SECTION 4

Establishing Patient Fees

The previous section described the process by which the retail transport price of providing ambulance services is calculated. While no further explanation would be needed if all transports were charged at the same rate, in reality most services have varying rate schedules depending on the type of transport (for example, ALS or BLS), and use different methods for charging patients.

Two examples of different ambulance service billing methods are the all-inclusive or flat-fee structure—in which all patients are charged the same amount—and itemized billing, the laundry list approach in which every supply item used and treatment performed is listed. Somewhere between these two extremes is the billing process used by most services.

Developing a Rate Structure

While it is inappropriate for a service to set the *amount* of its charges according to how much Medicare will reimburse, it is beneficial to determine *how* to charge based upon which items and amounts the local Medicare carrier will reimburse. Significant differences in reimbursement levels may exist for providing the same services in different regions, depending on how the rates are structured and coded for Medicare filing. Also, since Medicare does not reimburse for all supplies and treatments, it is necessary to determine whether it is worthwhile to bill patients for items that will not be reimbursed by Medicare or are not covered. Covered services vary from one area to another. In some areas, Medicare will reimburse for night calls, while in others no such provision exists.

Medicare classifies ambulance transportation as non-emergency, emergency and ALS. Within these categories, particularly ALS, it allows for three methods of billing charges: all-inclusive, all-inclusive with non-reusable supplies billed separately, and ALS base rate plus all supplies. Obviously, revenue can be improved if the billing most advantageous under Medicare is selected, since 30 percent to 50 percent of the patients transported by an ambulance service are likely to be Medicare beneficiaries. However, since it is illegal to charge Medicare patients at different rates than other payers, the rate structure selected through this process should be used for all patients, not just those eligible for Medicare. The reimbursement amounts can be obtained from the service's Medicare carrier.

The two primary charges for which Medicare reimburses are the base rate and mileage. These two items should represent the major income sources for the service. Often the all-inclusive or all-inclusive with non-reusable supplies billed separately categories offer the greatest Medicare reimbursement opportunities. All-

inclusive, in its purest form, means that only a base rate and mileage will be reimbursed. In the second category, specific additional items can be reimbursed separately, such as night calls, oxygen and monitoring. Again, specific information may be obtained from the carrier.

To obtain better reimbursement levels, it may be advantageous to bill emergencies or ALS in the all-inclusive manner and bill non-emergency patients according to the base rate plus supplies and treatments. In this case, consistency can be maintained by service line rather than throughout the entire patient mix. This is discussed below.

Regardless of the rate structure selected, all procedures and supplies should be documented for each patient. The rate structure should be reviewed periodically and may be modified if reimbursement policies or amounts change.

Figure 6.6 identifies a potential array of items for which charges can be developed.

Pricing by Service Line

An ambulance service may provide only one service line (such as ALS emergency service), or it may offer a number of lines such as ALS and BLS emergencies, non-emergencies, scheduled transports, long-distance transportation and wheelchair services. A different pricing structure may be appropriate for each of the service lines.

Emergency services

The most expensive ambulance service activity is the provision of emergency response. This is primarily because of the cost of allocating necessary resources. If a service always responds with ALS resources, there is little cost difference between an ALS and a BLS call. Thus, it may be best to price these services at the same level.

The fact that collection rates for emergency services are much lower than for non-emergency services should be considered when the retail transport price for emergency activity is calculated. Since contractual allowances and bad debt may be much higher for these services, the difference between the amount charged and the amount collected is greater.

Non-emergency services

There is no formula for determining the difference between emergency and non-emergency rates, but it is not uncommon for non-emergency rates to be one-half to two-thirds that of the emergency rate. There are a number of reasons for the large discrepancy in cost: for example, the collection percentage is higher, and it is easier to schedule the ambulances or the trips to provide these services in a more economical manner. Some ambulance services even offer discounts for

Figure 6.6: Sample of Chargeable Items

							Act charcoal
							Aminophylline
							Ammonia ampules
		ALS base rate					Atropine sulfate
		BLS base rate					Benadryl™
		Emergency charge					Bretylium
		Night charge					Calcium chloride
		ALS mileage					Decadron™
		BLS mileage					Demerol™
		Critical care base					Dextrose
		Critical care mileage					Diazepam
		Waiting time/1/2 hour					Epinephrine 1:10,000
		No transport charge					Epinephrine 1:1,000
		Other					Inderal™
							Intropin™
		Disp. tonsil tip					Ipecac syrup
		Endo-locks					Isuprel™
		Endotracheal tube					
		O/2 delivery device					Lasix™
		O/2 humidifier					Lidocaine 100mg
		O/2 per hour					Lidocaine 2mg
		Oropharyngeal airway					Morphine sulfate
		Suction catheter					Narcan
		Venturi mask					NTG TABS
							Nitrous oxide
		Cold pack					Pitocin™
		Dressing—Small					Sodium bicarb. 50 meq
		Dressing—Medium					Sodium bicarb. 10 meq
		Dressing—Large					
		Dressing—X-Large					D5W (500ml)
		Hot pack					D5W (1,000ml)
		Triangular bandage					1/2 Normal saline (ns) (1,000ml)
		Wire ladder splints					Sol'n NS
							Sol'n H20
		Code blue (thumper)					Lactated Ringer's (1,000ml)
		Defibrillator pads					NS (1,000ml)
		Disposable electrodes					
		EKG telemetry					BVM/demand valve use
		Monitor charge					Esophageal obt. airway
		Prep razor					Endotracheal intubation
							Backboard/scoop
		Disp. OB kit					Blood specimen drawn
		Emesis basins					Cervical collar
		Convenience bags					Cricothyrotomy
		Extrication/1/2 hour					Defibrillation
		Incubator					Drug adm.-IV
		Incubator per hour					Drug adm.-IM
		MAST application					Drug adm.-ET
		Sterile burn sheets					Drug adm.-SQ
							IV adm
		Extension set					Needle Thoracentesis
		IV arm board					OB delivery
		IV catheter					Oxygen adm.
		Mini adm set					Sand bags
		Phlebotomy set					Air splint
		Primary adm set					Traction splint app.
		Secondary adm set					Other splint
							Suctioned airway

prescheduling non-emergency transports because this allows more efficient scheduling of the ambulance crews.

