Mark D. Lindquist, MD
Senate Governmental Affairs Committee Testimony
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I wish to thank Chairman Lieberman and Ranking Member Thompson for inviting me to appear before this committee to discuss the proliferation of Medicare denials of ambulance claims and the inconsistent application of standards with regard to claim adjudication. I also wish to thank Senator Dayton for his hard work on the issues we are discussing today. I am honored to be present for this hearing.

I am an emergency physician practicing in Detroit Lakes, Minnesota. I am the Medical Director of four Advanced Life Support air and ground ambulance services and eight police, fire and rescue departments in Minnesota. I am also the co-owner of an air ambulance service, an ambulance billing and consulting company, and until recently, two ground ALS ambulance services.

On July 17th, 2000, my 69 year-old father suddenly collapsed while painting a gazebo in the back yard of his home in Moorhead, Minnesota. My mother was trapped inside the gazebo for a short time, as my father was lying unconscious against the door, bleeding from a head wound. She was eventually able to push the door open, moving him away enough to go to a phone and call 911.

Fargo-Moorhead Ambulance Service paramedics arrived quickly. My father began to regain consciousness. He had marked post-concussion confusion and agitation. Whether he also had neck or other injuries was unknown at that time. He was brought by ambulance to the Emergency Department at a Fargo hospital, where an evaluation showed the presence of a large, complex brain aneurysm. My father's sudden collapse had been caused by a small leakage of blood from the aneurysm, an event usually followed within a month by a catastrophic aneurysm rupture and massive brain bleeding.

Because of the size, location and complexity of the aneurysm, he was referred to a neurosurgeon at the University of Minnesota who specializes in aneurysm repair, and he underwent surgery on July 28th. The long, complex surgery resulted in a serious secondary brain injury. He subsequently developed serious infections and respiratory failure, and he died on August 13th, 2000.

Medicare initially denied payment of the $500 911 ambulance call to his home where he had collapsed. The explanation from WPS, the HCFA contracted carrier, stated that the ambulance transfer from his home to the hospital was not medically necessary. Apparently, according to WPS, my 67 year-old mother should have been able to load his

190 pound body into a car and drive him to the hospital.

Upon being informed that the claim had been denied, my mother promptly paid the ambulance bill. It was only when I asked her several weeks later whether my father's medical bills were being covered that she told me the claim had been denied by Medicare. Like most non-medical laypersons, she was unaware that 20% or more of all Medicare ambulance claims are denied by HCFA contracted carriers. I urged her to obtain a letter explaining medical necessity from the attending physician and appeal the denial. The bill was resubmitted to Medicare, along with a letter from my father's attending neurologist explaining why the ambulance transport had been necessary. The explanatory letter was returned to the neurologist by a WPS customer service employee, who stated he did not understand the purpose of the letter. The bill was resubmitted a third time and was finally partially paid by Medicare after the third submission.

Needless to say, my mother was perplexed. She did not understand why the ambulance claims were denied, as she felt strongly that skilled emergency medical care was required when my father collapsed. I have been unable to give her a logical explanation, and I am frankly disgusted by the disregard shown by WPS for the competent medical judgment of my father's physicians.

As an owner of ambulance services and an ambulance billing company, I am very aware of these frequent claim denials, including cases where payment has been denied for patients in complete cardiac arrest, the explanation being given that an ambulance transport was not necessary, even though the patient's heart had stopped beating.

This summer, the mother of one of my employees was brought by ambulance to a hospital in Fargo after developing pneumonia while recovering from a broken hip. The one-year mortality rate for patients recovering from a fractured hip is as high as 50% because of such complications. The woman was short of breath, had low blood oxygen levels and a build up of fluid in her chest, and she died 16 hours after being brought to the hospital. WPS stated the ambulance transfer was not medically necessary and denied payment of the claim. The patient's daughter, who is a flight nurse, resubmitted the claim with a harsh letter, and it was ultimately partially paid.

The Prudent Layperson Standard contained in ***Senate Bill 1350, The Medicare Ambulance Payment Reform Act of 2001*** states that if a prudent, non-medically trained layperson has reason to believe that a medical emergency exists when calling for an ambulance, Medicare would be required to pay the claim. Currently, an ambulance claim filed by a patient who suffered chest pain can be denied if he or she is eventually found to have a non-cardiac source of pain. Of course, at the time of the initial symptoms, it is

impossible for the patient, paramedics or even emergency physicians to know that the source of pain is not an emergency condition.

I ask you to carefully consider implementing the Prudent Layperson Standard as part of ***Senate Bill 1350,The Medicare Ambulance Payment Reform Act of 2001.*** The standard would eliminate much of the inconsistency currently found in the payment or denial of Medicare claims. Thank you for the opportunity to address this committee.