Senate Committee on Governmental Affairs
Senator Joseph Lieberman, Chairman

Hearing on

Oversight of the Centers for Medicare and Medicaid: Medicare Payment Policies for Ambulance Services

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Written Testimony of
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Chairman Lieberman, Ranking Member Thompson, Senator Dayton and members of the Senate Committee on Governmental Affairs, on behalf of the American Ambulance Association (AAA), thank you for this opportunity to testify before you today. My name is Mark Meijer, and I am the Immediate-Past President of the American Ambulance Association and owner and C.E.O. of Life EMS Ambulance Service of Grand Rapids, Michigan. Life EMS provides emergency and non-emergency Basic and Advanced Life Support services to the communities of Grand Rapids, Kalamazoo, Lansing as well as many rural portions of Michigan including Ionia, Newaygo and Lake Counties.

The American Ambulance Association represents for-profit, not-for-profit and public ambulance services that provide emergency and non-emergency medical transportation services to over 95% of the U.S. urban population. As a result, many of our members provide the critical 9-1-1 and emergency ambulance services that comprise the backbone of our nation's health care safety net. The AAA was formed in 1979 to respond to the need for improvements in ambulance and emergency medical services. Today, the Association serves as a primary voice and clearinghouse for ambulance providers nationwide.

As former president of the AAA and a current member of its Board of Directors, I hear from ambulance service providers across the country regarding problems with Medicare claims administration as well as the impact that the proposed Medicare ambulance fee schedule will have on their organization. As an ambulance service provider myself, I also have firsthand knowledge of these issues. It is with these experiences in mind that I sit before you today.

Medicare Ambulance Fee Schedule

Under the Balanced Budget Act of 1997, Congress mandated that ambulance services be placed on a fee schedule for Medicare reimbursement. To develop the fee schedule, Congress required that a Negotiated Rulemaking Committee be convened to establish certain policies of the fee schedule.

The AAA was a member of the Negotiated Rule Making Committee and is, for the most part, pleased with the process and outcome of the issues the Committee was allowed to debate and negotiate during the proceedings. It is important to understand that the issues that most of us bring to you today with regard to the problems that will undoubtedly result from the implementation of the fee schedule were NOT a part of these negotiations. From the start of the negotiations, the representatives on the Negotiated Rule Making Committee who represented the Health Care Financing Administration (HCFA) insisted that issues of critical importance were deemed “off the table” and would not be discussed as a part of the process. Again, let me stress that the AAA has not disputed the outcome of

the negotiations. However, we believe that the Centers for Medicare and Medicaid (CMS) intends to implement the fee schedule without regard to certain decisions made by the Negotiated Rule Making Committee and without a reasonable solution to issues that they received numerous comments about in response to their Proposed Rule published last year.

We have met with CMS personnel on numerous occasions and have included the following issues in each of our meetings, comments and correspondence. While we have been very pleased that the new staff at CMS has been very supportive and have helped us with several of the issues we have brought to their attention, we believe there are still several issues that must be resolved to ensure that providers and beneficiaries will not be negatively impacted.

Need for Use of Current Data to Calculate Fees

Originally, the fee schedule was to be implemented in January of the year 2000. Data used to calculate both the baseline budget or "pot of money" which is then used to derive the base fees for the new fee schedule was to be based upon the most current calendar year's data available at the time – 1998. Due to the problems associated with Y2K issues and other issues which have arisen since then, the fee schedule is now scheduled for implementation sometime in 2002. Many changes have occurred in our industry and with Medicare claims processing systems since we initially began discussing the fee schedule. As a result, we believe that current data is far more reflective of the industry today and is more accurate of dollars spent for the volume of services performed. We have made a good case that CMS should use the most current data available now for the 2002 implementation which would be the calendar year 2000. Because of staffing issues and the additional time and effort it would take to perform the recalculation using the current data, CMS has <u>refused</u> to use the more current and accurate data to derive the fee schedule reimbursement levels. We believe this will cause the base fee to be far less than it should be. Because many ambulance providers will already suffer large declines in reimbursement with the new fees, this refusal to ensure that every dollar of current monies spent on ambulance services is included in the pot of money will surely worsen the negative impact on these providers.

