Medicare Update

Illinois State Ambulance Association

September 22, 2016

2017 Medicare Ambulance Fee Schedule

Projected 2017 AIF

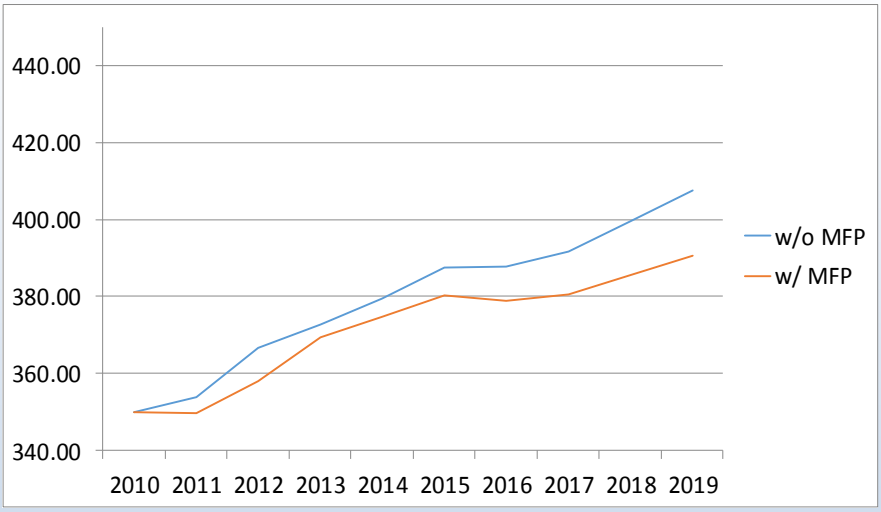
AIF = CPI-U – MFP

CPI-U = 1.00%

MFP = 0.5%

Projected 2017 AIF = + 0.5%

Impact of MFP



Medicare Payment Reform

Legislative Vehicle

- Medicare Ambulance Access, Fraud Prevention and Reform Act (H.R. 745, S. 377)
  - H.R. 745 by Congressmen Greg Walden (R-OR), Peter Welch (D-VT), Devin Nunes (R-CA) and Richard Neal (D-MA
  - S. 377 by Senators Charles Schumer (D-NY), Pat Roberts (R-KS), Patrick Leahy (D-VT) and Susan Collins (R-ME)
  - Makes all the temporary increases permanent
  - Also, changes status to provider, implements cost survey and requires repetitive prior authorization

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Payment Reform Components

- Components of Current and Near-Term Medicare Ambulance Payment Reform
  - Make permanent the current temporary Medicare ambulance increases
  - Change status under Medicare to "providers" of health care services instead of "suppliers"
  - Direct CMS to collect ambulance cost data through survey methodology
  - Target fraud and abuse with repetitive nonemergency transports of dialysis patients

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Cost Data Survey

- Middle Class Tax Relief and Job Creation Act
  - Signed into law in February 2012
  - Extended temporary Medicare ambulance increases
  - Authorized MedPAC review and GAO survey of ambulance industry
- AAA hired The Moran Company to determine viability of collecting ambulance cost data
  - 2007 GAO report just looked at Medicare margins
  - Data and collection process needed in short-term to educate MedPAC and determine GAO report margins
  - Collection process and data required for future reform

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Survey – Moran Findings

FINAL REPORT Detailing "Hybrid Data Collection Method" for the Ambulance Industry:

Beta Test Results of the Statistical & Financial Data Survey & Recommendations

April 2014

The Moran Company determined due to the varying characteristics of ambulance services and small size of average operation that ***survey approach was best method to collect cost data***.

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The Cost Survey Process

Initial Data Collection	Cost Data Collection
Mandatory	Mandatory
All report first year	Survey method: all report within category
Refresh data periodically	At least once every three years
Collect demographic data	Collect revenue and cost data
Purpose: define cost data categories	Purpose: provide accurate view of costs

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The Cost Survey Process

Initial demographic data reported
- All services

CMS determines categories for organization designations
- Within each category, CMS will determine a statistically valid number of services that need to be surveyed

CMS informs survey group of need to report cost information
- Only those survey need to provide data
- Those surveyed will not need to provide data again until all in category surveyed
- If do not reply, subject to 5% penalty

CMS evaluates data and provides public sample files
- Allows for reliable source for making policy decisions

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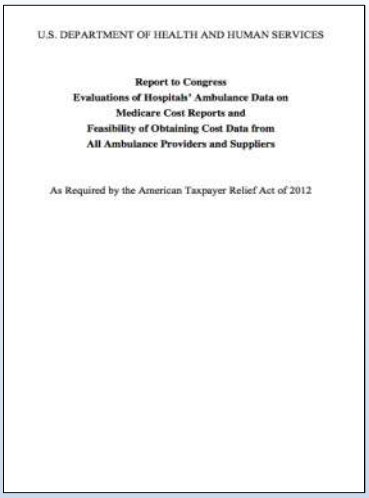
ATRA Report Supports Survey



U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

Report to Congress
Evaluations of Hospitals' Ambulance Data on Medicare Cost Reports and Feasibility of Obtaining Cost Data from All Ambulance Providers and Suppliers

As Required by the American Taxpayer Relief Act of 2012

"Difficult to develop a standard cost reporting tool for all providers and suppliers of ambulance services, and for ambulance entities to furnish cost data."

Any cost reporting tool must take into account the wide variety of characteristics of ambulance providers and suppliers."

"Efforts to obtain cost data from providers and suppliers must also standardize cost measures and ensure that smaller, rural, and super-rural providers and suppliers are represented."

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2014 Medicare Payment Data

2014 National Payment Data

	Description	2014 Allowed #	2014 Paid $
A0425	Ground Mileage	143,405,477	$873,832,937
A0426	ALS Non-Emergency	337,906	$69,521,172
A0427	ALS Emergency	4,960,998	$1,620,350,387
A0428	BLS Non-Emergency	6,818,397	$1,139,530,047
A0429	BLS Emergency	2,834,772	$792,611,731
A0430	Fixed Wing	11,331	$37,484,808
A0431	Helicopter	60,262	$217,560,926
A0432	Paramedic Intercept	2,710	$787,981
A0433	ALS-2	114,075	$53,722,856
A0434	Specialty Care Transport	95,359	$55,593,919
A0435	Fixed Wing Mileage	2,062,052	$19,058,382
A0436	Helicopter Mileage	3,546,916	$88,007,404
Totals		**164,250,255**	**$4,968,062,550**

2014 National Payment Data

	Description	2013 Allowed #	2014 Allowed #
A0425	Ground Mileage	140,891,705	143,405,477
A0426	ALS Non-Emergency	325,531	337,906
A0427	ALS Emergency	4,974,507	4,960,998
A0428	BLS Non-Emergency	6,833,969	6,818,397
A0429	BLS Emergency	2,726,768	2,834,772
A0430	Fixed Wing	10,820	11,331
A0431	Helicopter	56,200	60,262
A0432	Paramedic Intercept	3,153	2,710
A0433	ALS-2	111,789	114,075
A0434	Specialty Care Transport	104,605	95,359
A0435	Fixed Wing Mileage	1,972,269	2,062,052
A0436	Helicopter Mileage	3,309,845	3,546,916
Totals		**161,321,063**	**164,250,255**

2014 National Payment Data

	Description	2013 Paid $	2014 Paid $
A0425	Ground Mileage	864,339,277	$873,832,937
A0426	ALS Non-Emergency	66,422,692	$69,521,172
A0427	ALS Emergency	1,615,499,541	$1,620,350,387
A0428	BLS Non-Emergency	1,182,578,453	$1,139,530,047
A0429	BLS Emergency	758,337,761	$792,611,731
A0430	Fixed Wing	35,462,990	$37,484,808
A0431	Helicopter	201,690,114	$217,560,926
A0432	Paramedic Intercept	908,676	$787,981
A0433	ALS-2	52,420,103	$53,722,856
A0434	Specialty Care Transport	61,021,808	$55,593,919
A0435	Fixed Wing Mileage	18,185,274	$19,058,382
A0436	Helicopter Mileage	81,690,492	$88,007,404
Totals		**4,938,557,181**	**$4,968,062,550**

ILLINOIS – CY 2014

	Description	2014 Allowed #	2014 Paid $
A0425	Ground Mileage	4,793,355	$28,841,818
A0426	ALS Non-Emergency	12,752	$2,606,925
A0427	ALS Emergency	246,742	$80,850,957
A0428	BLS Non-Emergency	248,103	$41,971,905
A0429	BLS Emergency	125,146	$34,479,317
A0430	Fixed Wing		
A0431	Helicopter	2,384	$8,8442,054
A0433	ALS-2	4,263	$2,016,388
A0434	Specialty Care Transport	7,650	$4,340,873
A0435	Fixed Wing Mileage		
A0436	Helicopter Mileage	120,588	$2,969,329
Totals		**5,560,984**	**$206,519,606**

ILLINOIS – FY 2014 vs. FY 2013

	Description	2013 Allowed #	2014 Allowed #	% Change
A0425	Ground Mileage	4,847,392	4,793,355	- 1.11%
A0426	ALS Non-Emergency	13,274	12,752	- 3.93%
A0427	ALS Emergency	256,328	246,742	- 3.74%
A0428	BLS Non-Emergency	250,052	248,103	- 0.78%
A0429	BLS Emergency	123,243	125,146	1.54%
A0430	Fixed Wing	1		- 100.00%
A0431	Helicopter	1,703	2,384	39.99%
A0433	ALS-2	4,657	4,263	- 8.46%
A0434	Specialty Care Transport	7,579	7,650	0.94%
A0435	Fixed Wing Mileage	196		- 100.00%
A0436	Helicopter Mileage	88,281	120,588	36.60%

