be referred to as “Non-Physician Certification Statements” or “NPCS forms”



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New Individuals that can sign NPCS Forms

Effective January 1, 2020, the following additional licensures are permitted to sign certification statements for non-repetitive patients (i.e., NPCS forms)

1. Licensed Practical Nurses (LPNs)
2. Case Managers
3. Social Workers



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This might be a good time to update your current PCS form to add these new licensures!!

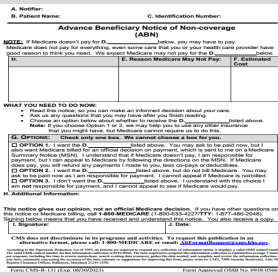


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New ABN Form

- On June 24, 2020, CMS issued an updated version of the Advance Beneficiary Notice of Non-Coverage (ABN)
- Use of the new version was initially set for August 31, 2020, but CMS delayed its implementation until January 1, 2020.
- No changes were made to when the ABN is required
 - i.e., it is still almost never required!!



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HIPAA – Third Party Directives

- In January 2020, a federal district court struck down several provisions of the HIPAA Privacy Rule related to “third-party directives”
- Court ruled that the requirement to honor third-party directives is limited to PHI maintained in an electronic format
- Court further ruled that cap on record retrieval fees did not apply to third-party directives
 - \$6.50 safe harbor does not apply
 - State law governs how much you can charge for third-party record requests

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Spotlight on Compliance


An Overview of the Compliance Challenges Facing EMS Providers

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Targeted Probe and Education (TPE) Audits

- The Medicare Administrative Contractors have re-started their Targeted Probe & Educate (TPE) audits
 - Paused in 2Q-3Q 2020
- Multi-round review of a particular base rate
 - Typically BLS non-emergency, but could be BLS emergency
- Focus on signature legibility and credentialing




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Post-Payment Reviews

- Several MACs have implemented large-scale postpayment reviews of ambulance claims
 - Majority of reviews appear to be focused on ALS emergency or BLS non-emergency claims



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Billing Privilege Revocations

42 C.F.R. §424.535 Revocation of enrollment in the Medicare program

(a) Reasons for revocation. CMS may revoke a currently enrolled provider or supplier's Medicare billing privileges and any corresponding provider agreement or supplier agreement for the following reasons:

(4) False or misleading information. The provider or supplier certified as "true" misleading or false information on the **enrollment application to be enrolled or maintain enrollment in the Medicare program**. (Offenders may be subject to either fines or imprisonment, or both, in accordance with current law and regulations.)




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False or Misleading Statement on 885B Enrollment Form

➤ALJ recently upheld the revocation of a Texas ambulance company based on “unequivocal evidence” that it submitted false or misleading information on its Medicare enrollment

- Compass ambulance revalidated its Medicare enrollment information in July 2018. As part of that application it inadvertently listed its former address as a “practice location”
- When the Medicare Site Visit Contractor visited that address, the investigator saw no signs of activity. The investigator informed Novitas, who concluded that the provider was no longer active at that practice location, and revoked the provider’s billing privileges




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Failure to Disclose “Adverse Event”

In June 2019, the Departmental Appeals Board upheld the revocation of fire district’s billing privileges based on its failure to report an adverse legal action against its interim fire chief. The chief had been charged with felony disorderly conduct for recklessly discharging a firearm, but the prosecution was suspended for two year’s pending the chief’s participation in an adult diversion program. The fire district argued that this was not an “adverse legal action” within the meaning of the applicable regulation.




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Failure to Pay Enrollment Fee

➤In August 2019, an ALJ upheld the temporary deactivation of the billing privileges of a New Jersey EMS agency for failure to pay the required enrollment fee in connection with its revalidation.

- The provider had timely revalidated, but failed to include payment of the fee with its submission. The agency also failed to respond to several requests from Novitas for the fee (apparently, the agency thought its billing agency would pay the fee).
- The agency eventually paid the fee as part of a second revalidation submission, but Novitas only reinstated its billing privileges effective as of the date the second submission was received. This resulted in a roughly one-month gap in its ability to bill



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HHS Office of the Inspector General

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AKS Safe Harbor for Local Transportation

➤ In November 2020, the OIG finalized its proposed revision to the AKS safe-harbor for free or discounted local transportation

- Safe harbor was limited to non-ambulance, non-luxury transportation of “established patients” provided within 25 miles of the hospital (or 50 miles in rural areas)
- OIG expanded mileage restriction rural areas to 75 miles, and eliminates mileage restriction entirely for patients being discharged from an inpatient facility back to their residence or a custodial facility (including SNFs)

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DEPARTMENT OF JUSTICE

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HIPAA Compliance

- On December 17, 2020, the HHS Office of Civil Rights (OCR) released a report on national HIPAA compliance.
- Key Findings:
 - Most covered entities met the timeliness requirements for providing breach notification to individuals;
 - Most covered entities that maintained a website properly posted their Notice of Privacy Practices (NPP) on that website;
 - **Most covered entities failed to provide all of the required content in their NPP.**
 - Most covered entities failed to properly implement the individual right of access requirements, such as timely action within 30 days and charging a reasonable cost-based fee; and
 - Most covered entities and business associates failed to properly implement the HIPAA Security Rule requirements for risk analysis and risk management.



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Questions?



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THANK YOU

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