Special services

Many ambulance services provide and charge for special activities that are not classified as either emergency or non-emergency ambulance transports. Among these activities are standbys for special events (for example, football games, races, concerts, parades and so on), intensive care transports, long-distance transports, wheelchair transportation and other activities.

Pricing for special services must be established based on costs, and it must include a contribution to the financial strength of the organization. It must also be undertaken cautiously. Although the initial intent may be to use on-duty personnel at straight-time rates, when the service gets busier or there is less interest in the duty it may be necessary to staff these activities with overtime personnel. Thus, it is generally best to establish pricing based on the overtime costs.

The pricing of services is a fundamental issue in an ambulance service, since underpricing can have far-reaching and long-term effects on the viability of the service. The price should be based largely on the actual cost of providing the service, taking uncollectible amounts into account; subsidies can be used to pay for uncompensated care or to reduce the rates to all patients.

Competitive Pricing

Many communities have more than one ambulance provider, prompting pricing decisions based on what the competitors are charging. This is particularly true with non-emergency, or transport, services. Typically, however, this type of pricing is poor and can result in bankruptcies and service closures. Even if the result is not quite this drastic, inadequate revenue can cause the performance and quality of the service ultimately to decline. It is important to note that ambulance services with higher quality and responsiveness have continued to increase their market share in most communities even though they often have higher rates.

A service must consider the market in which it functions, and it must have adequate knowledge of what competitors are charging when establishing rates. At all times, though, the goal is to develop an attractive price and still be able to maintain high levels of service and quality personnel.

Determining Marginal Costs

In certain circumstances, it is necessary to calculate the marginal cost of providing service to a specific customer or contracting agency. This approach is often used in determining how much to charge a hospital for round-trip transports from the hospital to other facilities for tests or treatment (for example, diagnostic-related group [DRG] transports) and to establish fees for standby events, especially those that are community sponsored.

The marginal, or incremental, cost includes the actual additional expense incurred on a per-transport basis for providing a group of transports. The concept behind marginal costing is that the service already has the infrastructure in place: vehicles, equipment, personnel, dispatch, and billing and collection services. Therefore, a few more calls will not add significant expense.

Marginal costs can be calculated with or without personnel expenses. The direct expenses of providing one additional transport would only include variables such as gas, wear and tear on the vehicle, billing costs, linen expenses and supplies used. However, this is based on the assumption that personnel are already on-duty and available to accomplish the additional work. This is a risky assumption. If too many transports are based on marginal costs without the personnel component, additional units will have to be staffed to service the other workload.

Direct personnel costs *should* be included in the marginal cost calculation and should be determined by the average time needed to complete an assignment. For example, if the typical round-trip transfer averages 1.5 hours, direct personnel costs will equal 1.5 times the combined personnel hourly rate.

Next, the personnel benefits percentage should be added to this figure. This amount, combined with the other direct non-personnel expenses of providing the transport, equals the marginal cost that needs to be recovered for the service to break even on the transport. An additional percentage or amount should be added to this figure as a contribution to the overhead or profitability of the organization. Normally, the fees are guaranteed to be paid and there is no uncollectible amount to be considered. A formula for calculating the marginal transport costs and appropriate price determination is provided in Figure 6.7.

Figure 6.7: Formula for Calculating Marginal Transport Costs

Personnel cost per transport		$_____
Vehicle cost per transport	+	$_____
Supply cost per transport	+	$_____
Billing cost per transport	+	$_____
= MARGINAL COST/TRANSPORT		$_____
Contribution to overhead or profit (percentage or amount)	+	$_____
TOTAL TRANSPORT CHARGE		_____

SECTION 5

Patient-Accounts Services

Every EMS and patient-transport service depends upon the money it receives. Even though revenue is an important factor, it is amazing how many services pay so little attention to billing and collections. One reason that so little progress is seen in this area is that many EMS organizations have evolved from, or are still, governmental or quasi-public agencies. It is well known that private industry places more emphasis than public services on recovering revenue.

This attitude is gradually changing as public money becomes tighter. Taxpayers are increasingly concerned about government efficiency and how their monies are being spent, and services are collecting more revenue from patients and their insurance companies rather than relying on public subsidies. All this has caused many public service managers to re-evaluate their billing and collection system. What they often find is a financial nightmare. One public EMS service reported that it collected only 13 percent of its receivables, and others discovered they are indulging in inadequate, inefficient and sometimes illegal activities. This section is devoted to helping managers evaluate and change their billing and collection systems to maximize the money received from patient services. This will have the long-term effect of keeping the total price of the service lower.

The secret to an outstanding billing-and-collection process is systemization. This means developing step-by-step procedures for handling patient accounts. It also means establishing clearly defined, written procedures that eliminate all confusion and any questions about how particular accounts are processed. The personnel involved should be well-oriented and trained in these procedures. Finally, there should be a clear audit trail.

The system described here involves three principles. First, maximize income, then decrease the time it takes to receive the payments, and, finally, handle income in the most cost-effective manner possible.

The essential ingredients for maximum collections include the following:

Medical care must be timely and of the highest quality. Field and office personnel must be courteous, competent and professional at all times.

Accurate and professional-looking invoices and statements should be provided to customers.

Third-party reimbursement procedures must be understood, and any necessary assistance for filing or helping patients file insurance claims should be made available.