ILLINOIS – FY 2014 vs. FY 2013

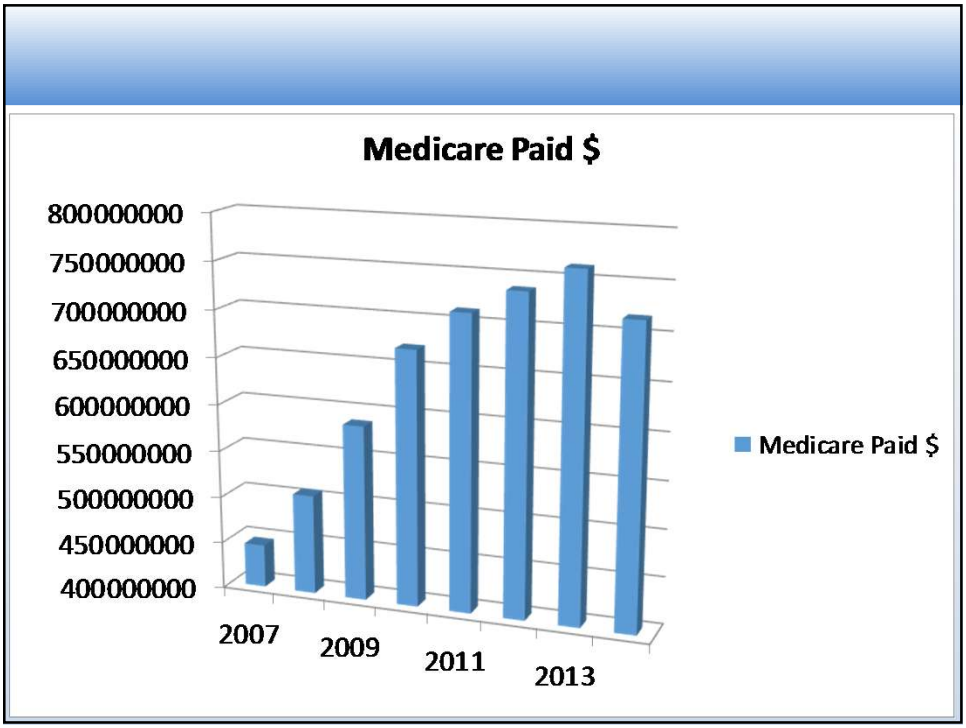
	Description	2013 Paid $	2014 Paid $	% Change
A0425	Ground Mileage	$29,366,557	$28,841,818	- 1.79%
A0426	ALS Non-Emergency	$2,713,844	$2,606,925	- 3.94%
A0427	ALS Emergency	$83,931,140	$80,850,957	- 3.67%
A0428	BLS Non-Emergency	$43,496,130	$41,971,905	- 3.50%
A0429	BLS Emergency	$34,043,709	$34,479,317	1.28%
A0430	Fixed Wing	$2,194		- 100.00%
A0431	Helicopter	$5,981,364	$8,8442,054	41.14%
A0433	ALS-2	$2,200,705	$2,016,388	- 8.38%
A0434	Specialty Care Transport	$4,306,607	$4,340,873	0.80%
A0435	Fixed Wing Mileage	$1,304		- 100.00%
A0436	Helicopter Mileage	$2,176,116	$2,969,329	36.45%

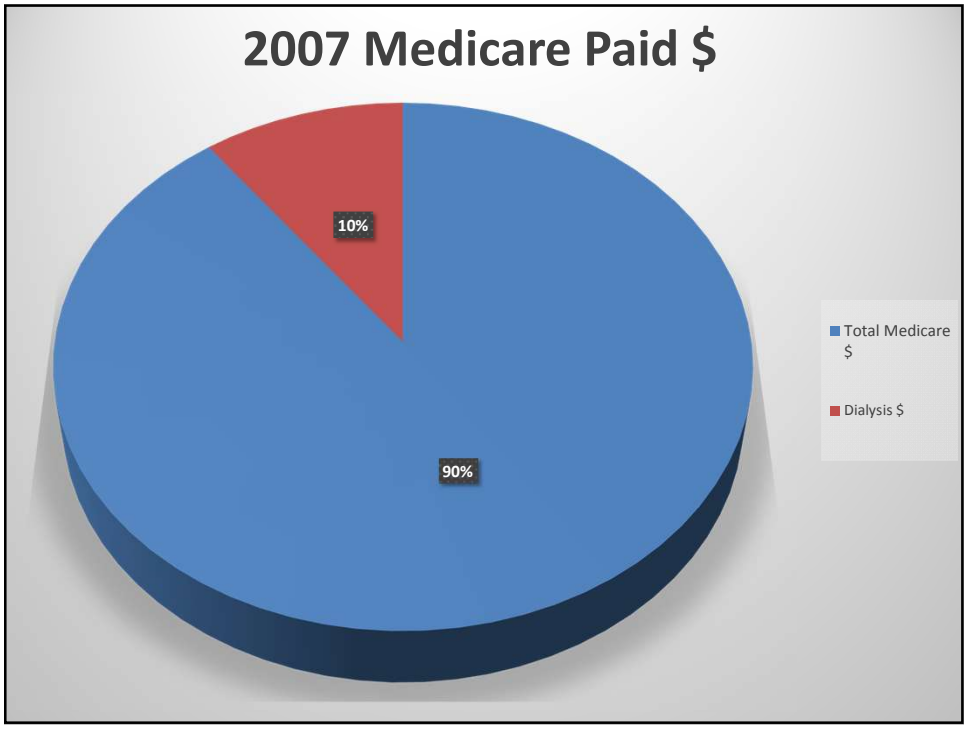
NATIONAL DIALYSIS 2014

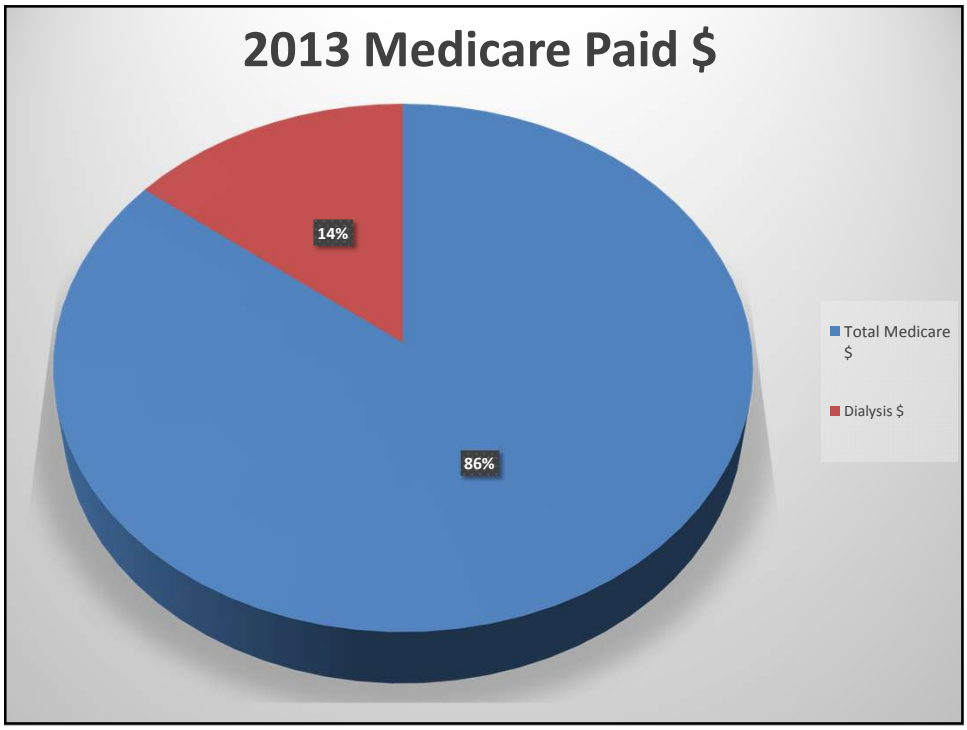
	Description	2014 Allowed #	2014 Paid $
A0425	Ground Mileage	24,328,658	$136,012,944
A0426	ALS Non-Emergency	8,248	$1,748,479
A0427	ALS Emergency	38,951	$12,664,002
A0428	BLS Non-Emergency	3,489,459	$558,381,856
A0429	BLS Emergency	24,509	$6,891,141
A0433	ALS-2	1,101	$ 533,685
A0434	Specialty Care Transport	1,417	$ 881,076
Totals		**27,893,345**	**$717,113,824**