Implementation of Condition Codes

A working group of the Negotiated Rulemaking Committee developed a list of condition codes and the Committee voted unanimously for these codes to be used to more accurately communicate the medical need for ambulance by describing the condition of our patient at the time of transport. Currently, we are forced to use a standardized list of diagnostic codes that are used in the hospital and facility settings after the patient has undergone diagnostic review and appropriate testing to arrive at the true nature of the problem. We do not diagnose patients – we treat the condition of our patients as we see it BEFORE the patient is tested at the hospital. We have been asked to fit a round peg into a square hole for decades and believe strongly that we have unanimously agreed upon a system that will allow us to communicate exactly what we do in the setting we work within. Regardless of this unanimous agreement, it is our understanding that CMS intends to move forward with the fee schedule implementation without using the new set of condition codes. The definitions of service that were developed by the NRM committee are linked directly to this list of conditions and we continue to stress that the fee schedule cannot and should not be implemented without the condition codes. The condition codes MUST be implemented simultaneously with the rest of the fee schedule.

Below Cost Reimbursement

The ambulance industry has been under enormous financial stress for many years. Ambulance service providers have historically been reimbursed for their services at levels far below their true operating costs. A recent Project Hope study reports the average cost of providing the most basic level of ambulance service at $236.58. Under the Proposed Rule, CMS has stated that the reimbursement level for this same service will be $161.09. Thus, once the

fee schedule is implemented, ambulance providers will be required to provide services to Medicare beneficiaries while losing an average of $75.00 for every transport.

With Medicare patients comprising 50% of total transports for our industry on average, we cannot shoulder this burden of below cost reimbursement and still remain in operation. Ambulance providers which deliver services to Medicare beneficiaries are also, in most cases, providing 9-1-1 emergency medical services in their local communities. These dramatic Medicare reimbursement cuts will seriously degrade our entire nation's emergency response system.

We urge you to do whatever is necessary to ensure that this does not happen. Ambulance providers should be able to cover their cost of providing service to Medicare beneficiaries and the fees should be increased accordingly to ensure that beneficiary access does not suffer as a result of the negative impact of the fee schedule.

Denials of Ambulance Claims

With Medicare reimbursement accounting for 50% of an ambulance service provider's revenue on average, the denial of a significant number of claims by a Medicare carrier can cause severe financial hardship for an ambulance service provider and their ability to not only serve Medicare patients, but their entire community.

Claim denial problems that ambulance service providers face are totally carrier dependent. Ambulance providers who have the same carrier often find that similar claims are being denied, while providers who submit claims to different carriers have no problems with reimbursement for the same type of claim. This is because Medicare carriers do not implement Medicare policy on a consistent basis. This results in a nightmare for ambulance service providers who are trying to determine why there claims are being denied.

Providers often learn that there is a perceived problem with their claims submissions totally by accident. There is no standard requirement that carriers contact a provider if a problem or issue is discovered with their claims. Carriers usually begin to mass deny claims or simply place a provider on a prepayment review process which requires providers to provide large quantities of additional documentation to become eligible for payment. In the case of an ambulance provider, this documentation requested is often not even within our possession. Carriers often require hospital discharge reports or medical charts from skilled nursing facilities and expect ambulance providers to somehow obtain this information – even though they do not have direct access or sometimes the permission to obtain these files. If these documents cannot be retrieved which is often the case, the claims are simply denied by the carrier. This causes a huge financial burden for beneficiaries since they then become responsible for the ambulance bill which SHOULD have been paid by Medicare.

We believe that the condition code system would substantially reduce the problems resulting from our inability to effectively communicate the true nature of our patient encounters. Once we are given an effective means of describing the patient condition that requires an ambulance transport at the time we render our service, we believe that claims denials, appeals and hearings will be unnecessary and claims will be paid or denied correctly from point of the initial submission.

Since our members communicate problems with claims denials and carrier issues on a continuous basis and request our assistance and advice to resolve these issues, the AAA has a good idea of these problems and their status as a part of our everyday activity. We have put together a summary for you and I will be submitting this as a part of my written statement. This summary will show you the problems ambulance providers regularly face with carriers across the country and the complicated process it currently takes to resolve these issues. Unfortunately, all too often, the cash flow shortages that are caused by these unnecessary denials and claims processing delays result in operational reductions, negative quality impacts and in some cases, providers are forced to close their doors to their

service altogether.

