MANAGEMENT FOCUS

— For Providers of Emergency Medical Services —

VOL. 17, NO. 2 FITCH & ASSOCIATES, LLC SUMMER, 2002

THE EMS INSURANCE CRISIS

Availability, coverage limitations and cost for liability insurance are causing considerable concern among ambulance services, nationwide. Some agencies have been denied coverage, some are operating under reduced coverage, while others have attempted to self-insure.

More than a dozen major carriers were writing ambulance service coverage two years ago. Today, there are two. Both of these are writing significantly less coverage than before.

The insurance crisis is an unanticipated aftershock from September 11 and the resulting economic downturn. The reason most carriers are no longer writing EMS is simple: loss exceeded profit. According to EMS insurance industry expert Bill Leonard, "claim severity is climbing."

Looking deeper, it's clear that insurance companies relied heavily on stock market investment income to offset losses. In the wake of the economic downturn, profits are now expected solely from underwriting. Carriers have withdrawn from high risk markets. Those that remain have reduced coverage limits and are priced in accordance with the underwriting risk.

Coverage reductions have also been common. Coverage is often reduced by dropping the "per incident" level from, say $3 million (standard not too long ago) to as little as $250,000. A medium-sized service in Southern California, for example, who paid as little as $80-$100,000 in premiums only five years ago now has significantly reduced coverage for $700,000 a year.

In the Midwest, insurance became a critical issue this summer when Kansas City's ambulance service provider received notice of non-renewal and was only able to obtain coverage within days of its contractual deadline. The local oversight agency reduced its requirement from $10M to $7M while the cost for the lower level of coverage doubled from the previous year.

Insurance carriers' perceptions of EMS are not good ones: personnel are young, driving a vehicle in excess of a ton, with lights and sirens used more than the industry would like, at speeds that are proven unnecessary for optimum patient care. And it is not their vehicle. The front page *USA Today* story (April 4, 2002) titled "Speeding to the Rescue Can Have Deadly Results" is an example of how negative perceptions are shaped and reinforced.

The insurance industry is cyclical. New players will eventually introduce new policies, instill some needed competition, rates will be reduced until a flurry of new claims returns the cycle to high premiums and a scarcity of coverage, where we appear to be now.

Here are six insurance strategies you can try:

1. Increase Awareness. Management's safety quo-

continued on page 3

FEE SCHEDULE IMPACT

The Medicare Fee Schedule was implemented for ambulance services on April Fool's Day. This event was anticipated with much trepidation. Many feared that the Carriers would not be able to smoothly implement the changes and that Medicare reimbursement would fall weeks, if not months, behind. Fortunately, this did not occur. While some Carriers experienced a few glitches, overall the implementation went smoothly.

Year one of the phase-in period initiates the decline in Medicare reimbursement for many organizations due to lower allowable rates and the immediate requirement to take assignment and cease balance billing. The full effect will not be felt until January 2006 when the majority of ambulance services are likely to see an increase in the Medicare allowable. The higher volume ambulance services in parts of the country will suffer the most from the fee schedule reimbursement levels.

Even though the transition to the fee schedule was relatively uneventful, there remains a number of areas that are causing ambulance services significant problems in understanding how to properly file Medicare claims.

<u>Rural Mileage</u>. Two questions frequently surface regarding how to take advantage of the increase in rural mileage reimbursement. First, do we have to charge three different mileage amounts for up to 17 miles, 18 to 50 miles and another rate for those over 50 miles? The second question is: Do I have to bill more than the fee schedule amount in order to receive maximum reimbursement?

Only one mileage rate can be billed to Medicare. All mileage should be entered on the claim on one line under the code A0425. The Carrier will calculate the amount to be reim-

continued on page 3

EMS & HOSPITAL TRENDS & NOTES

Supervisors & Disasters. The National Institute for Occupational Safety and Health (NIOSH) recently published suggested guidance for supervisors at disaster sites. The document outlines essential elements of a work plan, a site safety checklist and a field team leader checklist. It also describes 13 potential hazards and recommendations. To download see: http://www.cdc.gov/niosh/emhaz2.html

Smallpox Vaccine. The CDC is continuing to solicit input on its vaccination policy. Its internal committee is recommending vaccination for healthcare personnels at risk for exposure in "facilities" that are pre-designated to receive these patients. As of July, CDC is awaiting input from state and local bio-terrorism officials to make a final decision.

Trauma Center Closure. The closure of Las Vegas' only Level-I trauma center in July is believed to be the nation's first in an urban area of more than one million residents and one of the first caused by an inability of doctors to find affordable medical liability insurance.

ER Volume Growing. New CDC data shows 14% increase in ED in the past five years. ACEP describes overcrowding as an epidemic. Largest growth segment is older Americans (75+) who have 65 visits per 100 persons per year compared with the national average of 39. Average non-critical wait time increased from 51 to 68 minutes.