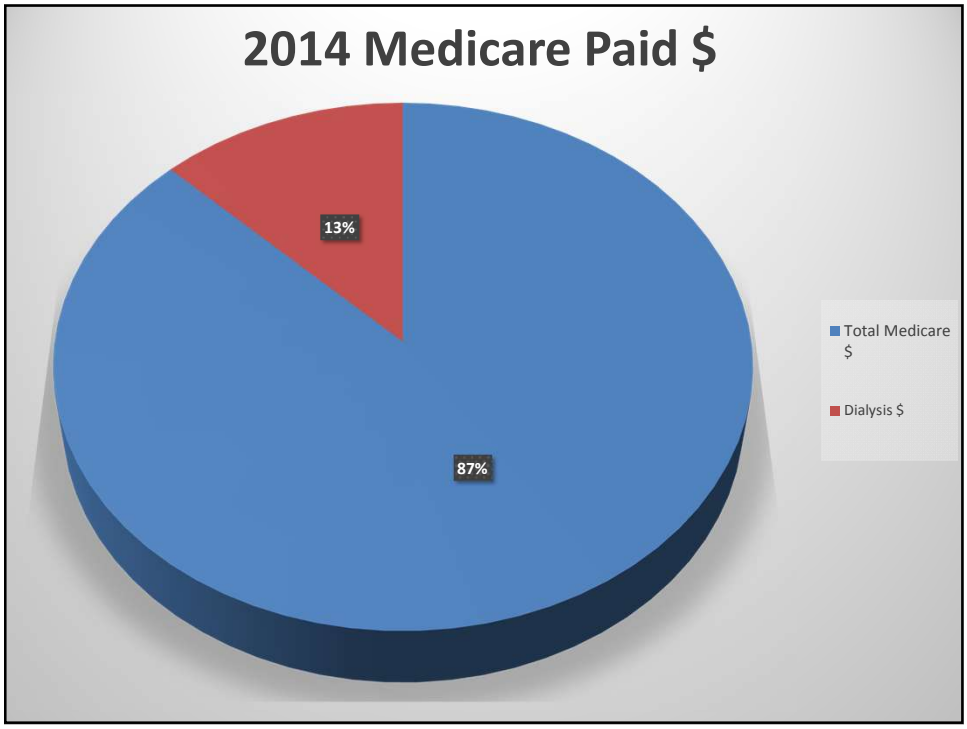
DIALYSIS FY 2014 VS. FY 2013

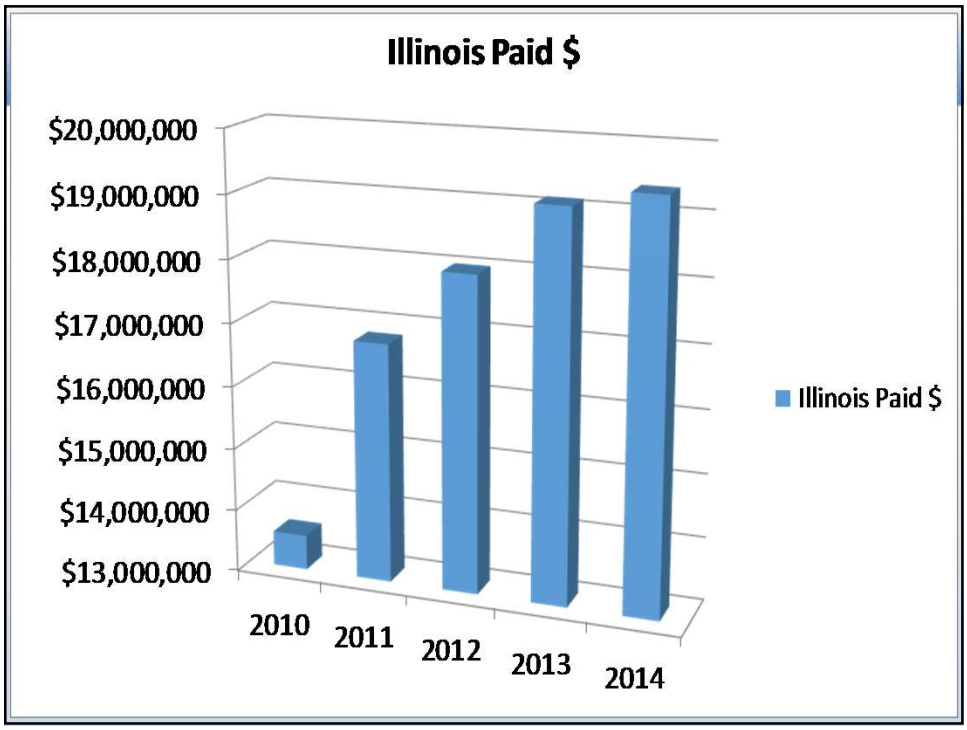
	Description	2013 Allowed #	2014 Allowed #	% Change
A0425	Ground Mileage	23,978,716	24,328,658	1.46%
A0426	ALS Non-Emergency	9,047	8,248	-8.83%
A0427	ALS Emergency	36,570	38,951	6.51%
A0428	BLS Non-Emergency	3,430,502	3,489,459	1.72%
A0429	BLS Emergency	23,513	24,509	4.24%
A0433	ALS-2	883	1,101	24.69%
A0434	Specialty Care Transport	8,032	1,417	-82.36%
Totals		**27,487,263**	**27,892,345**	**1.47%**

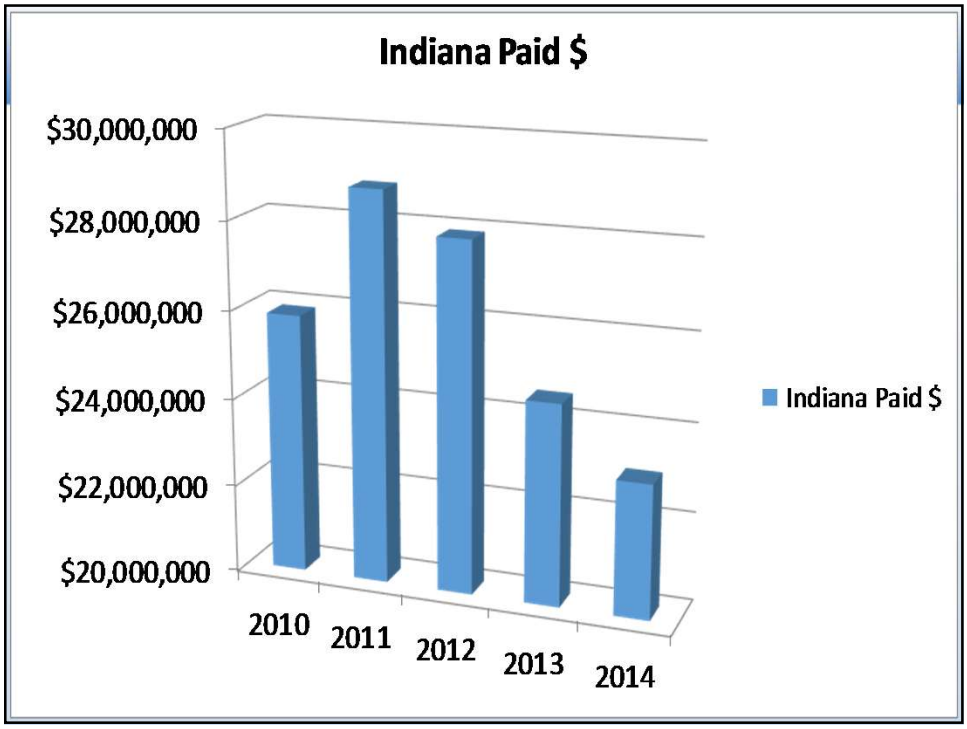


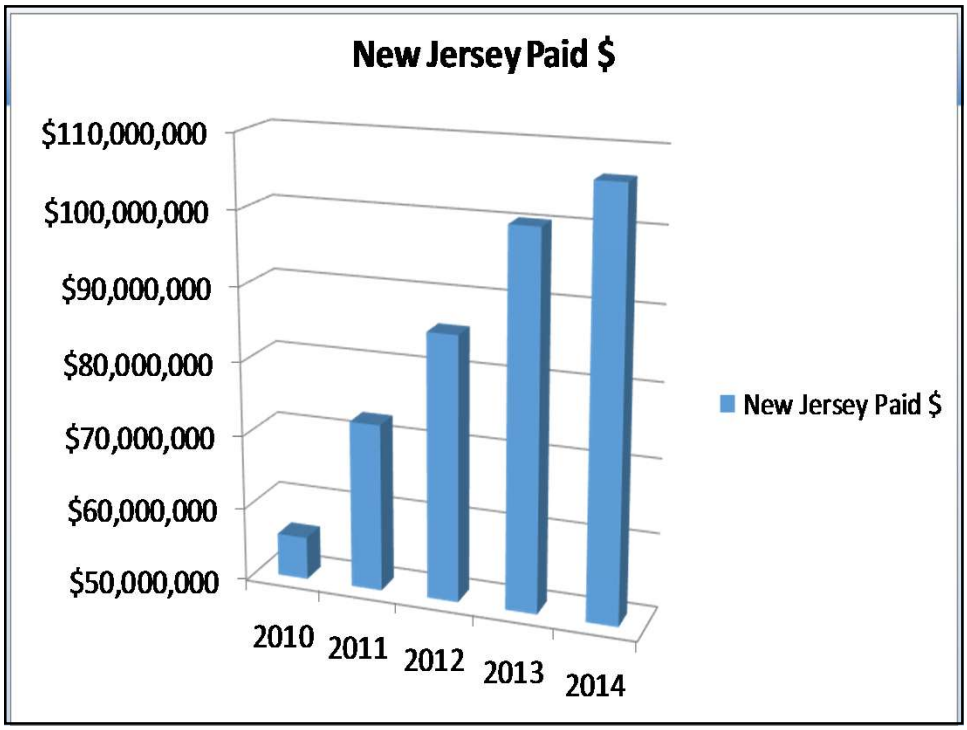

2007 Medicare Paid $
10%
90%
Total Medicare $
Dialysis $


2013 Medicare Paid $
14%
86%
Total Medicare $
Dialysis $


2014 Medicare Paid $
13%
87%
Total Medicare $
Dialysis $


Illinois Paid $
$20,000,000
$19,000,000
$18,000,000
$17,000,000
$16,000,000
$15,000,000
$14,000,000
$13,000,000
2010
2011
2012
2013
2014
Illinois Paid $


Indiana Paid $
$30,000,000
$28,000,000
$26,000,000
$24,000,000
$22,000,000
$20,000,000
2010
2011
2012
2013
2014
Indiana Paid $


New Jersey Paid $
$110,000,000
$100,000,000
$90,000,000
$80,000,000
$70,000,000
$60,000,000
$50,000,000
2010
2011
2012
2013
2014
New Jersey Paid $

State Dialysis Comparison

State	Medicare Population (July 2012)	ESRD Population (July 2012)	2013 BLS-NE Dialysis Transports
New Jersey	1,397,532	13,781	461,399
Michigan	1,754,367	15,425	78,090
Pennsylvania	2,385,084	17,899	275,473
South Carolina	839,989	9,139	281,353
Missouri	1,058,418	8,364	1,590
Arizona	1,009,292	8,731	98

Final Rule on Reporting and Refunding Overpayments

BACKGROUND

- February 16, 2012, CMS issued a proposed rule designed to implement new ACA regarding return of overpayment
  - "60 day" rule
- February 17, 2015, CMS published a notice in the Federal Register extending for another year the time for it to finalize that rule

FEBRUARY 2016 FINAL RULE

- On February 12, 2016, CMS issued its final rule on the reporting and refunding of overpayments
  - Effective March 16, 2016
- Implements Section 6402(a) of the Affordable Care Act

DEFINITION OF AN "OVERPAYMENT"

An "overpayment" for these purposes is:

"[A]ny funds that a person has received or retained under [Medicare] to which the person, after applicable reconciliation, is not entitled…"

OVERPAYMENT "IDENTIFIED"

CMS indicated that an overpayment will be deemed "identified" to the extent that:

"[A] person has, or should have through the exercise of reasonable diligence, determined that the person has received an overpayment and quantified the amount of that overpayment"

"Reasonable Diligence"

CMS indicated that a reasonable diligence means a timely, good faith investigation of any credible report of a possible overpayment.

