

MANAGEMENT FOCUS

— For Providers of Emergency Medical Services —

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DANGER CODE: ALS 1 - EMERGENCY

It has been more than 5 years since the Centers for Medicare & Medicaid Services (CMS) established new definitions for ambulance levels of service. The definitions for BLS, ALS 1, ALS 2, Specialty Care Transport (SCT), emergency and non-emergency patient transports were established and specific codes created for filing claims. The Healthcare Common Procedure Coding System (HCPCS) codes are submitted on claims to Medicare and other insurance companies for reimbursement. They define the level of service and determine the amount that these payers will pay.

Higher reimbursement is available for ALS (as compared to BLS) and for emergency patient transports. It is essential that EMS and ambulance organizations fully understand the definitions in order to appropriately code the patient transport. The ultimate goal of the service should be to get the highest *appropriate* level of reimbursement for each call. The operative word here is “*appropriate*.”

Healthcare in general and the ambulance industry specifically have been rife with providers who attempt to recover payments for which they are not eligible. For ambulance services, CMS and the Office

of Inspector General (OIG) have focused on inappropriate ambulance practices of “upcoding” of services. A number of ambulance services have been identified and penalized for filing for ALS reimbursement when only BLS services were provided and claiming that a transport was an emergency, when in fact the call did not meet the CMS definition of an emergency event.

The new definitions clarified the levels of service but the changes introduced one “DANGER CODE” of ALS-1 Emergency when no ALS

treatment is provided to the patient. The process used to develop the Medicare fee schedule for ambulance services resulted in establishing a definition where the ALS-1 level of service can be reimbursed when an ALS assessment is provided even though the patient did not ultimately require ALS services or treatment. EMS organizations have been implementing their interpretation of this level of service with a wide variety of results. Some organizations are billing ALS-1 Emergency only when ALS services or treat-

ment are provided and not taking advantage of the definition that allows the higher level of reimbursement based on the provisions of an ALS assessment. Other EMS organizations bill all emergency calls at the ALS-1 Emergency level.

An ALS assessment cannot be used to justify billing at the ALS level for non-emergency requests. We will clarify the appropriate use of the ALS-1 Emergency code when the ALS assessment is the only higher level

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“AN ORGANIZATIONAL SELF-ASSESSMENT”

A common concern felt by many community leaders and conscientious EMS managers is: How do I know we are doing a good job? With minimal oversight, little standardization, and few clear best practice systems to model, how can you accurately size up the quality of your system? Here are just a few broad areas to consider.

Designed for the Patient. EMS systems exist for the benefit of the community and most managers would say they are acting in the best interest of their patients. While true, an objective review of most systems and their operational

practices would likely reveal that factors like tradition, labor, convenience, political issues, and unchecked competition heavily influence system design and operational decisions in advance of looking at the patient’s needs.

Examples of these operational decisions include: is your communications center using protocol based dispatch to ensure patients are triaged effectively and receive the most appropriate resources, is response time reliability measuring the entire EMS system response from initial phone contact to when the wheels stop at the

call location within an established goal (e.g. 8.59 @ 90%), and does your ambulance deployment plan adequately match resources to demand? Each of these operational questions can be tackled very differently. Some choices clearly aim to serve the patient first, but many do not. Which is true for your system?

Truly being a patient advocate requires leaders to ask how every decision benefits the community and the patients first. If the answer isn’t clear or the benefit is secondary to one

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EMS & HOSPITAL TRENDS & NOTES



Treat Cardiac like a Trauma? A new study in this month's *Circulation* looked at the proximity of patients to hospitals that perform angioplasty. The closest hospital for 58% of patients could not perform the procedure, but in most cases a hospital that could was less than 30 additional minutes away. The study asks, should patient's be diverted?

National Attention: DC EMS Responses. Not long after a critical article in an EMS trade journal, the DC

Fire & EMS department is catching national scrutiny over its response to assist former NY Times reporter David Rosenbaum who would later die of a head injury from an assault. In question are the quality of EMS' assessments and the efficacy of tiered response. DCFD says it acted "...by the book." Could "the book" be wrong?

Changes at NHTSA. With recent debate over the federal oversight of EMS, NHTSA announced the establishment of the Office of EMS to "elevate the stature of the EMS Division to meet its expanding role." The Office of EMS will report to an Associate Administrator at NHTSA and was described as helping to contribute close coordination between the office and federal partners.

CMS Surprise. In a February Open Door Forum, the Centers for Medicare & Medicaid Services made 2 announcements that startled participants: 1) It admitted erring in 2 areas of calculating the 2006 Medicare rates and advised a transmittal would correct these errors. Until then, however, CMS announced claims would not be processed; 2) Referencing a transmittal from last year, CMS announced that some carriers will not be implementing condition codes.

Phoenix Emergency Services Mogul to Retire. In EMS, there are but a handful of leaders who are "household names;" Alan Brunacini – chief of the Phoenix Fire Department is one of them. In his 48 years in the department and 28 years as fire chief, Brunacini established

his department as an industry benchmark and forced people to look differently at providing service. He officially retires in June. No word yet on his replacement.