A current accounts-receivable system should be established to reduce the backlogs of statements to be sent, claims to be filed, calls to be made or action to be taken on past-due accounts.

A means of measuring, documenting and analyzing accounts should be established so that managers can maintain control and determine the system's results.

Finally, *personal* attention and contact with patients should be developed and maintained.

Establishing Patient-Accounts Services

The number of employees required in the patient account department is determined by the size of the service and the number of accounts to be processed. It may be that one person can do everything or that dozens of individuals are required. Still, regardless of the number of people, certain activities must be accomplished in the billing-and-collection process. These steps should be accomplished accurately, in a methodical manner and in a logical order.

Source documents

The billing-and-collection process begins when the source documentation is prepared. This data is produced by two primary groups: dispatch and field personnel.

The dispatch log or card, whether automated or manual, provides initial information regarding the assignment. In many communications centers, much of the patient information required for billing and collection is gathered at the time of the request for non-emergency transport. In the case of emergency responses, which do not allow for the opportunity to gather information prior to the ambulance response, primary collection of patient and insurance information falls to the field personnel.

Field personnel, as a part of their job responsibilities, are required to carefully document all aspects of their interaction with the patient. Part of this process includes collecting patient demographic information, insurance documentation and carefully noting medical care and treatment. All of these categories are essential for billing and collection efforts. Figure 6.8 is an example of a patient-care report that is also designed to comprehensively collect patient and insurance information.

Dispatch/field reconciliation

Just as one would reconcile a monthly bank statement by matching checks and deposits with the information provided by the bank, it is necessary to reconcile dispatches with the paperwork. This requires that each dispatch originating at the communications center results in the proper paperwork being prepared in the field.

ANYTOWN'S
Ambulance
P.O. Box 123
Somewhere, USA 01234
Tax I.D. 00-0000000

Mo. Day Year
Date of Run | Incident Number | Speed Bill # | Unit # | Amb. | C.C.
Dispatch Time | Return Number | Account Number | Driver | Attendant

PATIENT INFORMATION

Last Name | First Name | Middle Initial

Street, Route, etc. | Apt. # | City

( ) - | State | Zip | Phone Number

- - | Male / Female | - - | Social Security Number | Mo. Day Year Age Date of Birth

RESPONSIBLE PARTY

Name

Street | Relationship

City | State | Zip

( ) - | Phone Number

TRIP INFORMATION

Location of Pickup | Name of Hospital, Nursing Home, Clinic or Street, Route, Highway #

City | County | State | Zip

Emergency | Auto Accident y n | Mileage to Location
Transfer | Work Related y n | Mileage to Destination

Patient Destination | Name of Hospital, Nursing Home, Clinic or Street

City | County | State | Zip

Physician

Diagnosis

INSURANCE INFORMATION

Medicare - - - | Medex#
Welfare - - - -

Blue Cross

Massachusetts, Federal, Other
Subscriber Number
Subscriber Name
Subscriber Relationship

Other Ins.

Insurance Company Name
Address
Group Number
Policy, Certificate or Card Number

Oxygen | Small Bandage | MAST Suit
Monitor | Medium Bandage | O.B. Delivery
E.O.A. | Large Bandage | Splint
Backboard/Scoop | Extrication | Suction
Other

I, the undersigned, hereby authorize payment directly to ANYTOWN Ambulance, of benefits otherwise payable to me but not to exceed the regular charges for this type of service. If I am entitled to Medicare benefits, I authorize any holder of medical or other information about me to release to Social Security Administration or its intermediaries or carriers any information needed for this or related Medicare claim. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits either to myself or to the party who accepts assignment below. I understand I am financially responsible to ANYTOWN Ambulance for charges not covered by this authorization and do hereby guarantee payment of this bill within forty-five (45) days. I further agree that if collection is made by suit or otherwise, I will pay all collection costs, including a reasonable attorney's fee. I hereby approve release of information pertinent to hospital confinement, doctor's treatment and diagnosis for claims for insurance benefits. NOTE: Nothing in the above statement shall provide a basis for denial of either emergency care or emergency transport because of inability to pay.

Signed X _____
Patient or Policy Holder

EMPLOYMENT INFORMATION

Company

Street | Occupation

City | State | Zip

( ) - | Phone Number

AUTO ACCIDENT

Owner's Name and Address

Registration # | Make/Model/Year | Phone #

License # | Insurance Company

Agent's Name

Agent's Address and Phone Number

VERIFICATION

Operations | Office

Figure 6.8: Sample Patient Care Report, Part 1

Figure 6.8: Sample Patient Care Report, Part 2

CALL PRIORITIES

To Location
Priority _____
To Destination
Priority _____
☐ ALS
☐ BLS
Dry Run ☐☐

☐ Problems en route, at scene, etc. Specify in narrative.

LOCATION

☐ Agriculture
☐ Clinic/physician's office
☐ Hospital
☐ Industry/work
☐ Nursing home
☐ Public place
☐ Recreation
☐ Residential
☐ School
☐ Trafficway
☐ Waterway
☐ Other _____

PRIOR AID GIVEN

☐ Police
☐ Fire
☐ First Responder
☐ Paramedic
☐ Physician
☐ Other _____

INJURY/ILLNESS CATEGORY

☐ Abdominal pain/problems
☐ Allergies/stings/med. reac.
☐ Animal bites
☐ Assault/rape
☐ Back pain
☐ Breathing problems
☐ Burns
☐ Carbon monox./inhal./hzmt.
☐ Cardiac/respiratory arrest
☐ Chest pain
☐ Choking
☐ Convulsions/seizures
☐ Diabetic problems
☐ Drowning (near)/diving acc.
☐ Electrocution
☐ Eye problems
☐ Falls
☐ Headache
☐ Heart problems
☐ Heat/cold exposure
☐ Hemorrhage
☐ Industrial/machinery acc.
☐ O.D./Poisoning ingestion
☐ Preg./birth/miscarriage
☐ Psych./behavioral prob.
☐ Sick (specific diagnosis)
☐ Stab/gunshot wound
☐ Stroke/CVA
☐ Traffic injury accidents
☐ Trauma injuries (specific)
☐ Unconsciousness/fainting
☐ Unknown prob. (man down)
☐ Other _____