Note: CMS indicated that an investigation should take less than 6 months, except in extraordinary circumstances

Duty to Inquire

- Review of billing records indicates that you were paid an incorrect rate for services;
- Where you learn the patient died prior to the date of service for which you billed (e.g., identify theft);
- Where you discovered the services were provided by an unlicensed or excluded provider;
- Where an internal audit discovers the presence of an overpayment;
- **Where you are informed by a government agency (or its contractor) as part of an audit that you have been overpaid**

60-Day Period

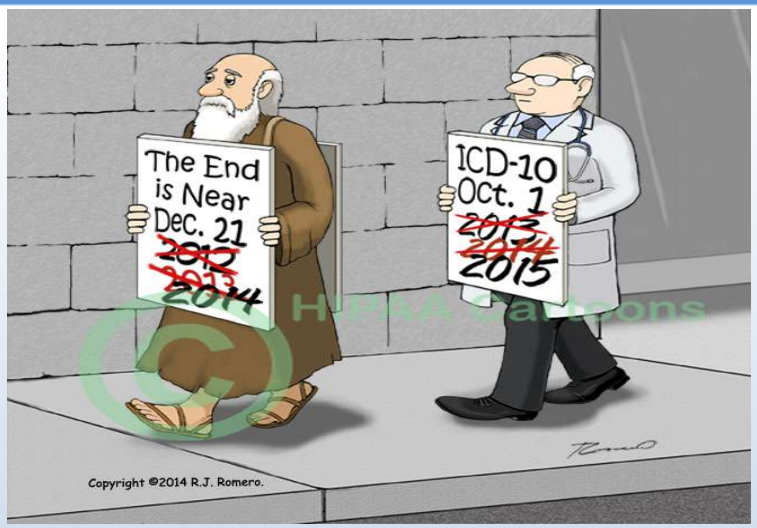
- Starts from the date you "identify" the overpayment
  - i.e., the date you can quantify the amount of the overpayment following a reasonably diligent investigation
- Date you receive credible information about an overpayment if you failed to conduct a reasonably diligent investigation

Refunding Payments

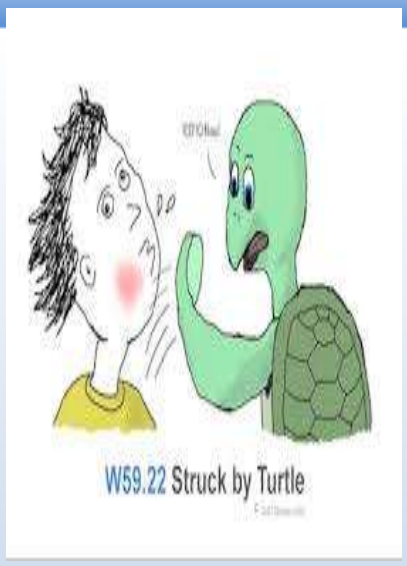
- CMS indicated that you can use the following to refund an overpayment:
  - Claims adjustment
  - Credit balance
  - Self-reported refund
  - Any other process established by the MAC

STATUTE OF LIMITATIONS

- CMS established a 6 year statute of limitations on the requirement that overpayments be refunded
  - i.e., you must refund all overpayments identified within 6 calendar years from the date of payment



SPOT THE FAKE




SPACECRAFT CRASH
INJURING OCCUPANT
KNOW THE CODE: V95.41XA


Burn due to water-skis on fire?
There's a code for that!
ICD-10 V91.07XA
INTELICODES


Stabbed while Crocheting
(ICD10) -Y93D1
Don't
bother me
while I crochet.


Knitting accident?
There's a code for that!
(ICD-9) E012.0
INTELICODES

ICD-10 Codes

- Went live **October 1, 2015**!!!
- CMS has released an updated version of the Medicare Condition Code List
  - https://www.cms.gov/Center/Provider-Type/Ambulances-Services-Center.html
  - 1000+ pages

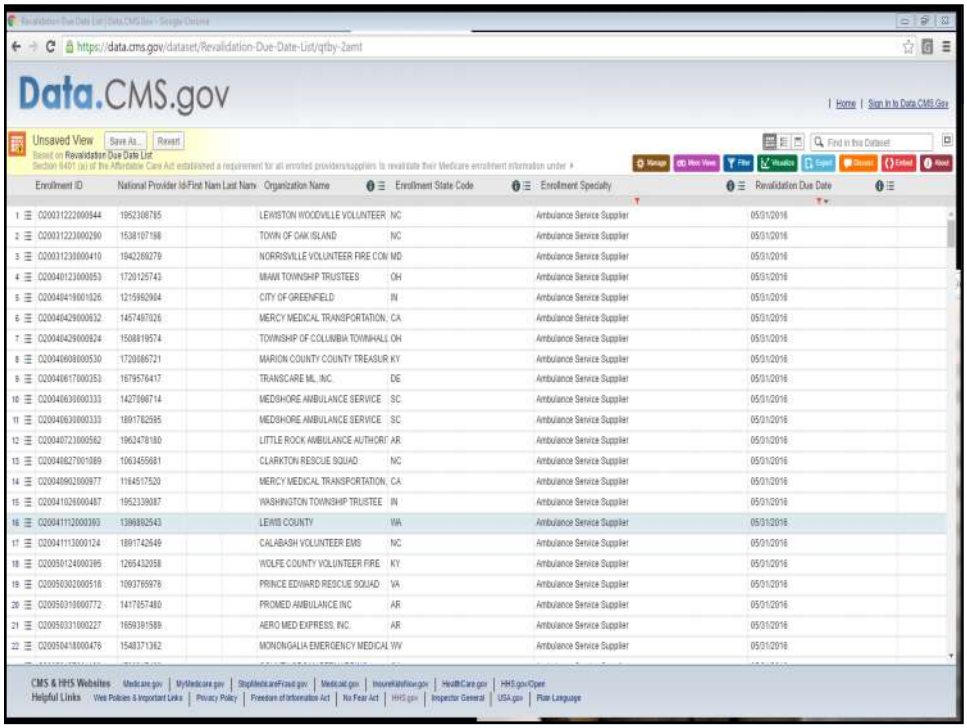
Animal Bites,other
*Primary code

870.0 Laceration of skin of eyelid and periocular area	**S01.111A** Laceration without foreign body of right eyelid and periocular area, initial encounter **S01.112A** Laceration without foreign body of left eyelid and periocular area, initial encounter **S01.119A** Laceration without foreign body of unspecified eyelid and periocular area, initial encounter **S01.121A** Laceration with foreign body of right eyelid and periocular area, initial encounter **S01.122A** Laceration with foreign body of left eyelid and periocular area, initial encounter **S01.129A** Laceration with foreign body of unspecified eyelid and periocular area, initial encounter **S01.131A** Puncture wound without foreign body of right eyelid and periocular area, initial encounter **S01.132A** Puncture wound without foreign body of left eyelid and periocular area, initial encounter **S01.139A** Puncture wound without foreign body of unspecified eyelid and periocular area, initial encounter **S01.141A** Puncture wound with foreign body of right eyelid and periocular area, initial encounter **S01.142A** Puncture wound with foreign body of left eyelid and periocular area, initial encounter **S01.149A** Puncture wound with foreign body

What Else is New?

Medicare Revalidation

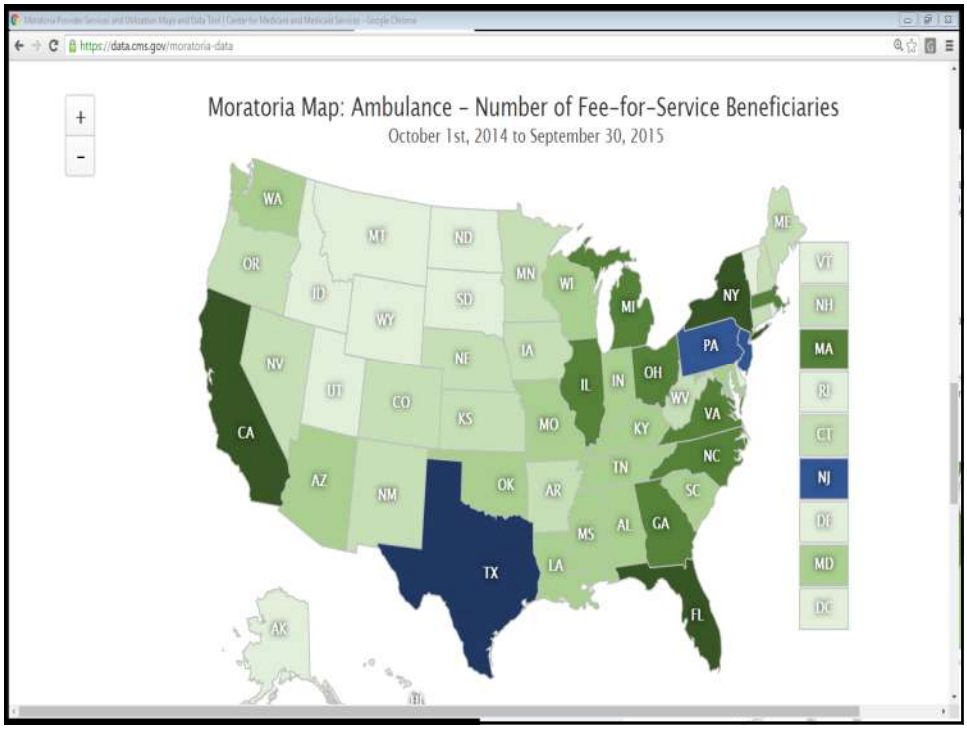
- CMS is continuing its efforts to require all existing Medicare providers and suppliers to "revalidate" their Medicare enrollment information
  - Original target date: March 2013
  - Extension: March 2015
- 2016 Enrollment Fee: $554
- Medicare contractors given discretion on when to revalidate various provider groups
- Failure to revalidate can result in 1 year ban on participation in Medicare!!
- List of all providers that have been asked to revalidate, arranged by calendar quarter
  - http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/Revalidationshtml