Response Time Update. Almost half of the ambulance services in the United Kingdom are meeting the nationwide 8 minute 75% compliance requirement for critical calls up from only 2 services last year. The nationwide standard is applied regardless of population density. The National Health Service has invested over $80M in recent years to upgrade service and response times. (see story below)

64 Hospitals Closed. Financial stress was cited as the primary reason for hospital closures in 2000, according to a Department of Human Services report released last month. 22 were rural and 42 were urban. Of the 64, less than 20 were closed as a result of mergers.

EMS INAPPROPRIATE USE CAMPAIGN

London's Ambulance Service is one of the world's busiest responding to over 1 million requests annually. It achieves 8 minute fractile response times at 57% reliability for critical calls, the lowest performing service in the country according to National Health Service data.

Performance issues include: deployment, staffing, CAD issues, population density, miserable traffic and inappropriate utilization. The LAS is working hard to improve its response times. After an independent study determined that Londoners used ambulance services more inappropriately than any other EMS service in the UK, LAS developed a unique strategy.

The service has undertaken a major public education campaign including public service announcements aired by the BBC featuring media personalities, public officials and crew members. Subway, bus posters, and patient advice cards are also being used.

According to Chief Executive, Peter Bradley, "We don't want to deter anyone with a genuine emergency from calling us but we're not a free taxi service. Committing ambulances to calls where they are not required can put the lives of other patients at risk - it's that simple."

Similar campaigns in the US have had non-intended results of increasing calls. When awareness increased, so did utilization. No program has been undertaken on such a large scale as the LAS. Next year *Focus* will report on the results of the campaign.

Samples of the radio spots and other information can be downloaded from http://www.londonambulance.nhs.uk/news/inappropriate/inappropriate.html.

MANAGEMENT FOCUS

published quarterly by
Fitch & Associates, LLC

Subscriptions are complimentary, and are available for download at www.fitchassoc.com or from Fitch & Associates, 303 Marshall Rd., Box 170, Platte City, MO 64079-0170
816-431-2600
sconroy@emprize.net

Quotes allowed with attribution.
Copyright ©2002 by Fitch & Associates

The publisher is not engaged in rendering legal, accounting or investment advice. You should discuss any tax, legal, or investment problem with your own lawyer, accountant, or financial advisor.

FEE SCHEDULE IMPACT

continued from page 1

bursed including the 50% add-on for the first 17 miles and the 25% add-on for 18-50 miles. Since the mileage has to be entered on one line, the rate has to be a fixed amount and the total units represent all of the loaded patient miles.

Medicare will reimburse the *lowest* of the calculated amount based on the fee schedule and the phase-in percentages or the charged amount. During the first 9 months (4/1/02-12/31/02) reimbursement is based on only 20% of the calculated amount and the remaining 80% on your current allowable. Therefore, unless your current allowable is high (greater than $5.00) and your charges are near or below your allowable, your charges should exceed the calculated amount. But, in the second year of the phase-in beginning in January 2003 the allowable is calculated based on 40% of the fee schedule amount. At that time, many services will be paid less than the allowable if they do not charge a high enough base mileage amount. By the end of the phase-in, it will be necessary to charge at least the amount of the rural mileage rate for the first 17 miles in order to maximize reimbursement. The amount will be $8.21 plus inflation adjustments.

Q Codes. There is much confusion among providers regarding the use of the "Q Codes." The codes Q3019 and Q3020 are *only* to be used by ambulance services that were reimbursed at the all ALS level because of government mandate. The Final Rule allowed for a phase-in of the impact of not being paid at the ALS level for all calls.

Services that were previously paid at the ALS rate by Medicare for all calls can use the "Q codes" for those calls on which ALS services or treatments are not provided. If a call meets the criteria for ALS 1 or ALS 2, then Q codes should not be used. Q3019 should be used when an ALS ambulance responds in an emergency and only BLS services are provided. Q3020 should be used for non-emergencies when an ALS transports and only BLS is provided. If an ambulance service is not required by local ordinance to respond to all calls with an ALS unit or was not reimbursed in the past at the all ALS level, then "Q codes" should not be used.

ALS 1 Definition. Medicare now defines ALS assessment as an ALS service. Therefore, if a patient is assessed by an ALS caregiver, the call can be submitted with the ALS 1 base rate for reimbursement if the following conditions are met: (1) Information received at dispatch indicated that the patient needed an ALS assessment, and (2) Dispatch has procedures or protocols to identify information from callers to determine that an ALS assessment is indicated, and (3) The call qualifies as an emergency.

ALS 1 can be filed regardless of whether the assessment indicated the need for ALS treatment. This is an important differentiation than the definitions used in the past, where ALS was only to be reimbursed when specific treatments were provided.

Only the agency that transports the patient can be reimbursed by Medicare. If a paramedic from one service assesses the patient and then the patient is transported by a BLS crew, the BLS agency can file for ALS 1 reimbursement. It would be up to the agencies to share reimbursement.