PREHOSPITAL INDEX

Components	Value	Score
Blood Pressure	>100	0
	86–100	1
	75–85	2
	0–74	5
Pulse	>120	3
	51–119	0
	<50	5
Respiration	Normal	0
	Labored/shallow	3
	<10/min.	5
Consciousness	Normal	0
	Confused/combative	3
	No intelligible words	5
Total	0–3	Minor trauma
	4–20	Major trauma

NOTE: Penetrating abdominal or chest injuries given 4 points in addition to calculated PHI.

TREATMENT

☐ Assessment
☐ Vitals taken
☐ Airway suctioned
☐ BVM ventilation
☐ Intubation
☐ Airway placed
☐ EOA
☐ Oxygen admin.
☐ Cricothyrotomy
☐ Pleural decompression
☐ CPR
☐ Cardiac monitor
☐ Telemetry
☐ Defibrillation
☐ Cardioversion
☐ Hemorrhage control
☐ Dressing applied
☐ Limb immobilization
☐ Traction splint
☐ Cervical collar
☐ Spinal immobilization
☐ MAST application
☐ IV admin.
☐ Blood drawn
☐ Cardiac medication
☐ Analgesic medication
☐ Other medication
☐ Chem strip
☐ Extrication
☐ Other _____

HOSPITAL COMMUNICATION

Base hospital _____
Orders received from _____

TIME	BLOOD PRESSURE	PULSE Character	RESP. Character	SKIN	PUPILS L R	LOC	OTHER PHI, Motor, etc.

Subjective 1. Chief complaint:

How was pt. found/mechanism of injury?

Objective 2. Med. Hx:

Med. alert?

Allergies:

3. Pt. exam

Rx meds:

Personal physician:

Analysis 4. Impression—suspected illness/injury

Plan 5. Treatment

FLUID ADMINISTRATION

☐ # of I.V. attempts _____
☐ Successful
☐ Unsuccessful
☐ D5W
☐ Saline
☐ Other _____
Number of I.V.s started ☐
Catheter size _____
Site _____
Volume infused _____

_____
Signature of person receiving patient Time

☐ Check if review by medical advisor is requested

_____
_____
Signature of crew

The reconciliation process ensures that each dispatch logged by communications personnel is supported by patient-care reports from field personnel. Since it is not uncommon for patient-care reports to be incomplete or lost, this process makes it possible for the omissions to be discovered quickly and ensures that all patients who are transported or who are due an invoice are billed.

Documentation verification

The next step in the process is to verify that dispatch records, patient-care reports and billing information are complete, accurate and legible. Those reports without adequate or complete information should be pulled from the process at this time for prompt action. This may involve phoning for additional information or re-routing the report back to the ambulance crews for completion.

Another part of the verification process involves monitoring the quality of the medical care and establishing that all supplies and procedures are accounted for and appropriate for the patient's condition.

Coding patient-care reports

Most services require that various aspects of the source documentation be coded. The type of call may need to be identified, as might the payment source (for example, the hospital contract). A universal or service-specific code may be used when processing insurance claims or entering data on treatments, diagnosis, presenting patient condition, procedures and supplies.

Data entry

Data such as dispatch, patient care, and patient and insurance information must be entered for those services that computerize their billing-and-collection process. In the case of computer systems that are interfaced with dispatch computers and even field personnel computers, much of the information may be directly transferred into the files used in the patient-accounts department.

The data entry process for services using a manual billing system corresponds to the entry of information on the daily charge log and the preparation of the patient ledgers.

Charge posting

The charge posting process is essentially the creation of a list of patients and their corresponding charges for the day. The charges generated for each day's work are posted (that is, added) to the total accounts receivable for the service on that day. Computerized systems generally allow for an edit printout of the daily charges prior to posting. Once the charges are posted, they cannot be changed except through specific accounting procedures for adjustments.

Invoice preparation and mailing

The invoice is the first notification to the patient or contracting agency requesting payment and may include patient instructions with regard to the service's billing policies. The preparation and mailing of the first invoice should occur as soon after the patient transport as possible, generally within 72 hours.

Claims processing

Many patients will have commercial insurance, Medicare, Medicaid or a combination of benefits that will pay the ambulance service charges. Most ambulance claims are filed on either a Medicare form specifically designed for ambulance services (Form 1492) or a universal insurance form (Form 1500), or on the specific form required by the state's Medicaid program. Most commercial insurance companies will accept the universal 1500 form for ambulance service filing.

A computerized service may be able to file claims electronically with Medicare, Medicaid and commercial insurers. The claims may be loaded onto a disk or tape, or filed over a modem for processing by the third-party payer's computer system. This process will reduce the turnaround time for the processing of payments from the insurer.

Statements

A statement is periodically sent to notify the patient of any payment received and balance still owed. Many services send statements out every 30 days. An alternative to this 30-day cycle is 21 days. This accelerated statement cycle has the advantage of being sent at different times of the month, so that the patient may be more able to pay the bill. More frequent statement processing also exposes the patient to the payment obligation more often.

Account follow-up

The collection of accurate information and the direct notification to payers of their obligations is only the beginning of the billing-and-collection process. Follow-up to ensure that accounts are paid is equally important.