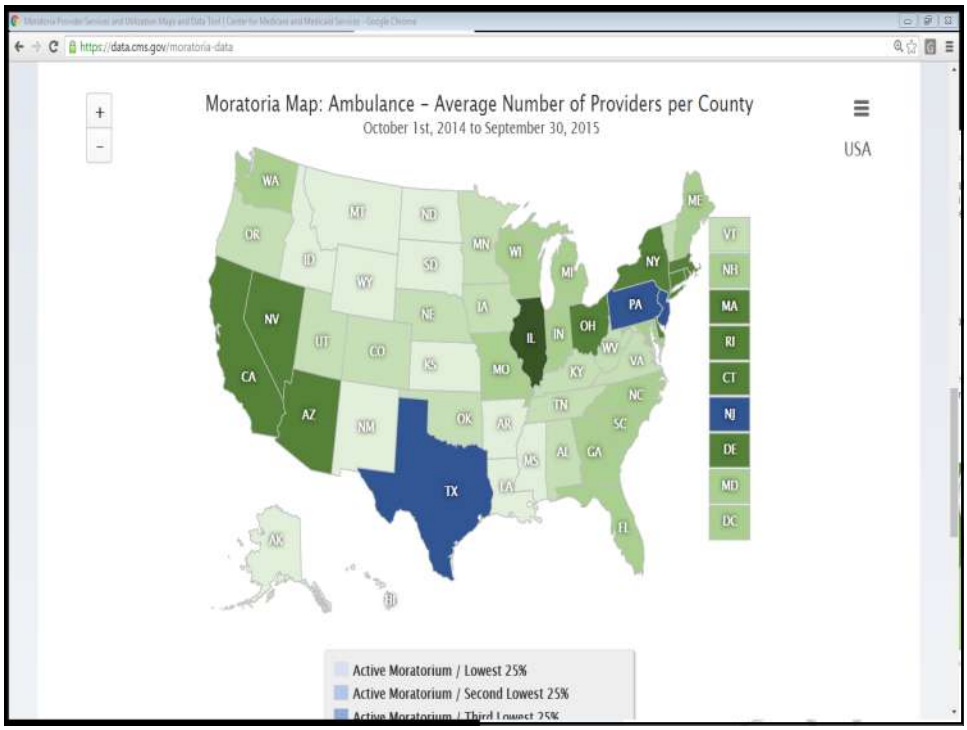


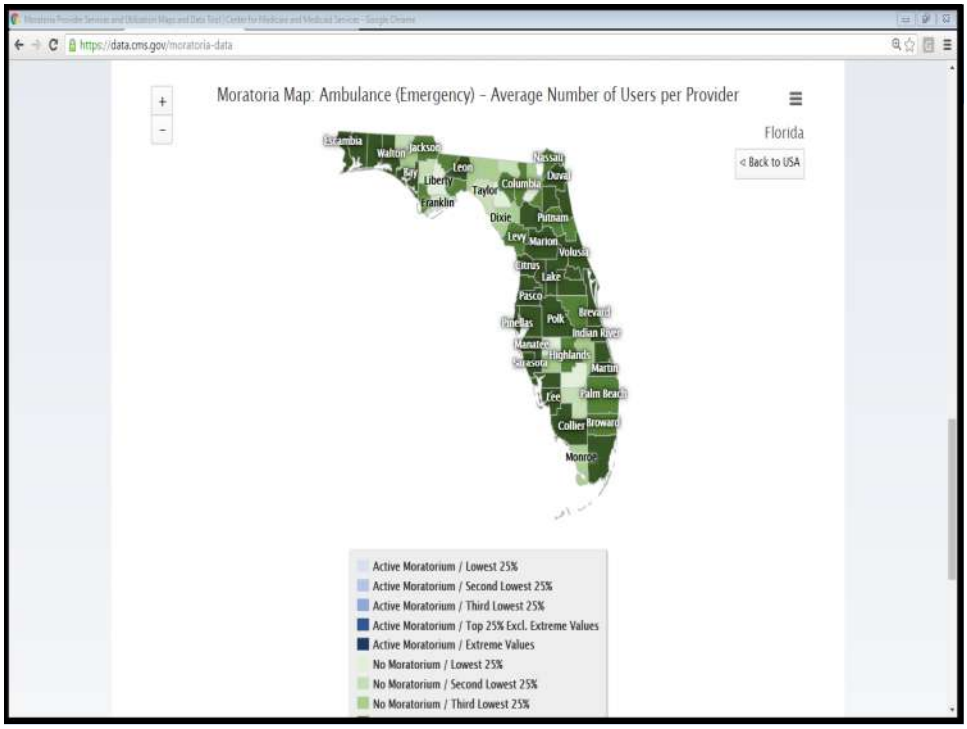
CMS MORATORIUM DATA SET

Interactive dataset that shows the "density" of certain metrics used by CMS to evaluate the need for temporary enrollment moratorium
State and County-level data

https://data.cms.gov/moratoria-data


https://data.cms.gov/moratoria-data
Moratoria Map: Ambulance - Number of Fee-for-Service Beneficiaries
October 1st, 2014 to September 30, 2015
WA
OR
CA
NV
ID
MT
WY
UT
AZ
CO
NM
ND
SD
NE
KS
OK
TX
MN
IA
MO
AR
LA
WI
IL
MS
MI
IN
KY
TN
AL
OH
WV
GA
FL
SC
NC
VA
PA
NY
ME
VT
NH
MA
RI
CT
NJ
DE
MD
DC
AK
HI


https://data.cms.gov/moratoria-data
Moratoria Map: Ambulance - Average Number of Providers per County
October 1st, 2014 to September 30, 2015
USA
Active Moratorium / Lowest 25%
Active Moratorium / Second Lowest 25%
Active Moratorium / Third Lowest 25%



CHANGES TO MORATORIA PROGRAM

- On July 29, 2016, CMS announced several changes to its existing moratoria in the Houston and Philadelphia metropolitan areas
- Key changes:
  1. CMS lifted moratoria on enrollment of new emergency ground ambulance providers
  2. Extended moratoria on the enrollment of new non-emergency ground ambulance providers to the entire states of NJ, PA, and TX

BILLING PRIVILEGES PROPOSED RULE

- March 1, 2016
- Providers and suppliers would be required to disclose affiliations with another provider or supplier that:
  - Owes an uncollected debt to the Medicare Program
  - Is under a payment suspension for a federal health program
  - Has been excluded from Medicare, Medicaid or CHIP
  - Has had its billing privileges revoked or denied
- Gives CMS new authority:
  - Deny an enrollment if the provider/supplier is revoked under a different name or identifier
  - Increase the maximum enrollment bar from 3 to 10 years
  - Prohibit a provider/supplier from enrolling in Medicare for up to 3 years if its enrollment was rejected due to false or misleading statements
  - Revoke a provider/supplier's enrollment if they have an unpaid debt owed to the US Treasury

NEW FROM THE OIG

AKS Safe Harbors – Proposed Rule

- Safe Harbor for Cost-Sharing Waivers for Emergency Ambulance Services:
  - Governmental ambulance provider or supplier
  - Qualified provider or supplier of "emergency ambulance services"
    - Would not apply to governmental ambulance services that provide **exclusively** non-emergent transportation
  - Waiver of coinsurance and deductibles must not constitute the provision of "free services"
  - Waiver must be offered on a uniform basis, without regard to patient-specific factors
  - Waiver must not be claimed as "bad debt" or otherwise shifted onto Medicare, Medicaid, other payers, or the beneficiary

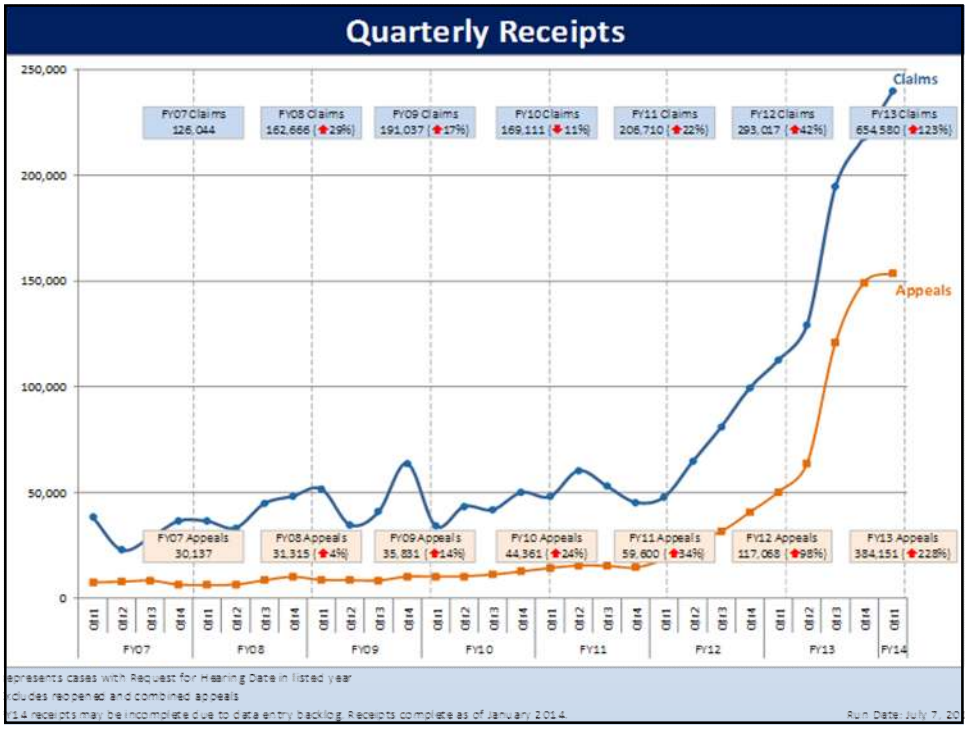
AKS Safe Harbors – Proposed Rule

- Safe Harbor for Free or Discounted Local Transportation
  - Provided by an "Eligible Entity"
  - Free or local transportation must not be determined in a manner related to past or anticipated volume, or the value of Federal health care program business
  - **Free or local transportation cannot take the form of air, luxury or ambulance transportation**
  - Free or local transportation must not be marketed or advertised, and no marketing or advertising can occur during the transport
  - Transport must be limited to:
    - Established patients and family members or others assisting patient
    - Within the local area
      - i.e., within 25 miles of the facility