Solutions To Reduce Number of Ambulance Claim Denials

In addition to the necessity of implementing the condition codes simultaneously with the fee schedule, which will go a long way toward solving many of these claims denial problems, we have also put together a list of more technical recommendations which would help reduce the amount of problems for providers, carriers and beneficiaries and result in a far more efficient and effective claims processing system. I am submitting this list of recommendations as part of our written statement.

Conclusion

Once again, thank you for allowing me to testify before you today on behalf of the American Ambulance Association. I would be happy to respond to any questions, either today in person or later in writing, that the members of the Committee may have on these issues.

Examples of Carrier Issues and Problems

The American Ambulance Association submits the following summary of examples of carrier issues and problems that have caused many suppliers to decrease the level of the services they are able to offer to beneficiaries, or in some situations, close their doors to their businesses altogether. Carrier problems can take inordinate lengths of time to resolve. As Medicare reimbursement averages over 50% of an ambulance provider's cash flow, lengthy problems with claims denials and inappropriate reimbursement of submitted claims can be devastating.

Railroad Retiree's Medicare Claims Administration (Claims Administrated by Palmetto Government Benefits Administrators)

Although the volume of an ambulance provider's claims submitted to the Railroad Retiree Claims Administration may be small, they are by far the most difficult and cumbersome claims to obtain appropriate reimbursement. Although the industry has attempted to work with Palmetto GBA who administers these claims under contract by CMS, we have had no success in resolving the problems. Current unresolved problems with these claims include, but are not limited to, the following issues:

- Inappropriate denial rates are extremely high. Claims, which clearly satisfy coverage requirements for payment, are routinely denied as not medically necessary services. Examples include:
    - Emergency claims that should clearly be paid are denied.
    - Non-emergent transports for bed confined patients are denied.
- Claims are routinely denied for "lack of information" when all information required by CMS regulations are initially submitted by the provider.
    - Physician Certifications are submitted but ignored during claims administration.

- Utilizing electronic claims submission is impossible since the claim will simply be denied.
  - The carrier ignores information in the narrative comment field within the electronic record, which is critical to communicating that the transport was medically necessary, and satisfies payment terms.
  - The carrier requests a hard copy of the Patient Care Record completed by the crew as well as a hard copy of the Physician Certification statement (for non-emergent transports) before they process any claim. Carriers who process all other Medicare claims do not routinely require these paper documents for electronically submitted claims.
- CMS payment policies are not followed when administering claims.
  - Advanced Life Support claims are paid using completely different criteria than stated in CMS claims processing polices.
- Because Palmetto GBA adjudicates claims nationally for all Railroad Retiree beneficiaries, they are not aware of services that are offered locally by area facilities. The carrier routinely denies claims appropriately submitted by suppliers, due to the lack of this local knowledge. For example, a transport from one hospital to another to obtain a higher level of care not present at the initial facility, normally a covered service, is routinely denied by Palmetto GBA since they are unaware of the different services that are offered at individual hospitals at the local level. These claims must ALWAYS be resubmitted and are normally overturned and paid once the carrier does the required research into the capabilities of the local facilities involved with the transport.

Minnesota (Claims administered by Wisconsin Physician Services – WPS and Noridian)

Minnesota ambulance operators continue to experience huge difficulties with appropriate claims processing and reimbursement from WPS (the company that administers claims for non-hospital based ambulance suppliers) and Noridian of North Dakota (the company that administers claims for hospital-based ambulance providers).

WPS Problems include the following:

- There has been a significant increase in denied claims since January 2001. Some companies report medical necessity denials of 70% or higher.
- Inconsistent claims processing – identically coded claims are submitted and some are paid and some are denied.
- Appeals have become incredibly cumbersome. Suppliers have to appeal everything; even when WPS has admitted the problem is their error.

- Suppliers are incorrectly told that they may not bill the beneficiary if the claim is being appealed which does not follow CMS guidelines.