Account follow-up takes many forms. Of primary importance is responding to requests for information and assistance from patients, insurance companies and other payers. Many ambulance accounts remain unpaid because of the service's failure to respond to simple requests for additional information. Also, if an account goes unpaid or shows no action for a period of, say, 30 days, direct intervention by the service's personnel is indicated. This may require a telephone call to the insurer, re-filing of the Medicare claim, or a phone call to the patient. These are some of the activities most critical to ensuring the ability of the service to maximize revenue recovery.

Receipt of payments

As payments for services are received, a careful trail of documentation should be processed daily. The payments need to be matched to the proper patient account and a deposit slip needs to be prepared for the bank. Daily deposits are required even if the amount of money received is small.

Payment posting

The posting of payments is similar to the posting of charges. The incoming payments are received and matched to the patient accounts, and the patient ledgers are updated to reflect the transactions. Once the payments are posted, regardless of whether a computer or manual system is used, the amounts cannot be changed except by official adjustments. The posting list generated by this process should be compared with the bank deposit slip to make sure that all payments are accounted for and posted and that no errors occurred during the process.

Writing off charges

Writing off a charge or a portion of a charge indicates that the organization no longer expects to be paid this amount. There are a number of situations in which this is appropriate. For example, certain agreements, particularly with Medicare and Medicaid, provide for contractual allowances (see Calculating Costs on page 285).

Take Medicare for example. As previously noted, if a service takes assignment on a particular transport, that service agrees not to charge or collect for any charges not allowed by Medicare. Only the annual deductible, charges for non-covered services and the 20-percent co-payment amount can be collected. If the ambulance service submits a base-rate claim to Medicare for $300, for example, Medicare may indicate that the allowable charge for this item is $200 and will reimburse the ambulance service approximately 80 percent of that amount, or $160. The ambulance service is then only allowed to bill the patient or other insurance company the difference between the allowable amount ($200) and the amount paid ($160), or $40. The remaining $100 of the ambulance bill cannot be collected and must be written off. This is called the contractual allowance.

Medicaid typically also requires that a service accepting Medicaid payments consider that reimbursement as payment in full. The service is not allowed to send invoices or statements to the patient once the patient is identified as a Medicaid beneficiary. Using the above example of a $300 charge, if Medicaid paid the ambulance service $75 for the transport, the ambulance service would not be allowed to collect any more money. Therefore, the remaining $225 also would have to be written off to Medicaid contractual allowances.

Other write-offs that an agency may include are discounts for specific services or charges to patients who are unable to pay.

Collection activities

Some collection activities have been described above in the follow-up section. Other collection activities include notification of delinquent accounts in a serial-letter process, which clearly notifies the patient of the account's delinquent status. More aggressive telephone contacts also can be included in the collection activities. These steps can be undertaken by the service, or the accounts can be turned over to a collection agency. Care must be taken with collection activities, as there are many state and federal laws and regulations that define which types of activities are allowable.

Patient-Accounts Personnel

The number of people required to maintain patient-account services is dependent on the ambulance service's volume. Personnel should be selected for their attention to detail, organization and communication skills.

Ambulance services employing a number of patient-accounts personnel have to rely upon specialization. In other words, each person is given a defined area on which to focus. For example, one person may be given responsibility for completing all functions relating to Medicare beneficiaries and another may work on Medicaid, while others focus on private-pay and commercial insurance accounts. Other methods of allocating work through specialization include all accounts being entered by data entry personnel regardless of the payer type, and collection personnel working on all types of accounts, and so forth. Both structures divide the labor and require specialization.

If personnel are highly specialized, it becomes important for the service to ensure that they also are adequately cross-trained. In the event that someone terminates employment, takes a vacation, or is unavailable for other reasons, someone within the office should be able to substitute for the absent employee.

Processing Various Types of Accounts

It is necessary to determine the primary payment source for patients' accounts early in the billing-and-collection cycle. Accounts can be separated into a number of different payer classes: private pay, Medicare, Medicaid, a combination of Medicare and Medicaid, indigent, contract accounts, commercial insurance, and so on. The processing of three types of claims—private pay, Medicare and Medicaid—is more fully discussed in this section.

The procedures for other types of payers are similar, but still have to be customized to fully enhance revenue potential. In this discussion, all other types of payers are said to be included in the private-pay system, in which patients accept responsibility for filing their own claims.

Accounts may move from one payer type to another. For example, if a patient is not listed initially as having Medicare, but later it is learned that the patient is indeed a Medicare beneficiary, that account would move from the private-pay system to Medicare processing. Thus, there really are not separate billing and collection systems based on payer types, but one billing and collection system with different types of accounts handled in specific ways. For discussion and learning purposes, it is easier to understand and describe the system by dividing it into separate collection procedures.

First, for Medicare and private payees, an itemized invoice should be mailed to the responsible party. This invoice should include all the necessary information needed by the patient to file insurance forms. Because people are more likely to pay an ambulance bill while the incident is still fresh in their minds, the invoice should be mailed within 48 to 72 hours of the transport.

The second step—personal and direct phone contact—is used for all patients. A phone call performs a number of functions. Although not part of the actual collection process, it is used to determine the patient's satisfaction with the service and to offer assistance with processing claims.

Courteous and friendly interaction via the phone should reassure the patient that the ambulance service is genuinely and personally concerned with its customers. The patient or responsible party should be asked about the services received. Was the service satisfactory? Were the crews helpful and timely? Are there any suggestions for improvement? Is there any other way the service can be of help to them? These types of questions serve two purposes. They break the ice with the patient and exhibit a sincere desire to know whether the patient was satisfied with the service. They also help measure the performance of the involved field personnel to determine how well they were received by the patient and family members.