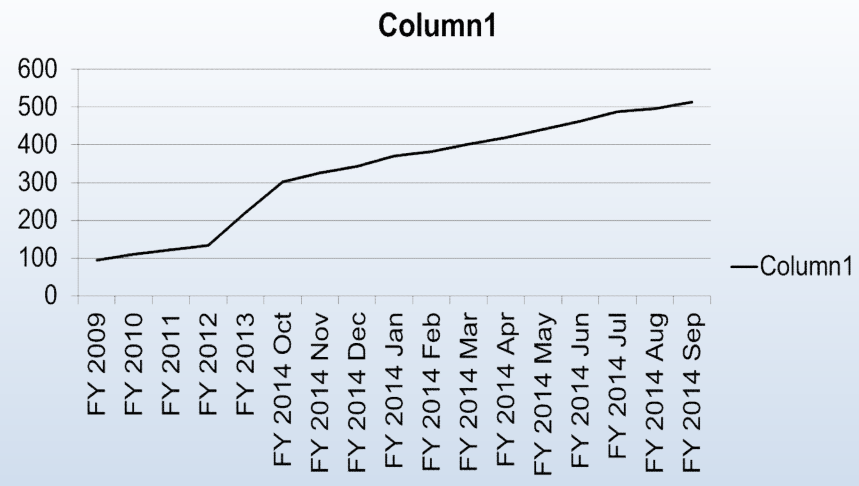
AKS Safe Harbors – Proposed Rule

- Exception to Prohibition on Inducements to Beneficiaries in Cases of Financial Hardship
  - Item or service must not be advertised
  - Item or service cannot be tied to the provision of other items or services reimbursable, in whole or in part, by a Federal health care program
  - There must be a reasonable connection between the item or service and the medical care of the individual
  - There must be a good faith determination of financial hardship on the part of the patient
  - **Would allow for prospective waivers!!!**

Medicare Appeals Process



ALJ AVG. PROCESSING TIMES



ALJ Decisions

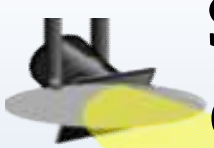
	FY 2012	FY 2013	FY 2014 (Through Aug)
Fully Favorable	53.2%	44.3%	36.5%
Partially Favorable	6.4%	5.2%	2.8%
Unfavorable	27.9%	25.5%	29.8%
Dismissed	12.5%	25.0%	30.9%

July 5, 2016 Proposed Rule

- In the preamble, CMS noted the following:
  - 1,223% increase in the number of appeals since FY 2009
  - As of April 30, 2016, there were more than **750,000 appeals** pending with OMHA
  - ALJs currently process approximately 77,000 appeals per year
    - Increase to 93,000 appeals by end of FY 2016

JULY 5, 2016 PROPOSED RULE

- Proposed Changes:
  - Give CMS the authority to designate certain Medicare Advisory Council decisions as "binding precedent"
  - Introduce "Attorney Adjudicators" to resolve certain matters pending before ALJs
  - Streamline appeals process through ALJ-level
    - e.g., bring Medicare Advantage appeals process closer to alignment with FFS appeals process



Spotlight on Compliance

An Overview of the Compliance Challenges Facing EMS Providers

Working Thesis

Today's ambulance providers and suppliers face the most challenging compliance environment in recent memory, certainly since the implementation of the Medicare Ambulance Fee Schedule, and most likely at any time prior to that

Medicare Fraud Strike Force Locations

Ambulance Kickbacks

- 5 ambulance companies in Southern California have agreed to pay a total of more than $11.5 million to resolve allegations related to potential kickbacks
  - Allegation was that ambulance companies engaged in "swapping" schemes to provide deeply discounted ambulance services to hospitals and nursing homes in exchange for referrals

Ambulance Kickbacks

- 9 hospitals in Jacksonville (FL) area have agreed to pay a total of $6.25 million to resolve allegations related to the improper use of ambulances for hospital discharges
  - 1 of 2 ambulance companies implicated has also settled
- Allegations were that the hospitals were knowingly ordering ambulances to discharge patients that could go safely by other means
  - Financial benefit was to ambulance companies
  - Intangible benefits to hospitals

OIG Report on Questionable Billing Practices

METHODOLOGY

- OIG analyzed claims data for 7.3 million ground ambulance transports during the first half of CY 2012
  - $2.9 billion in total Medicare payments
  - 2.9 million Medicare beneficiaries
  - 15,614 unique ambulance suppliers

KEY FINDINGS

- 21% of ambulance suppliers tested "positive" for at least one of the 7 "questionable billing" practices the OIG examined
  - ~ 4% tested positive for 2 or more questionable billing practices
  - ~ 1% tested "positive" for 3 or 4 questionable billing practices

Table 4: Questionable Billing Among Ambulance Suppliers, First Half of 2012

Measure of Questionable Billing	Median Among All Suppliers	Suppliers That Had Questionable Billing	
		Threshold	Number of Suppliers
No Medicare Service at the Origin or Destination	0 transports	3%	2,038
Excessive Mileage for Urban Transports	10 miles	34 miles	642
High Number of Transports per Beneficiary[1]	4 transports	21 transports	533
Compromised Beneficiary Number	1%	7%	358
Inappropriate or Unlikely Transport Level	<1%	3%	268
Beneficiary Sharing[1, 2]	1.2 suppliers	2.3 suppliers	168
Transports to or From PHPs	0 transports	<<1%[3]	127

Note: We identified suppliers that had questionable billing and calculated median levels for each measure among all suppliers to which the measures applied. For example, the measure "excessive mileage for urban transports" applies to suppliers with urban transports. Appendix B provides a detailed description of how each measure was calculated.

[1] Among suppliers that provide dialysis-related transports.

[2] As represented by the number of suppliers per beneficiary.

[3] "<<1" means that the number would round to 0, but is above 0.

Source: OIG analysis of Part B data for Medicare ambulance services, 2013.

ANTI-DISCRIMINATION RULES

- On May 13, 2016, HHS issued final regulations designed to implement explicit protections from discrimination on the basis of gender identity
  - Aimed primarily – but not exclusively – at health plans

"TAGLINES"

- Covered entities must post notices of nondiscrimination and "taglines" that alert individuals with limited English proficiency about the availability of language assistance services
  - Must be posted in at least the top 15 non-English languages spoken in the state

HIPAA AUDIT PROGRAM – PHASE 2

- HHS Office of Civil Rights has announced an ambitious audit program for 2016
- Phase 1 completed December 2012
- Phase 2 will focus on policies and procedures implemented to ensure compliance with Privacy, Security and Notice of Breach Rules
  - Covered entities **AND** business associates

Stages of Phase 2

- Stage 1 – Contact verification
  - Emails sent to covered entities and business associates to confirm mailing addresses and other contact information
- Stage 2 – Questionnaires
  - Surveys designed to get a sense of an entity's size, scope, and nature of operations
- Stage 3 – Audit Subject Pools
- Stage 4 – Audit notification letters and document requests
- Stage 5 – Findings and entity input

HIPAA Violation

- Lahey Hospital & Medical Center (Burlington, VT) paid $850K in fines related to the breach of patient protected health information
  - Stolen laptop used to operate a CT scanner contained information on 599 patients
  - Stolen from an unlocked treatment room in 2011

GAO REPORT RE: CMS AUDIT ACTIVITIES

- May 13, 2016
- Report on comparative effectiveness of
  - RACs v. MACs
  - Prepayment v. Postpayment Reviews

GAO Report re: CMS Audit Activities

- Key findings:
  - RACs limited themselves to postpayment reviews
    - Primarily Hospital Inpatient Claims
  - MACs focused almost exclusively on prepayment reviews
    - Physician and other Part B claims

GAO Report re: CMS Audit Activities

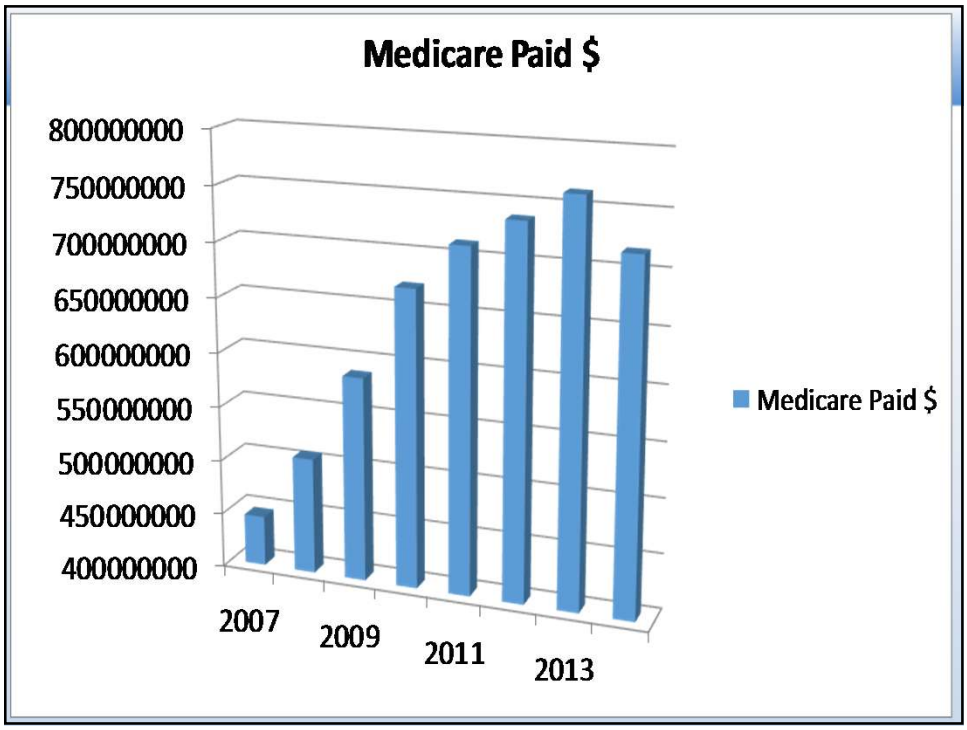
- Key findings:
  - RACs identified $4.5 billion in improper payments during FY 2013 and FY 2014
  - Paid $312 million
    - $14 in improper payments per dollar paid

