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NFPA RESHAPING EMS & FIRE SERVICE STANDARDS

The National Fire Protection Association has recommended specific EMS standards for the organization and deployment of Career Fire Departments. Set for May approval, NFPA 1710 will necessitate changes for many public and private agencies.

NFPA 1710 includes response time, certification and minimum staffing requirements. The standard requires jurisdictions to impose these same standards when another organization or private agency provides these services.

Response times. Four minutes (240 sec) is set for first responder arrival. Eight minutes (480 sec) is stipulated for ALS unit arrival. Departments are to achieve this with 90 percent reliability. The most recent modification also contemplates 60 seconds "turnout time." The net effect is a 9 minute/90% compliance standard (often referred to as 8:59 or the 9/90%). There is flexibility for departments to evaluate the standard annually and to consider geography within the jurisdiction in setting its objectives.

EMS Certification. Units that provide EMS care shall be staffed at a minimum with personnel trained to the first responder/AED levels. Units that provide BLS trans-

ports must be staffed with EMT-Basics and units that provide ALS transport must be staffed with EMT-Paramedics or as otherwise approved by the state agency responsible for EMS licensing.

EMS Staffing. Units providing BLS must be staffed with at least *two* EMT-Basics. Units that provide ALS transport must be staffed with *two* EMT-Paramedics. The proposed standard contemplates that the two mem-

ber crew assignments may be assembled from multiple agencies.

Other provisions. The establishment of a quality management program is required that must document response time compliance and clinical care reviews. ALS services are required to name a physician medical director according to requirements of state law and to have immediate communications capability with medical oversight.

In addition to EMS, FD

staffing provisions set both engine and truck companies minimum staffing at four on-duty personnel. Suppression response times for initial arriving companies and full alarm assignments including turnout time are set at 5 and 9 minutes (90%), respectively.

Implications. "Huge" is the way one Midwestern City Manager describes the standards. "These response time requirements are the first ob-

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2001: A REIMBURSEMENT ODYSSEY

Implementing the Medicare fee schedule resembles Stanley Kubrick's quintessential film: "2001 – a Space Odyssey." Like "Hal" the computer voice, HCFA keeps droning on toward the implementation. Despite delays, there are changes that are being implemented.

Required Changes. For dates of service beginning January 1st, 2001 the following changes are required:

⇒ Claims must include the new HCPCS codes for base rates.

⇒ Services should continue to use A0380 and A0390 for ground ambulance mileage (Do not use A0425).

⇒ Include the zip code of patient origin on claim/bill.

⇒ ALS transportation without ALS services should be billed at ALS1.

⇒ Suppliers should continue to use Methods 1,2,3, or 4 and providers continue to use Method 2.

Delayed Changes. A number of the proposed rule changes have been delayed. It will not be necessary for the providers and suppliers of ambulance services to change policies and procedures until final implementation of the fee schedule. These delayed changes include:

⇒ Mandatory assignment-services that do not take assignment agreement can still balance bill.

⇒ ALS reimbursement based solely on ALS being

provided—ALS ambulances used to provide BLS transportation and currently being reimbursed at the ALS rate can continue to file with the ALS1 and ALS1-emergency HCPCS.

⇒ Implementation of a single ambulance mileage code and reimbursement rate for ALS and BLS.

⇒ Payment based on the condition of the patient—current carrier and intermediary policies still apply.

The Problem. Many of the carriers, intermediaries, and insurance companies are not ready. A survey of sample of carriers, intermediaries, Medicaid programs, and in-

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EMS & HOSPITAL TRENDS & NOTES



EMT gunned down at fire station by coworker. EMT David Beck was charged with first degree murder of EMT Kimberly Paswaters at the Campbellsport, Wisconsin fire station. Paswater and Beck had an intimate relationship which she ended the previous week. According to the criminal complaint, the victim was explaining that she didn't want to hurt Beck and wanted to remain friends. Beck previously told his brother that he wanted to hurt her as much as she hurt him. Armed with a 9mm semiautomatic Beretta handgun, Beck allegedly fired 5 shots in her chest. According to Beck's police statement, "I pulled her jacket back, and all of her chest here was all soaked red, and I looked (at) her, and her eyes were rolling up into her head." The victim

leaves behind four daughters between the ages of 8 and 15.

Editor's note. This sad event reminds EMS that we are not immune from our increasingly violent society. Workplace relationships are common in younger workforces and EMS is no exception. Administrators have frequently taken a "don't ask/don't tell or a keep it off the job" policy. In the future, a more thoughtful approach may be required. Your comments/insights are invited by email to cjackson@emprize.net.