A number of other issues have not been fully addressed. These include the restriction on ALS 2 medications to only those administered intravenously and the requirements for Physician Certification Statements for non-emergency transportation.

All in all, the transition to the fee schedule was relatively smooth. Although a few Carriers had some problems, they have been largely resolved. Most ambulance services will not see huge swings in the amount reimbursed by Medicare during the first 9 months of the phase-in. But, those services anticipating an improvement in reimbursement should start seeing the benefits in January 2003. Likewise, those services that will receive lower payments will begin to feel the effects next year.

THE EMS INSURANCE CRISIS

continued from page 1

tient is a key to loss control. Brokers and underwriters are becoming more perceptive at what agencies represent a higher risk. Management commitment and staff involvement in risk management is a key factor.

2. Improve Employee Selection. Difficult but necessary in a tight labor market. Bad actors will continue to give poor performances. Don't hire them.

3. Increase Driver Training. Leadership must support education and reinforce changing behaviors. This must be done routinely as part of the recognized quality improvement process.

4. Conduct Routine Risk Assessments. Take responsibility for recognizing and reducing risks. (e.g. is there a medical reason for running hot to all emergencies?) This can be accomplished internally or through an external review process.

5. Enforce Existing Policies. (e.g. wearing seat belts, lifting practices, driving policies). Educate those you can to follow policies; terminate the rest.

6. Aggressively Defend Claims. When claims happen, work closely with your carrier to provide an aggressive defense. Avoid the attitude "we paid for the coverage-now you pay the claim."

Using these six strategies offer no guarantees of continued coverage or that it will be affordable. However, in this market, demonstrating that the service is a solid risk by the attitudes and actions taken is the best opportunity to maintain coverage.

LEADERSHIP CONFERENCE 2002
CREATIVE APPROACHES FOR PATIENT TRANSPORT SERVICES

Services are searching for innovative ways to cope with the rapidly changing service delivery and reimbursement environments.

This year's annual Leadership Conference sessions are a mix of insight and strategy. Topic highlights include: Futuristic System Designs, Hospital Diverts and other Transport Blockages, Integrated Specialty Care, Leveraging the Web, Maximizing Reimbursement, Responding to Terrorism: Keeping your Staff Safe, and Dealing with the Insurance Crisis, among others.

The pre-conference theme for this year's conference is "*Integrating People, Operations and Service.*" In a tightening labor market managing human resources becomes a central success factor. Topics include: Positioning Personnel for Success, Recruiting by Attracting the Best in a Competitive Market, Competency Based Employment, Injury Prevention and Appreciative Supervision.

Faculty for the conference include: Jay Fitch ,PhD; Chris Zalar; Rick Keller; Connie Eastlee; Beth Taylor; Seth Myers; Nadine Levick, MD; William Gerard, MD, Jim Eastham, ScD; David Nelson; Mike Williams; and, Alan Murray.

This year's Leadership Conference will be held at the Marriott Marquis in Atlanta, Georgia, Thursday, September 19 through Saturday, September 21.

Stay the weekend and see the sights! Visit Underground Atlanta, the underground mall built around the site where the city began to rebuild after the Civil War. Just a soda can's throw from Underground is the World of Coca-Cola, a tribute to the world's most popular soft drink, invented in Atlanta in 1886. A few blocks away, visitors can get an inside look at another of Atlanta's internationally recognized companies - the Cable News Network.

The Leadership Conference is sponsored by Fitch & Associates. For additional information or downloadable registration form see www.fitchassoc.com/conferences.htm

CONFERENCES SPONSORED BY FITCH & ASSOCIATES

2002 Leadership Conference
September 19-21, 2002
Atlanta, Georgia
Discounted registration due: August 15, 2002
www.fitchassoc.com/conferences.htm

Ambulance Service Manger's Certificate Program (ASM)
(in conjunction with the American Ambulance Association)
Discounted registration due: August 15, 2002
www.fitchassoc.com/conferences.htm

Communications Center Manager's Certificate Program (CCM) (in conjunction with the National Academies of Emergency Dispatch)
Discounted registration due: October 1, 2002
http://www.emergencydispatch.org/CCM-description.shtml

DO WE HAVE THE RIGHT PERSON?

If the person, company name or address is incorrect, or if you would like additional managers to receive the *Management Focus*: Fax this page with correction to 816.431.2653 or email sconroy@emprize.net. Alternatively, requests for an electronic version of the *Focus* can be made at www.fitchassoc.com/ManagementFocus.htm

MANAGEMENT FOCUS
FITCH & ASSOCIATES, LLC
303 Marshall Road, Box 170
Platte City, Missouri 64079-0170
Address Correction Requested

PRESORTED STANDARD
U.S. POSTAGE
PAID
PERMIT 1422
KANSAS CITY, MO

Please Expedite: News Materials