GAO Report re: CMS Audit Activities

- Recommendations:
  - CMS should seek legislation to permit RACs to transition to prepayment reviews
    - CMS disagreed with the recommendation, noting that it had other programs in place to avoid "pay and chase"
  - CMS should clarify the reporting obligations of MACs with respect to program integrity reviews

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES


585.6
ESRD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OIG Report on Utilization

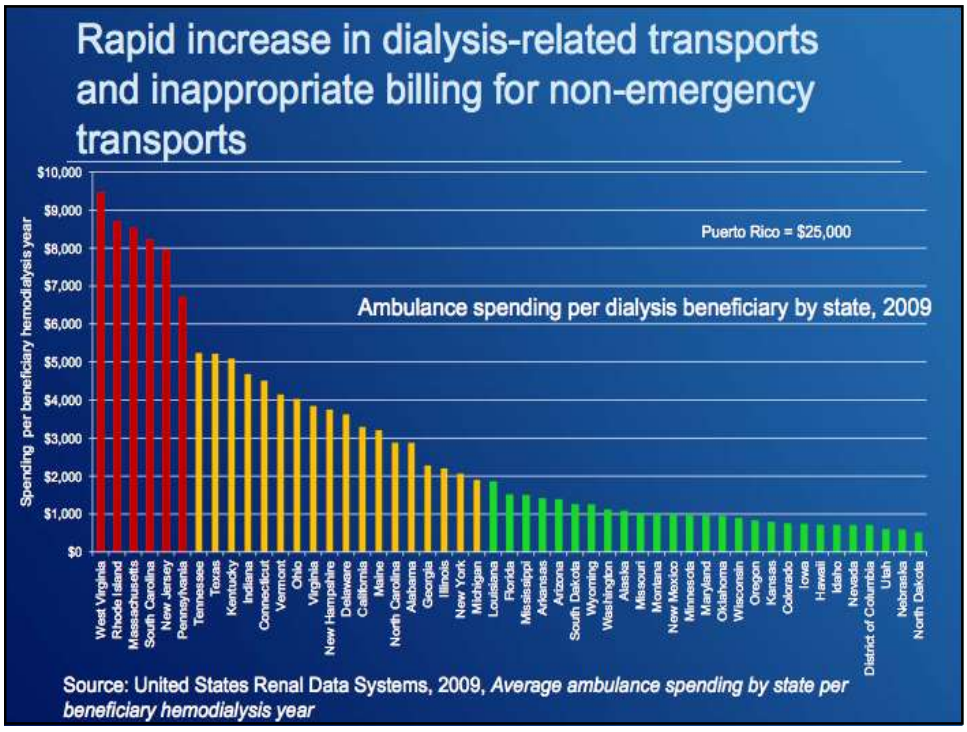
- Between 2002 – 2011:
  - **269% increase in dialysis transports**
    - 85% increase in number of ESRD patients

OIG Report on Utilization

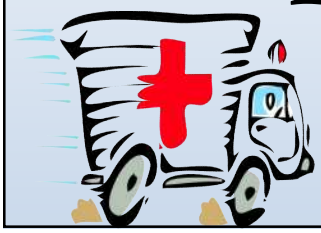
- Between 2002 – 2011:
  - 69% increase in Part B ambulance transports
  - 34% increase in number of beneficiaries requiring ambulance transport
  - 26% increase in number of ambulance suppliers
    - ~ 100% increase in number of BLS-NE suppliers
  - 829% increase in transports to partial hospitalization programs

2013 MEDPAC REPORT

- Number of ambulance providers has grown steadily since 2007
- Ambulance volume increased by 10% from 2007 to 2011
  - Most of increase in volume was from increase in BLS-NE
  - Dialysis in particular
  - Increase centered in urban areas



Prior Authorization Program



Timeline for National Expansion

- National expansion is conditioned on issuance of a report confirming that the demonstration project:
  - Reduces expenditures **AND**
  - Does not create access to care issues
- CMS has indicated that the study will not be completed by January 1, 2016
  - No timeline for completion

Therefore, as of today, it does not appear that prior authorization will be expanded nationally by January 1, 2017!!!

Prior Authorization

- Medicare contractors will continue to process claims for the first three round trips with a 30-day period for the beneficiary
- Starting with the fourth round-trip claims will be subjected to a pre-payment medical review
  - Unless a prior authorization request has been submitted and approved

Prior Authorization Request

- Requests can be submitted by mail, fax, or through the Electronic Submission of Medical Documentation (esMD)

Response Time Frame

- Medicare contractors will "make every effort" to postmark decisions on an initial submission within 10 business days
  - 20 business days for a resubmission

Tracking Numbers

- Each request for a prior authorization will be assigned a "tracking number"
  - Unique Transaction Number (UTN)
  - Follows patient
- For approved requests, the tracking number must be submitted on subsequent claims

Approved Requests

- If approved, the MAC will authorize up to 40 round trips (80 total trips) for a 60-day period
  - Approval is provider-specific
  - Any provider submitting claims without a prior approval on record will be subject to prepayment review

Therefore, if two ambulance providers are both transporting the patient for a repetitive service (e.g., one to dialysis and another to wound care), both will need to obtain a prior authorization!!

Expedited Reviews

- CMS indicated that there will be a process for requesting an expedited review when the timeframe for making the prior authorization decision would jeopardize the life or health of the beneficiary
  - Decisions within 2 business days
- CMS indicated that it expects requests for expedited reviews to be "extremely rare"
  - **You should assume it would NEVER apply!!!**

Representative Payee

- Towards the end of December 2014, ambulance providers in the affected states were receiving "non-affirmations" indicating that the patient was not eligible for participation in the PA program because they had a "representative payee" on file with the SSA
  - i.e., an individual who was responsible for receiving their SS payments
- CMS confirmed that these patients were not included in the demonstration project
  - Submit claims without a UTN
- **Effective January 1, 2016 (or thereabouts) Representative Payees are no longer excluded**

Novitas – PCS

Novitas initially rejected PCS forms that were signed and dated with a date prior to December 15, 2014 (i.e., the start date of the program)

Catch-22: to cover trips on or after December 15, 2014, you needed to submit the prior authorization request prior to that date. If the PCS needed to be signed prior to the date you submitted your request…how could it be signed on December 15, 2014?

MDS Form

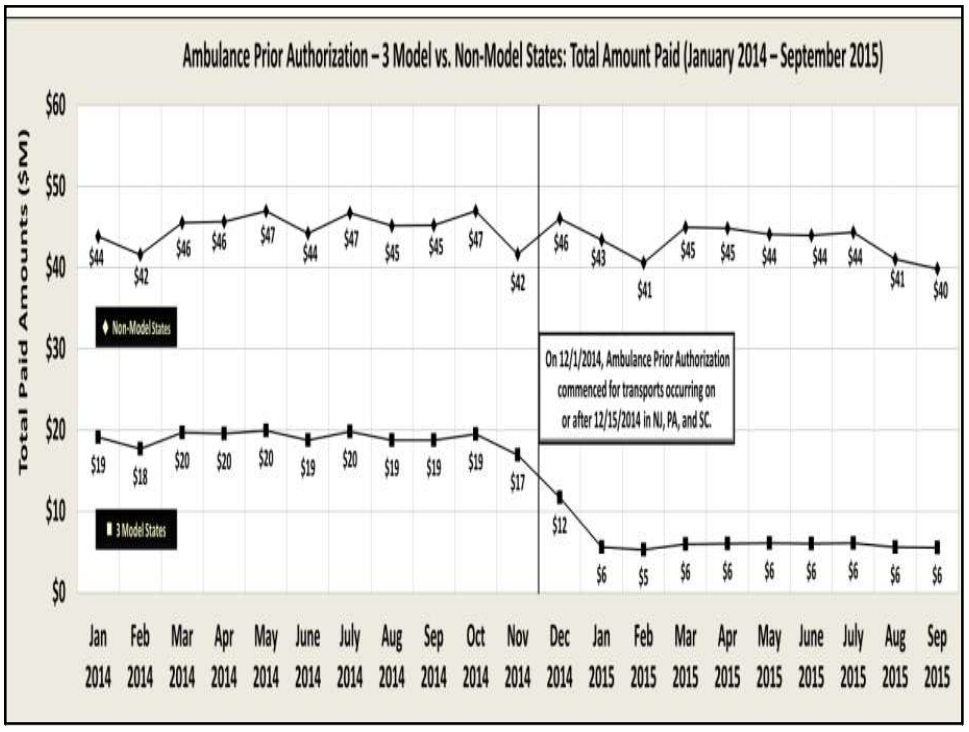
- Novitas would not accept portions of the MDS form
  - Novitas' stated concern was that omitted portions contained information that conflicted with the information provided

Catch-22: Novitas would not read the entire form if submitted

Novitas – Physician Letters

- Novitas initially would not accept a letter from the physician indicating why the patient required an ambulance
  - Novitas wanted to see the actual physician progress notes

The Surreal: not only would Novitas refuse to assign any value to the physician's letter, it would reject the entire request because it included an unacceptable documentation



KEY LESSONS FROM DEMONSTRATION PROJECT

1. Ambulance benefit is a limited one!!!
2. There exists some differences of opinion between the provider community and the MACs as to what constitutes a "covered" patient
3. Being in "sync" with the MAC is more important than being right

PRE-IMPLEMENTATION

- Seek clarity on your state and local regulatory environment
  - Does your state permit stretcher vans?
  - If so, are their any restrictions on their use?
  - Is your MAC aware of any such restrictions?