After breaking the ice and measuring performance, it is possible to go on to the third step: gathering account information about insurance and discussing other missing items. Again, the emphasis should be on helping the patient and family members during this trying time. This is a good time to discuss the service's policies on insurance assignment, Medicare filing and so on. It is also a good time to find out if there is anything unique about the patient's situation that could affect how the account will be handled.

The timing of the call is important. Ideally, this conversation should take place after the invoice is mailed but prior to it having been received by the patient. It often seems that a patient's satisfaction with the service is inversely proportionate to the amount of the bill. Thus, a more objective opinion about the service is usually received before the patient is billed. It also may reduce complaints about the service later on.

All three procedures of dealing with accounts are based on a 90-day maximum cycle. If the service doesn't receive payment within 90 days, the chances of getting paid drastically decrease. Every effort should be made to collect payment as soon as possible.

Private-pay accounts

After phone contact, private-pay accounts essentially follow one of three paths: the account is paid promptly in full, the patient makes a partial payment, or no action takes place.

If the account is promptly paid in full, no further collection action is needed unless the patient requests assistance in filing insurance claims. This is the ideal way for an account to be cleared. It may be advantageous to offer a discount, such as 5 percent, to patients who pay their accounts in full within 30 days.

Following the second path, a patient may begin making partial payments. Many people have limited financial resources, especially after a medical problem that requires ambulance transport. As long as payments are regular, at least monthly, patients should be supported in their paying efforts. Their accounts should be reviewed periodically to make sure that the agreed-upon payments are being made, and monthly statements should be sent as reminders. Eventually, most of these accounts will be paid in full.

Unfortunately, no payment action will occur on some accounts. These accounts require special attention. One option is to write to and phone these customers after 30 days to remind them of their account status. This direct contact may initiate payment on inactive accounts.

If an account goes 65 to 70 days with no payment or without adequate explanation, it likely will be necessary to take firmer action by initiating collection efforts as previously described. This type of effort is also required on accounts toward which previous payments were made but that have been inactive for 45 days or more.

If no money is received and no adequate plan for payment is arrived at, it will be necessary to take final action. Depending on the patient's economic situation and effort, the account should either be turned over to a collection agency or written off as a charity case.

Medicare accounts

The itemized statement and phone call are initially directed toward the patient or responsible party. If the patient is economically depressed or a likely nonpayer of debts, it will probably be best to file assignment for Medicare.

Sometimes, full or partial payment will be made. If payment is made by the patient, no other action is needed except filing non-assignment for the patient so Medicare will reimburse part of the out-of-pocket expenses. Often, patients will

apply their total reimbursement checks to the account. Ambulance services are *required* to file Medicare claims for patients, regardless of whether assignment is taken or not.

All patients, except those with Medicaid, should receive regular statements that show the current status of their accounts. If a patient pays on a Medicare-assignment account and then payment is also made by Medicare, it will be necessary to reimburse any money the patient previously paid to the service over and above the co-payment and deductible amounts.

Assignment accounts

If no activity occurs within 60 days of filing a claim, the claim should be re-filed with the Medicare carrier. When payment is received, items which are not covered, the 20-percent co-payment and the remaining annual deductible should be billed to the patient. If Medicaid is involved, write off the remaining balance as a contractual allowance for Medicaid. Also write off any non-allowed charges to Medicare allowances.

Sometimes, the claim will be denied. In that case, the full charges then can be billed to the patient.

Non-assignment accounts

As with assignment accounts, if the patient notifies the service that nothing has been received from Medicare 60 days after the claim has been filed, the service should re-file with the carrier. Otherwise, the account is handled as a private-pay account, with regular statements mailed indicating payments as they occur. If no further activity has taken place after another 30 days, other collection procedures should be used, such as reminder letters, phone calls, pre-collection letters and, finally, a collection agency.

Medicaid

Medicaid regulations are generally strict, and it is important that these accounts be handled properly. If Medicaid is filed, or if it is known that the patient has Medicaid, the service is forbidden to bill the patient or accept payments on the account.

Once Medicaid is filed, do not send statements to the patient. If a Medicaid payment is not received within 60 to 90 days (it usually takes longer than Medicare), the claim should be re-filed. When a payment is received from Medicaid, the remaining balance *must* be written off to Medicaid contractual allowances.

The other possibility is that the claim may be denied. In this case, the patient may be billed directly for all charges, and the claim is processed similarly to the private-pay system. The only difference is that the unpaid accounts will probably be written off to charity rather than turned over to the collection agency.

Miscellaneous Information

- ***Returned mail***: Patient accounts with incorrect or incomplete information, such as wrong addresses or patient names, need early action. If accurate information cannot be obtained from hospitals or by other means and it is impossible to reach the patient or responsible party, these accounts should be traced or turned over to a collection agency as soon as possible. The sooner the agency can start its investigation, the better the results.
- ***Collection agency***: Collection agencies are like any other business; some are more effective than others. The selection of a collection agency requires the evaluation of its past experience, especially regarding medically related accounts. Also, if the organization is going through the evaluation process, it may be possible to negotiate a better percentage for service with competing agencies. Another strategy is to split similar accounts between two different agencies to determine which one brings a higher return.
- ***Bankruptcy***: Often, the service will be notified that a patient has declared bankruptcy. The remainder of that patient's account will be written off to charity or as bad debt.
- ***Probate***: A deceased patient's estate can be tied up in probate for a considerable period of time. Keep these accounts open, and follow all proper procedures for recovery of funds through probate.
- ***Liens***: Hospitals have, for a long time, filed liens with insurance companies for auto accident victims. This ensures them of the best possible recovery of funds. Since EMS is also health-care related, it may be possible for ambulance services to use such lien laws to their advantage. This avenue can be researched with the service's legal adviser to evaluate the possibility of including it in the service's procedures.
- ***Over-90-day reviews***: A collection system can work effectively only with close monitoring. At least once a month, every account that is more than 90 days old should be reviewed to determine what is happening with the account and what action, if any, is necessary. Actions that may be needed include a phone call to the payer, writing off the claim, turning it over to collections, re-filing, and so on.
- ***Computerization***: Many services have grown to the point that accounts receivable requires computerization to increase efficiency and effectiveness. Selecting a computer system for an ambulance service can be a difficult, if not overwhelming, responsibility for the manager. Often, the selected system has many flaws, especially if it is not specifically designed for ambulance services. Ambulance accounts-receivable systems come in three basic varieties.