- Telephone claims reviews are not granted by WPS, which is a normal step before an appeal process, which is routinely granted by other carriers in the claims adjudication process.

- In July 2001, when a huge problem already existed with claims processing delays, the Minnesota provider services department was closed and WPS referred all calls to their Illinois call center. It now takes over 2 days to get a returned telephone call to answer provider related issues.

- Covered charges for supplies and drugs are routinely denied which should be paid.

- Physician Certification Statements are being required for transports that are not within the scope of this requirement outlined in the CMS regulations.

- Transports for dialysis patients are routinely denied even though they meet CMS coverage guidelines.

Noridian Problems include the following:

- The provider call center is unable to provide timely, adequate and consistent information.

- The beneficiary call center routinely informs beneficiaries that the provider has not yet submitted their claim, even though the claim has already been processed and denied by Noridian.

- All ambulance services were placed on “focused review” in January 2001. As a result, providers are required to submit not only ambulance records for claims review, but entire hospital records for the patient as well. It is believed that Noridian is basing their payment on the ultimate diagnosis made for the patient after their hospital testing and treatment has occurred rather than the condition of the patient at the time of the ambulance transport. One provider reports that at one time during this year, over 1,500 claims were outstanding with Noridian while this unnecessary review was conducted.

- Noridian frequently reports that they are not receiving claims, medical records and appeals that providers are submitting. As a result, providers have been forced to send claims manually through a method that requires a signature for proof of delivery, which adds substantial cost and delays to the claims process.

- Because secondary payers routinely require a denial from Medicare to process a claim for payment, providers will submit a claim to the carrier using a code that instructs the carrier to automatically deny payment so that the claim can be submitted to the patient's secondary insurer. Noridian routinely pays these claims coded for denial which causes huge confusion and additional processing requirements by providers who must then reimburse Noridian and ask that the claim be reprocessed correctly before payment can be sought by the alternative insurer.

- In May 2001, one Minnesota ambulance provider notified Noridian that their computer was incorrectly calculating patient co-pay amounts. As a result, Noridian is now withholding payment on ***ALL*** claims until the problem is fixed. Providers have also been notified that when the computer glitch has been rectified, Noridian will hold providers accountable for any incorrectly processed claims.

- Noridian routinely ignores information submitted in narrative fields on electronic claims, which results in large quantities of denials for lack of medical necessity, even though the information has been properly submitted on the claim.

Mississippi (Claims formerly administered by United Healthcare)

In 1998, the former claims carrier, United Healthcare, began denying claims in huge percentages. Cash flow problems within the provider community were enormous. Senator Trent Lott (R-MS) and other elected officials had to become deeply involved to resolve the problems and these individuals need to be credited for saving the entire local ambulance supplier community from extinction. The problem began when the carrier reviewed some Focused Medical Review Data and determined that Mississippi suppliers were receiving twice the national average for Advanced Life Support emergency ambulance transports. There was a very easy explanation to this anomaly, but the carrier did not ask for any explanation from the provider community and simply began incorrectly denying claims in large percentages. The majority of these claims were then appealed and overturned for payment, causing huge processing delays, cash flow

shortages and significant and unnecessary processing costs for the industry and the carrier. The largest provider in the state reported denials that were overturned on appeal at 75% in 1999, 72% in 2000 and 79% in 2001. This carrier no longer services the Mississippi ambulance community.

Upstate New York – (Claims administered by Blue Cross Blue Shield of Western New York)

This carrier placed most of the larger ambulance suppliers in the area on pre-payment review for all claims submitted involving a patient transported after a hospital discharge. The carrier demanded hospital discharge summaries as a part of the submitted record, which were not in the possession of the ambulance supplier and were very difficult, and in some cases, impossible to obtain. Claims were then routinely denied as "not medically necessary", even when this document was obtained. The cash flow problems that ensued were severe and denial rates soared to 84% by the fall of 2000. Senator Charles Schumer (D-NY) intervened on behalf of the industry and with the help of high-level CMS and HHS personnel, the carrier finally terminated the pre-payment review action in the late spring of 2001. In a June 20, 2001 letter from HHS Secretary Thompson to Senator Schumer, the Secretary indicated that the denial rate for hospital discharge transports had been reduced from 84% to 23% in April of 2001. Secretary Thompson also verified that the carrier had been using incorrect payment review criteria to satisfy coverage requirements, which had also been rectified prior to his correspondence. Unfortunately, since this problem had taken over a year to resolve many ambulance suppliers were forced to institute service reductions to compensate for the huge cash flow shortages that resulted from the carrier's refusal to rectify its claims processing issues on their own.