911 settlement. The City of Chicago recently approved a \$500,000 payment to the family of a 30 year old that died from a ruptured ectopic pregnancy. The 911 dispatcher did not use the EMD card system and independently determined the patient was suffering from "the flu." The City failed to follow its own procedures and never allowed the caller to explain the chief complaint, according to testimony before the committee.

The call was triaged to a BLS provider. In the second frantic call to 911 that the patient had stopped breathing, the City failed to provide pre-arrival CPR instructions.

Sentencing. The former President of Abbott Ambulance in St. Louis was sentenced to serve over a year in jail following his conviction of nine counts of Medicare Fraud. Terry Dougherty will also pay a \$250,000 fine and the service paid restitution of \$5.4 million dollars. Prosecutors argued that "ticket managing" and upcoding practices had been a 15 year scheme.

RSI endorsed. The National Association of EMS Physicians endorsed Rapid Sequence Intubation (RSI). RSI involves the use of neuromuscular-blocking agents to facilitate endotracheal intubation by paramedics in the January-March 2001 issue of Prehospital Emergency Care. NAEMSP's position recognizes that the procedure may

not be appropriate for all EMS systems and outlined key elements that should be included in any RSI program. Reprint requests of the NAEMT position paper should be addressed to Henry Wang, MD. Email: wanghe@msx.upmd.edu.

Getting "high" on duty. A dessert dropped off at an Elkhart, Indiana fire station during the holidays was apparently laced with marijuana. Eleven firefighters tested positive after eating a Christmas treat and becoming ill. Two were treated at a local hospital.

Real time 911. In Seattle, anyone with Internet access can go to the FD's website to track activities. The site provides a list of dispatch calls, location, time, type of call and incident number. According to Leonard Roberts, IT Director for SFD, the site updates every minute and has already cut down information calls to dispatchers.

NFPA from page 1

jective performance benchmarks applicable to the fire service. It will facilitate internal service improvements." The minimum staffing requirements will have a significant fiscal impact, once implemented.

The impact may not be immediately felt since the NFPA does not have regulatory authority. However, many communities routinely use NFPA as the basis for building codes and other public safety standards.

In the long term, compliance to these standards may be a result of the potential litigation exposure for non-compliance according to industry legal experts. Municipalities may not be motivated to change response times and staffing until after litigation occurs. If a "voluntary standard" like NFPA becomes the accepted practice, then it becomes the standard against which juries consider an award. Litigation against local governments for flawed

EMS designs and response times are increasing.

The NFPA's 1710 applies to career departments and a less stringent standard is applied to volunteer departments. These are outlined in NFPA's proposed standard 1720. In December, the International Association of Fire Chiefs recommended approval of NFPA 1710 with a minor clarification. This was seen as a key step in its final passage by the NFPA membership.

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REIMBURSEMENT ODYSSEY *from page 1*

insurance companies during the first week of January 2001 revealed that:

⇒ One intermediary had not updated its electronic claims software to accept the zip code of the patient's pick-up location.

⇒ One carrier did not know where the zip code should be entered on the 1491 form (this is left up to the carrier to determine the field on the 1491 claim form for zip code documentation).

⇒ One carrier has required all air medical mileage to be billed in nautical miles was unaware of the requirement for billing Medicare in statute miles.

⇒ None of the four state Medicaid programs contacted would accept the new HCPCS codes for ambulance services.

⇒ None of the insurance companies contacted had implemented procedures to accept the new HCPCS codes.

⇒ Many insurance companies and Medicaid programs indicated that changes might occur later.

⇒ The insurance companies indicated that all supplemental claims must be coded with the same new HCPCS codes used in the initial Medicare filing.

Likely Results. Many services will experience problems with claims filed for dates of service beginning January 1st. Possible problems will include:

⇒ Inability to file claims because the payers' electronic claims software will not accept the new HCPCS or zip codes.

⇒ Denial of all claims because the system has not been modified to accept the new HCPCS or zip codes.

⇒ Denial of all claims because the provider/supplier has not changed to the new HCPCS or included zip codes.

⇒ Delay of reimbursement while the payers attempt to sort out their problems.

⇒ Rejection of claims to insurance companies and Medicaid programs if new codes are used and the payer systems have not been modified to accept the codes.

⇒ Rejection of supplement-

tal insurance claims if the new HCPCS are not used.

⇒ Denial of future claims to insurance companies and Medicaid programs if they change to the new codes prior to the providers and suppliers being aware of the changes.