- ***Packaged system***: Although these generic systems may be generally designed for ambulance services, managers may find it frustrating that they do not meet the particular needs of their service.
- ***Fully customized***: This software is usually a basic EMS computerized medical-billing system, modified by consultants to meet specific service requirements.
- ***Home-grown***: This type of system usually causes the most frustration and, in the end, may be the most expensive in terms of time. It is usually developed by a local programmer and may need to be replaced within six to 12 months.

Most services underestimate both the initial cost and the ongoing maintenance and programming costs for computers. Even small services, however, should seriously consider computers, since they can significantly improve cash flow. Regardless of whether the billing and collection system is manual or computerized, it will require increased attention by EMS managers in the future.

SECTION 6

Third-Party Reimbursement

A pivotal factor in the success of any ambulance operation is the amount of revenue generated from patient services. This revenue is primarily influenced by the reimbursement practices of various health insurers, including Medicare, Medicaid, private insurance firms and Worker's Compensation. More than 80 percent of all U.S. citizens are covered by some form of health and accident insurance. The ambulance manager's task is to appropriately capture these funds for the provision of prehospital care and medical transportation, lowering the actual direct cost of service for both user and taxpayer.

There are thousands of companies providing health insurance, but the majority of the patients transported by ambulance are covered by Medicare, Medicaid, Blue Shield or a combination of the three. This section will focus on Medicare and Medicaid, since most services receive a significant amount of income from these two sources—and understand them the least.

History

Both Medicare and Medicaid went into effect in 1966 as a result of President Lyndon B. Johnson's Great Society program. Medicare provides federally

funded government health insurance for people 65 years of age and older. Administered by the Health Care Financing Administration (HCFA), it is composed of two programs—hospital insurance funded through the Federal Hospital Insurance Trust Fund (Part A of Medicare) and medical insurance funded through the Federal Supplementary Insurance Trust Fund (Part B of Medicare). Medicare coverage is available only after appropriate medical-necessity guidelines re met. Unless ambulance-service managers understand entitlement and its qualifications, they cannot secure the maximum benefits a patient may be able to receive.

Medicare regulations are extremely complex. Certain types of care are only covered under Part A, while others are only covered under Part B. For example, Part A helps pay for inpatient care in a hospital or a skilled nursing facility (SNF). Part B covers ambulance services, doctors' services, outpatient hospital care and health services and supplies not covered by Part A. If a provider ambulance service is considered a department of a hospital, however, medical transportation services are covered under Part A.

Medicaid is a combined federal-state program in which the federal government contributes a portion of the total funds required. The program is administered by individual states to provide medical care for people whose low incomes would otherwise prevent them from receiving care. Unlike Medicare, Medicaid is intended to cover all medical needs of the recipient regardless of age.

Since each state defines the qualifications for Medicaid differently, there are wide variations in programs. Also, although most states have medical-transportation benefits available for its recipients, the Medicaid program has been the victim of the budget axe in recent years. Because of these cutbacks, Medicaid usually reimburses ambulance services at amounts far below their actual costs.

Medicare

The largest single payer for ambulance services in the United States is Medicare. Thus, a clear understanding of the Medicare program as it relates to ambulance services is important for the EMS manager. To understand the program, it is necessary to first learn the following Medicare terminology:

Carrier: A commercial insurance firm or Blue Shield plan administering Part B of Medicare. There may be a single carrier or multiple carriers in each state. Each carrier is responsible for a specified region, and all of the providers in that region file with that carrier. The problem with this approach is that each carrier formulates many of its own policies. In other words, even though the federal government has specific guidelines for all carriers, each carrier interprets these guidelines differently so that reimbursement practices vary.

The carrier provides the ambulance service with a manual of specific guidelines used to obtain reimbursement for services. This manual describes in

detail how to fill out each claim and gives instructions on what information is necessary.

Accuracy when filing a claim is critical. An ambulance service should achieve at least a 98-percent accuracy level on claims submitted to Medicare. Each time a claim is improperly completed, it delays reimbursement and adds expenses for re-handling time.

Beneficiary: A patient receiving the service or supply who is an eligible participant in the Medicare program.

Provider: An ambulance service, physician or supplier who is an eligible and bona fide member of the Medicare plan, as determined by the carrier through an application and approval process.

Co-insurance: A provision by which a portion of the medical expenses are paid by the patient. This refers to the 20 percent of reasonable charges for which the Medicare beneficiary is responsible after the deductible has been met.

Covered services: These are medical and health services covered under Medicare Part B. Certain field procedures are covered, while others are not. When a payment is received from the Medicare carrier for services, the non-covered services and amounts are listed. These non-covered services can be billed directly to the patient.

Types of covered transports: Not all ambulance transports are covered under Medicare Part B. However, each carrier will have guidelines that determine if a transport is covered. Some of the transports that are covered include:

- Transport from an injury scene to the closest hospital;
- Transport from hospital to hospital if the discharging hospital does not have the medical services required for the patient's condition;
- Transport from a hospital to an SNF if, and only if, medical necessity can be established and the facility is near the institution;
- Transport from an SNF to a hospital and back to an SNF if the pickup point is within the service area of the destination, and the service is determined to be medically necessary;
- Transport from a hospital to a hospice center if the hospice center is determined by the carrier to be the medically best-suited facility for the patient's condition.