Wisconsin (Claims administered by Wisconsin Physician Services – WPS)

The state's four largest ambulance companies were placed on pre-payment review for all non-emergent ambulance claims submitted for payment. Some pre-payment reviews included emergency transports as well.

In addition, the following problems occurred:

- The carrier denied large quantities of claims that should have been paid.
- The carrier claimed that while they knew how to place a supplier on pre-payment review, they were unclear how to remove them from this process.
- Claims overturned on appeal were not included in the calculations of the denial percentage, which was what the carrier determined was the cause to keep them in the pre-payment review process.

- The carrier did not have a methodology, which allowed suppliers to ask for a claim to be automatically denied until March 2001. Claims submitted "for denial only", which is a requirement by secondary payers before suppliers can obtain reimbursement, were inappropriately included in the calculation of the supplier's denial ratio, which was the reason they had been placed into the pre-payment review process in the first place..

Southern California (Claims administered by National Heritage Insurance Company - NHIC)

NHIC took over processing ambulance claims for Southern California in December 2000. There have been continuous system problems that have caused huge problems with inappropriate claims denials since this occurred. Major cash flow problems still exist for many of the suppliers in this service area. Some examples include:

- Provider payment screens were initially loaded into the NHIC system incorrectly causing suppliers to be grossly underpaid for services rendered

for many months. (This problem was only rectified when the central CMS office intervened.)

- When new procedure codes were implemented on January 1, 2001, additional claims processing problems began:
  - Suppliers were denied all mileage payments on claims.
  - Claims were denied for lack of medical necessity, which clearly should have been paid.
  - All hospital discharges to a second hospital for a higher level of care were routinely denied, even though coverage requirements were met.
  - Claims containing zip codes listed as valid by the US Postal Services are still denied because the carrier does not recognize the zip code submitted.

Kentucky/Indiana (Claims administered by AdminaStar)

Beginning in August 2000, AdminaStar began arbitrarily denying ambulance claims. The volume of these denials was so high; that claims resubmitted for review by suppliers became substantially backlogged. The Carrier estimated it would take more than a year to process reviews and almost two years for suppliers to obtain a hearing on improperly denied claims.

Examples of these inappropriately denied claims include the following:

- Valid emergency claims routinely denied as not medically necessary services.
- Non-Emergent claims were routinely denied since the carrier stated that all patients had to be bed confined AND have another reason for transport to satisfy coverage requirements. These are not the same coverage requirements outlined within CMS regulations.
- The carrier incorrectly determined coverage by the patient's ultimate diagnosis once treated by the receiving facility, NOT by the condition of the patient at the time of the ambulance transport.
- Even when claims were resubmitted and paid, most were downgraded to a lower payment level based upon the level of treatment given rather than the service level required by the condition of the patient.

Although the issues were resolved in February of 2000 after the central office of CMS and elected representatives intervened; cash flow problems within the provider community were severe. In fact, three suppliers who were sole operators in rural communities had to close their doors.

Maryland (Claims administered by Trailblazer)

Suppliers submitting high volume of ambulance claims were placed on pre-payment review for all claims in 1999. The carrier justified this action through their review of data, which apparently indicated that they were paying more per 1,000 beneficiaries for ambulance services than other states. For a provider to be taken off of pre-payment review status, they had to get their denial percentage below a certain percentage known only internally at the carrier, which they refused to share with the provider community. Long delays for claims payment and review ensued which caused severe cash flow problems for suppliers. Meetings with high-level carrier personnel were finally granted and some important discoveries were uncovered. Unfortunately, by then, many suppliers either closed their doors completely or curtailed services offered to local beneficiaries. As a result of this action by the carrier, the number of certified suppliers and licensed vehicles has decreased by 50% in the past 18 months. This has caused a significant delay (i.e., hours) for non-emergency responses in the entire service area.