PRE-IMPLEMENTATION

- Pay attention to any notices or other communications from your MAC
  - Are you on the correct listserv?
  - Will they be holding meetings on their process in your state?
  - Are they looking for hosts?

PRE-IMPLEMENTATION

- Create/update your processes and procedures for managing your repetitive patient population
  - PCS Forms
  - Independent Patient Assessments?

PRE-IMPLEMENTATION

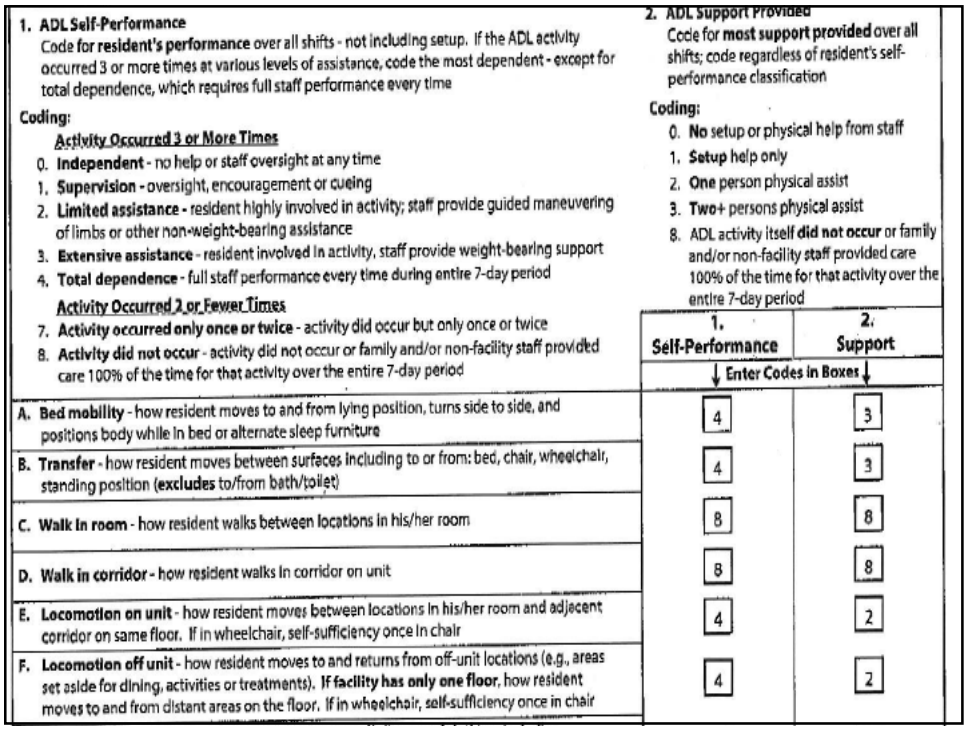
- Conduct a review of your current repetitive patient population
  - Confirm that they meet medical necessity
  - Identify areas of weakness with your documentation
- Be realistic!!
  - Anecdotal evidence suggests that Novitas is rejecting more than 70% of all patients submitted for prior authorization

RISK PROFILES

- One option is to categorize your repetitive patients based on the likelihood that they will be approved for prior authorization
  - High – almost certain to be approved
  - Medium
  - Low – likely to be rejected

Initial Submission Checklist

- Create a list of all documents you will need for a new patient
  - Prior Request Cover Sheet
  - Valid PCS form
  - Supporting documentation
    - **SNF Minimum Data Set**



1. ADL Self-Performance
Code for **resident's performance** over all shifts - not including setup. If the ADL activity occurred 3 or more times at various levels of assistance, code the most dependent - except for total dependence, which requires full staff performance every time

Coding:

Activity Occurred 3 or More Times
0. **Independent** - no help or staff oversight at any time
1. **Supervision** - oversight, encouragement or cueing
2. **Limited assistance** - resident highly involved in activity; staff provide guided maneuvering of limbs or other non-weight-bearing assistance
3. **Extensive assistance** - resident involved in activity, staff provide weight-bearing support
4. **Total dependence** - full staff performance every time during entire 7-day period

Activity Occurred 2 or Fewer Times
7. **Activity occurred only once or twice** - activity did occur but only once or twice
8. **Activity did not occur** - activity did not occur or family and/or non-facility staff provided care 100% of the time for that activity over the entire 7-day period

2. ADL Support Provided
Code for **most support provided** over all shifts; code regardless of resident's self-performance classification

Coding:
0. **No** setup or physical help from staff
1. **Setup** help only
2. **One** person physical assist
3. **Two+** persons physical assist
8. ADL activity itself **did not occur** or family and/or non-facility staff provided care 100% of the time for that activity over the entire 7-day period

	1. Self-Performance	2. Support
	↓ Enter Codes in Boxes ↓	
A. **Bed mobility** - how resident moves to and from lying position, turns side to side, and positions body while in bed or alternate sleep furniture	4	3
B. **Transfer** - how resident moves between surfaces including to or from: bed, chair, wheelchair, standing position (**excludes** to/from bath/toilet)	4	3
C. **Walk in room** - how resident walks between locations in his/her room	8	8
D. **Walk in corridor** - how resident walks in corridor on unit	8	8
E. **Locomotion on unit** - how resident moves between locations in his/her room and adjacent corridor on same floor. If in wheelchair, self-sufficiency once in chair	4	2
F. **Locomotion off unit** - how resident moves to and returns from off-unit locations (e.g., areas set aside for dining, activities or treatments). **If facility has only one floor**, how resident moves to and from distant areas on the floor. If in wheelchair, self-sufficiency once in chair	4	2

G0300. Balance During Transitions and Walking

After observing the resident, code the following walking and transition items for most dependent

Coding:
0. Steady at all times
1. Not steady, but able to stabilize without staff assistance
2. Not steady, only able to stabilize with staff assistance
8. Activity did not occur

Enter Codes in Boxes	
8	A. Moving from seated to standing position
8	B. Walking (with assistive device if used)
8	C. Turning around and facing the opposite direction while walking
8	D. Moving on and off toilet
2	E. Surface-to-surface transfer (transfer between bed and chair or wheelchair)

G0400. Functional Limitation in Range of Motion

Code for limitation that interfered with daily functions or placed resident at risk of injury

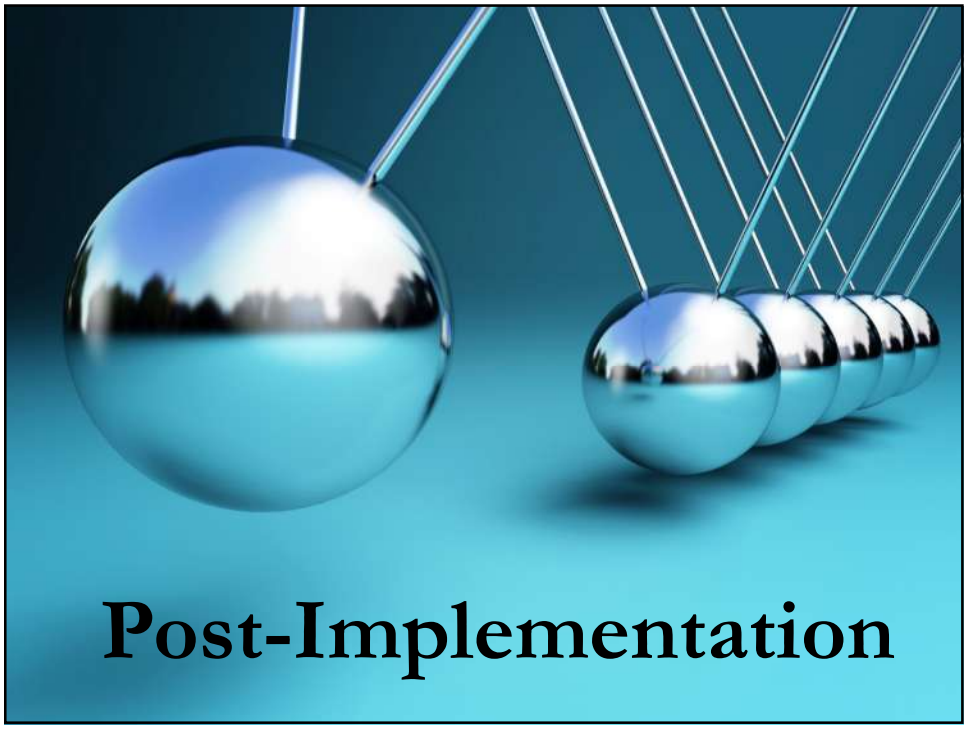
Coding:
0. No impairment
1. Impairment on one side
2. Impairment on both sides

Enter Codes in Boxes	
0	A. Upper extremity (shoulder, elbow, wrist, hand)
0	B. Lower extremity (hip, knee, ankle, foot)

G0600. Mobility Devices

Check all that were normally used

☐	A. Cane/crutch
☐	B. Walker
☒	C. Wheelchair (manual or electric)
☐	D. Limb prosthesis
☐	Z. None of the above were used



Post-Implementation

3 Months Later…

- You want to try and get a sense of how strict (or how lenient) your MAC is being with granting prior approvals
  - This should guide your long-term strategy for handling repetitive patients

Risk Profiles

MAC is consistently approving even those patients you categorized as "low" likelihood

Risk Profiles

MAC is consistently rejecting even those patients you categorized as "high" likelihood

Next Steps?

Options

1. **Resubmit for approval**
   Likely will require additional documentation
2. **Submit individual claims**
   Will be denied
   Will require appeals
3. **Ask yourself, is it possible the MAC is correct?**

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