Action Steps. Unfortunately, many of the unfavorable results of the changes imposed by HCFA will be unavoidable. It will be necessary for each provider or supplier to monitor all reimbursement (particularly denials and rejections) closely to insure that the payers are properly processing air and ground ambulance claims. There are some basic steps that should be taken by each agency. These include:

⇒ Call your intermediary or carrier and make sure you and the carrier or intermediary understand exactly what is required by the new rules and you understand exactly how to include the changes on your electronic or paper claims.

⇒ Contact your Medicaid programs to determine if they are accepting the new ambulance HCPCS codes.

⇒ Air programs that have been billing nautical miles should contact their carrier or intermediary to inform them of the change to statute miles.

⇒ Contact major insurance payers to determine if they are allowing the use of the new HCPCS codes.

⇒ If carriers or intermedi-

aries are not prepared to accept claims with the required changes, you should notify your regional HCFA office.

accept the new changes required by Medicare. Ambulance services should prepare for the negative cash flow impact that these delays will create.

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⇒ When modifying billing systems, ensure that re-filing on accounts with dates of service prior to 2001 will generate claims with the old HCPCS. Many computer based billing systems allow changing of the HCPCS for a particular service, but this then is associated with old accounts that were billed with different codes.

Conclusion. HCFA has mandated changes for filing for Medicare reimbursement. Many of the contracted carriers and intermediaries are not ready to process claims with the required changes. This will result in increased denials and delays in reimbursement. Each service should be aware and extremely vigilant in monitoring all claims for reimbursement. Most of the non-Medicare payers have not modified procedures to

The 2001 reimbursement odyssey continues with the passage of the Balanced Budget Act Relief Bill late in December. A few provisions of the Bill impact ambulance services and will cause HCFA "Hal" to modify its databases further prior to reaching the final destination of implementation of the fee schedule. The important components of the Bill for ambulance services include the increase of ambulance rates to the inflation update plus 1% from July 1, 2001 to December 31, 2001. An additional rural mileage benefit is included to provide an extra 25% for each mile from 18 to 50 for trips originating in rural areas.

Three other provisions affect ambulance services. These include an mandate for two studies on rural ambulance service costs and issues, the repeal of consolidated billing for Part B ambulance services by nursing homes, and cost-based reimbursement allowed for Critical Access Hospitals at least 35 miles from the nearest other ambulance provider.

The odyssey continues... stay tuned for further sequels.

If you have any questions or would like to share specific problems with your payers, you can email Richard Keller (rkeller@emprize.net). Common issues will be shared with other respondents.

"Ambulance services should prepare for the negative cash flow impact that these delays will create."

EMS & HIPPA – THE NEXT REGULATORY WAVE

The Healthcare Insurance Portability Act (HIPPA) and its associated procedural changes is the sneak attack that will “bomb” ambulance providers on the heels of the fee schedule implementation. But HIPPA has yet to command the attention it deserves due to other parts of the sky “falling.” Despite the lack of enthusiasm about compliance with yet another federal regulation, the implications of HIPPA are “huge” for public and private providers alike.

HIPPA includes measures to standardize and computerize the transactions of healthcare billing, claims processing and reimbursement. The law also outlines that electronic transactions must

be transmitted securely and handled confidentially.

HIPPA gives consumers control over how their personal health information is used and limits the release of information without a patient’s consent. Specific patient authorization is required before any records can be used for marketing, sales or rental of information, fundraising, employment uses or research unrelated to their treatment.

The Act restricts the amount of patient information that can be shared between physicians and other caregivers to the “minimum necessary.”

HIPPA requires privacy-conscious business practices.

This includes designating a privacy officer and training staff about patient confidentiality.

HIPPA requires that paper records and oral communications be protected from privacy breaches.

HIPPA allows patients to review and request amendments to their medical records.

Under the regulations, all healthcare organizations will need to define and implement effective administrative, physical and technical measures to protect health information. Failure to comply can result in penalties ranging from \$50,00 and up to a year in prison and up to \$250,000 fine and 10 years in

prison if the offender intends to sell or otherwise profit from the information.

The regulation is to be phased-in over two years. A recent study by the American Hospital Association pegged the cost of compliance during the first five years at \$22.5 billion.

To prepare, EMS organizations should familiarize themselves with the 630+ pages of regulations, designate a HIPPA compliance team, define the project of achieving compliance, perform a GAP analysis, implement compliance steps, and commission an external certification review to document that the agency meets the standard.

2001 Ambulance Service Manager's (ASM) Certificate Program March 23-27, May 18-22, July 20-24

Key areas of emphasis include leadership skills, operation systems & issues, finance, budgeting & reimbursement, HR issues/increasing personal effectiveness, marketing and developing community support.



2001 Leadership Conference September 27-29 Kansas City, Missouri

The Leadership Conference focuses on the current issues and opportunities that leaders and managers in medical transportation services must address.

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