Check Your Claim

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If your EMS agency provides advanced life support services and bills Medicare for those services, there are three key compliance risks your agency should keep in mind. In fact, my suggestion is that you start looking into these important compliance risk areas as soon as you're done reading this article. These three issues continue to be ones we see consistently in federal False Claims Act cases involving ambulance services across the U.S.

ALS-to-BLS billing ratio

The first ALS compliance risk area is the easiest and quickest one you can check. Run a report in your billing software or ask your billing company to do so if you outsource your billing. Find out how many emergency claims you submitted in the last 12 months. To keep matters simple, include BLS-Emergency and ALS1-Emergency codes in your query; those are the A0429 and A0427 procedure codes. Then determine the percentage of claims billed at the ALS level compared to those billed at the BLS level.

The closer your Medicare ALS billing percentage is to 100%, the more compliance risk you run. Keep in mind that Medicare does not regulate your deployment; it regulates your billing. That means your agency is free to put paramedics on each response. However, Medicare rules only permit claims to be billed at the ALS1-Emergency level if one of two conditions is met: the call qualified for Medicare's "ALS assessment" rule, which requires an ALS-level emergency dispatch, or an ALS intervention. Nearly 10 years ago, Medicare abandoned the rule that permitted ambulance services to bill at the ALS level merely because they provided services in an ALS ambulance. Now, payment is based on whether the patient's condition required the ALS assessment or ALS intervention.

Put another way, your agency is not entitled to *bill* 100% ALS even though it may deploy 100% ALS.

So, what is an appropriate ALS-to-BLS ratio? The national average of emergency claims billed to Medicare in 2012—the last year in which complete data are presently available—was 65% ALS to 35% BLS. These percentages could be influenced by a variety of factors at the state and local level, such as your local dispatch protocols, and we'll discuss this in more detail below. ALS systems with ALS-to-BLS claim ratios in the 80th percentile, 90th percentile, or near 100% should look closely at their billing to determine if they have a potential Medicare compliance problem. Again, this has been an issue in several recent False Claims Act cases.

Dispatch protocols

Closely related to the issue of your ALS-to-BLS billing ratio is the use of dispatch protocols in making billing determinations, particularly when it comes to application of Medicare's "ALS assessment" rule.

Medicare defines an ALS assessment as "an assessment performed by an ALS crew as part of an emergency response that was necessary because the patient's reported condition at the time of dispatch was such that only an ALS crew was qualified to perform the assessment. An ALS assessment does not necessarily result in a determination that the patient requires an ALS level of service."[1]

To properly apply this rule, there must be a qualifying dispatch; that is, an emergency call for a reported ALS condition. In its online manuals, Medicare states these determinations must be made in accordance with "standard/accepted dispatch protocols." While Medicare does not require the use of a particular protocol and agencies are free to develop their own, they must remain mindful of the "accepted/standard dispatch protocol" admonition when making billing decisions.

Again, it's fine if your system chooses to deploy 100% ALS, but it may only bill Medicare for ALS assessments when the dispatch qualifies as ALS based on the patient's reported condition. Chest pain, for example, would justify an ALS response under any protocol. A possible broken toe would not justify an ALS assessment in Medicare's eyes. If your system chooses to send an ALS unit to that call, the cost of the ALS-level deployment is on you and cannot be billed to Medicare. The reported condition of the patient at the time of dispatch did not necessitate an ALS response.

When billing, your agency should be sure it uses care in deciding which calls justify the application of the ALS assessment rule based on "accepted/standard dispatch protocols." Your agency can't bill ALS merely because it sent an ALS provider to the call.

Medical necessity of ALS interventions

Finally, the third ALS billing compliance risk area is billing for ALS interventions merely because they were performed —without regard to whether those interventions were medically necessary.

Consider this example: You're reviewing a patient care report which states the patient has no complaints, normal vital signs and no remarkable physical findings or medical history. The narrative notes the patient "rested comfortably" on the stretcher and the crew "started an IV D5W and transported without incident." In this scenario, hopefully you ask yourself one key question when you read the IV start on the PCR: "Why was the IV started when the patient appeared to be stable with no medical need for the intervention documented on the PCR?"

This example may be applied to other ALS interventions as well. For instance, if a cardiac monitor was used, did the PCR document a valid clinical reason? ALS interventions must be medically necessary before using them to justify billing Medicare at a higher ALS rate as compared to a BLS rate.

Typically, there are several reasons given why ALS interventions may be performed for reasons other than the presenting condition or symptoms of the patient. The reason we most often hear is that clinical protocols required the procedure. First off, no protocol should mandate the performance of medically unnecessary procedures. But, beyond that, a compliance risk arises when Medicare or enforcement agencies allege your protocol is purposefully skewed toward ALS interventions merely to bill at the ALS rate. In other cases, we often hear that the emergency department staff, for example, expects an IV will be started on all patients before they arrive in the ED. We've even been told in some cases that IV starts are justified to give the medic or student practice at starting IVs.

While these sometimes questionable operational reasons may be cited as attempts to justify the performance of some ALS interventions, the touchstone for ALS billing purposes is whether the interventions are medically necessary. In the example stated above, it is clear the PCR lacks a clinical justification for the initiation of an IV. The patient had no complaints, his vitals were normal, and no medications were required to be pushed into the IV. Starting an IV may be an everyday, routine matter, but it's a medical intervention; if it's not medically necessary, it can't be relied upon to satisfy Medicare's ALS level-of-service definition.

Here's where the judgment and critical thinking skills of properly-trained and compliance-minded billers must come into play. A biller reviewing a PCR like the one mentioned above can't simply review a PCR, look at the IV start, and say "this qualifies as ALS because an IV was started." A core part of a trained and compliant biller's job must be to read the PCR in sufficient detail to determine if a valid medical reason exists for the procedure. It's the job of the medic to not only perform the procedure skillfully, but also to fully and accurately document the condition of the patient requiring the intervention in the first place. Billers should not assume the intervention was necessary merely because it was performed, and should not adopt the posture of deferring to the medic or clinical protocol because those represent medical "authorities." Billers must be educated on the billing rules and apply them properly using their

training, judgment and experience—much as a provider would assess and treat a patient based on their education, protocols and judgment.

Billing Medicare for ALS-level services is appropriate when a qualifying ALS assessment—based upon an ALS dispatch and emergency response—or medically necessary ALS intervention—justified by the patient's documented condition—is performed. Billing Medicare for ALS services merely because an ALS unit was deployed can raise significant compliance risks and should be monitored on an ongoing basis by all EMS agencies that provide ALS-level care.

REFERENCES

1. 42 C.F.R. §414.605.

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