CPR – Breaking the Training Barrier. A recent study conducted with American Airlines employees found lay people can learn CPR from a video in 20-minutes. Increasing the numbers of CPR-trained citizens in the community has long been a goal of strengthening the chain of survival and, along with an AED shock, can be a key factor influencing survival. EMS short courses like this one opens the door to expanding training to the lay public and corporations where large groups of people work together in close quarters.

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of service provided. First, one must understand CMS' definition of "Emergency." To qualify as an emergency, the request for service must come through 9-1-1 or an equivalent process. Secondly, the ambulance service must take the necessary steps to respond immediately to the call.

When no ALS procedures are provided, 7 criteria must be met in order for a call to meet the requirements for the ALS-1 Emergency level of service based on ALS assessment. The criteria are:

#1: The call must be

an emergency originating from the 9-1-1 system or equivalent.

#2: There must be an immediate response by the ambulance provider.

#3: The dispatch center must have triage/prioritization procedures in place to identify calls that may need ALS.

#4: The request must meet the criteria of the triage/prioritization process that ALS may be indicated for this particular event.

#5: There must be an ALS provider on the scene.

#6: The ALS provider must conduct an ALS assess-

ment of the patient.

#7: The ALS assessment must be documented on the patient care report.

If these 7 criteria are met, it is appropriate to bill for ALS-1 Emergency reimbursement. If any of the criteria are not met, the ambulance service should not seek reimbursement at this higher level. If the call meets the emergency definition, it should be billed at the BLS Emergency level of service.

CMS has indicated that the frequency of filing at the ALS level has increased significantly since the implementation of the fee sched-

ule. It should be expected that this ALS-Emergency "Danger Code" will receive increased scrutiny by CMS and OIG in upcoming years.

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“AN ORGANIZATIONAL SELF-ASSESSMENT”

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that first helps the organization or field staff, it should be seriously evaluated. Systems designed for the patient serve people and save lives.

Fiscally Responsible. Available funding dollars for EMS are becoming increasingly scarce, the cost of providing service is rising, and people's expectations of EMS are growing. In the face of all of these pressures, what is your organization doing to remain fiscally responsible? Is it acting responsible every day or only when times are tight?

Unfortunately, as belts tighten and spending habits require change, managers are more often cutting muscle and not fat. For many, being fiscally responsible is like dieting. If we are not paying close attention to how we spend, we make bad choices, spend too much and waste money, requiring us to go without in order to get back on track. The result is temporary results, but long-term implications. Those that are conscientious and at times frugal are more agile when tough times occur and hopefully have more reserves in which to be flexible.

At a basic level, fiscal responsibility means not spending more than you earn and making smart decisions about what you buy. It should occur all of the time and not just in the tight years. Before you make a purchase or consider a budget cut, ask yourself how it will contribute to the patient and the people who serve them. If

the answer isn't clear, you should re-evaluate the decision or look somewhere else for the answer.

Quality Focused. Quality management (QM) has been in EMS for over two decades. Adapted from our healthcare peers, organizations have established quality committees, incorporated medical directors, and spent hours reviewing run forms. With so much effort, why has quality management not taken off like it has in just about every other industry? Are we missing something?

The result was a narrow focus of the program and a failure to gain universal commitment.

Quality is a function of the entire organization. It starts when the call hits the communications center and continues to the day the bills are paid and beyond. Serious organizations view performance management as one activity encompassing the entire organization. They track data on the performance of processes and focus attention on improvements for the future. When

then wonder why employees don't stay. However, today's generation of workers have different, less tangible, motivators including greater work schedule flexibility, a need for constant learning and development, and a desire to feel engaged. When these needs are met, the level of compensation they receive becomes less of an issue and loyalty to an organization increases.

Progressive EMS organizations are looking for guidance from other industries that have been adapting for some time and are attempting to create positive cultures and workplaces that meet employee needs. If you have any doubt about where your service stands, visit with a few crews and ask them what is important in their lives. Ask them when they feel most engaged or happy. A little exploration will reveal there are many layers of needs that are more important than compensation, and most are yet to be satisfied.

Managing an EMS organization is no easy job. It requires industry knowledge, people skills, business acumen, and far reaching focus. Success is within your reach if you are willing to take an objective look at where things stand today, draft a vision of where they should be in the future, and then draw a map of change from one to the other. Remember, big changes start with small changes that build on each other.

HOW CAN YOU SIZE UP THE QUALITY OF YOUR SYSTEM?

Quality management has not thrived in EMS because we have failed to apply its practices in two areas: 1) attention has only targeted clinical practice and 2) efforts have focused on looking backwards to see if quality occurred and not on making process improvements for the future. The first quality programs viewed performance from two aspects: did we follow the protocol and were we successful in applying our advanced skills. This only looked at calls that had already occurred though and not on how to improve processes for the future. In addition, since QM was initially focused on clinical service, it was pigeonholed and never applied as an organization-wide management

looking at your quality program activities, are they focused on assuring a standard was met or do they have their sites set on improving the process for tomorrow?

Pro-Employee. Employees represent one of the largest investments an organization makes. Finding quality people is always a challenge and retaining them is no easy task. Making matters worse, today's workforce does not see job change as a stigma and are very willing to switch employers if another workplace better meets their needs.

EMS organizations are fighting an uphill battle and are far behind the curve. Far too many employers still believe a job and a paycheck are good enough and

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