Pennsylvania (Claims administered by XACT/HGS Administrators)

In 1999, the carrier denied all claims for transports originating in a Skilled Nursing Facility based upon wording included in HCFA Transmittal AB-99-53 dealing with the newly instituted SNF/PPS payment policies. They refused to pay any of these claims until they received written clarification from HCFA stating that the claims could be paid. Once this was received, the carrier began paying the claims but the long delays set in motion major cash flow problems for suppliers.

Shortly thereafter, HGS began pre-payment reviews and other procedures that caused further cash flow shortages for the industry.

- Additional information was routinely requested from healthcare facilities before ambulance claims would be paid or processed. Since this request was made to a source outside the scope of the ambulance supplier, claims payment became dependent upon a supplier who had very little reason to comply with the information request. As a result, most claims were denied when the requested information was not received.

- Supporting documents, which were successfully obtained by ambulance suppliers and submitted with their claims were routinely lost.

- Because of these additional documentation requirements, claims were not processed for at least 90 days, which caused huge cash flow shortages for the local ambulance community. Further, because the documents required were usually not in the possession of the ambulance operator, most claims were ultimately denied even after this lengthy delay.

As a result of these issues, many ambulance suppliers in the area were forced to institute service reductions to accommodate for the cash flow shortages which occurred.

South Carolina (Claims administered Palmetto Government Benefit Administrators)

In February 2000, Palmetto GBA arbitrarily began denying over 75% of all Medicare ambulance claims. The carrier stated that the denials were a direct result of the content of the ambulance regulation that was effective on February 24, 1999. The regulation stated that non-emergency ambulance transports are only covered if the patient is bed confined, but this error was clarified by HCFA in a Q&A dated March 12, 1999 which was well in advance of the instituted policies incorrectly implemented in early 2000. The clarification stated that other non-emergencies are covered even if the patient is not bed confined as long as other reasons for transport, which established the medical necessity for the service were provided. Palmetto incorrectly interpreted this clarification to mean that patients had to be bed confined *in addition to* an alternative reason for ambulance transportation in order for payment to occur. The carrier also alleged that HCFA advised them that they had been paying too many claims and they should increase their denial ratio. It took over 5 months and enormous pressure from local elected officials working on behalf of the ambulance community to force the carrier to abandon these incorrect payment polices. Unfortunately, by the time this issue was resolved, many suppliers suffered cutbacks in service in order to keep their doors open while they experienced the resulting severe cash flow shortages. Other problems with reimbursement for covered non-emergent transports remain unresolved and some covered claims continue to be incorrectly denied by this carrier.

Recommendations to Resolve Claims Processing Problems

- Railroad claims for ambulance should be processed by the local Medicare carrier. It will save the industry and Medicare substantial administrative expenses currently resulting from the huge number of appeals and manual claims processing costs, which are required by the current carrier.

- Require that Medicare carriers have a special unit to process ambulance claims.

- Appoint an ambulance representative to the Carrier Advisory Committee and include them whenever an ambulance issue is on the agenda.

- Before putting the ambulance industry on pre-payment reviews based on Focused Medical Review data, require the Carrier to meet with industry representatives to see if there is a logical reason for the apparently aberrant data.

- Require education to occur and allow providers to rectify problems BEFORE placing them on pre-payment review.
- Allow advance payments, based on a set formula, e.g. 80% of the supplier's average payments, when there is a problem with a Carrier's system for processing claims that cause payment and processing delays.
- Open eligibility files so ambulance providers can determine if there is a payer that is primary to Medicare.
- Eliminate signature authorization requirement for suppliers. Require that Medicare obtain the signature at the time of enrollment. Allow electronic patient signatures.
- Providers should only have to submit documents that are within their custody and control. Pre-payment reviews, development letters and audits should not request documents from us that are not directly within our custody and control.
- Allow us to send the Physician Certification Statement and all other claims processing requirements electronically. Manual claims are far more costly for providers and carriers alike.
- Carriers should not include claims where the supplier requested a denial for determination of denial percentages used to place providers onto the pre-pay reviews process.