Some of these covered transports may be denied if it is determined the trip was not medically necessary or if the patient could have been transported by other means—even if the other means of transportation were not available to the patient. Many other claims are rejected because of poor documentation.

Non-covered transports: The following transports are not covered by Medicare:

- Transport from an SNF to an airport or any other non-medical destination;

- Transport from a hospital to a physician's office, from an SNF to a physician's office or from a home to a physician's office. Medicare will not cover transport to a physician's office unless it is medically necessary to stop en route to a hospital. However, it is best to check with the carrier on this point, as recent interpretations indicate that carriers have been paying for specific physician trips when the procedure could be done less expensively than in a hospital;
- Transport to a free-standing medical facility;
- Long-distance transport by ground ambulance;
- Transport from hospital to hospital if the carrier determines the discharging hospital to be medically suitable for the patient's condition, regardless of whether the patient's physician is on staff at the discharging hospital;
- Transport for the convenience of patient or family;
- Transport from home to an SNF or from an SNF to home.

There are other times when transports are unlikely to be covered, but these are considered on an individual basis by the carrier. Transport from a hospital to the patient's home is often denied, as the carrier may believe that a patient who is well enough to be discharged should be able to travel by other means. Also, many transports from an SNF and back are considered medically unnecessary and are therefore denied.

Should a Service Accept Assignment?

There are two ways to file a Medicare claim: for assignment or non-assignment. If the service accepts assignment on a Medicare claim, that service then agrees to accept the Medicare allowable charges as payment in full for the service.

For example, a $200 ambulance bill is submitted to Medicare. The carrier determines that all the charges are covered. It also determines that the *allowable* charges for the services are $140. If the service accepts assignment on this claim, the provider will be eligible to receive 80 percent of the allowable charges, or $112, from the Medicare carrier. In addition, the service could then bill the patient for the remaining 20 percent of the allowable charge, which in this case would be $28. The balance of $60 would have to be written off to Medicare contractual allowances. The patient *cannot* be billed for any part of the non-allowed charges by the carrier. To be eligible to bill the patient for the deductible, however, the service must obtain the patient's signature authorizing it to file the Medicare claim.

There are a few more peculiarities and rules when filing for assignment. If the service accepts an assignment, it receives payment directly from the carrier. Also, if the deductible has not yet been met by the patient, this amount is directly billable to the patient. Once an assigned claim is submitted, it cannot be changed before the claim is paid.

Finally, even if the ambulance service files for assignment, the service can bill non-covered services to the patient at full charge. (In the example above, all of the charges were covered, so this did not apply.) Many services miss this step and, thus, they miss an opportunity to increase their revenue. The Medicare beneficiary is responsible for the co-payment amount as well as the annual deductible that has not been met—plus any non-covered services.

Ambulance services *must* bill the patient for the co-insurance amounts and deductibles. The purpose behind this requirement is to reduce service utilization by forcing beneficiaries to pay for a portion of the charges.

Many ambulance services receive requests from Medicare to sign provider agreements and accept assignment. While this agreement says the service will accept what Medicare determines as allowable on claims as payment *in full* except for the annual deductible, it also stipulates that the service will accept assignment on *all* Medicare claims. It is important to note that there is no penalty for those ambulance services that do not sign the agreement. It is also important that managers carefully determine the impact of signing such as agreement before doing so. It is possible that the agreement may not be in the service's best financial interest.

The other option for the service is to file non-assignment. If this option is taken, the ambulance service *must* file the non-assignment claim form for the patient. In this case, the reimbursement check from the carrier will go directly to the patient.

If a non-assignment claim is filed, the service can bill the *entire service charge* to the patient, often collecting the total bill before the Medicare claim is processed. The service is not bound by any agreement with Medicare to accept what the carrier has deemed to be reasonable charges for the services provided.

Consider the previous example of the $200 ambulance bill. In the case of non-assignment, the entire $200 bill is sent to the patient for payment. The service submits a claim to the carrier, and the patient receives reimbursement of $112. Regardless of the amount that Medicare pays, the patient is responsible for the entire $200 bill.

There are many arguments for filing non-assignment. Unfortunately, many are not based on the issues. It should be emphasized that services can decide assignment status on a claim-by-claim basis, as long as the service has not signed the participating supplier agreement. Returning to the example, if the service bills the patient $200 for services rendered and makes diligent attempts to collect over a 60- to 90-day period, but is unsuccessful, it can still file for assignment and receive the $112 from Medicare. It can then try to collect the $28 from the patient once the claim is paid by Medicare. It is more appropriate to file non-assignment or assignment as soon as possible after the date of service, however.

There are two exceptions to this. If the service has previously signed a Medicare Provider Assignment Agreement, and if Medicaid is filed (Medi/Medi), then assignment on Medicare is required.

Deciding on a claim-by-claim basis eliminates many of the arguments for accepting assignment on all claims. One argument frequently heard is, "If the patient gets the money, we'll never see it." This is a valid argument in some cases, but it is more likely a reflection on the service's billing and collection practices. Competent billing personnel and an efficient billing system, whether manual or computerized, will identify many of the bad risks prior to filing. If not, the next time the patient who failed to reimburse is transported, the service can file an assigned claim to ensure that funds go directly to the service.

This non-assignment approach does require more sophisticated billing and collection procedures. However, most services that have done a cost-benefit analysis indicate that it is well worth the investment when considering the net return to the organization.

Many publicly operated services historically have filed for assignment on a routine basis to simplify the billing process. Times are changing, however, and services are searching for additional revenue. These same services may be able to significantly increase their reimbursements simply by improving their billing systems.

Reasonable-Charge Determination

If the reasonable charges allowed by Medicare carriers were actually reasonable and uniform, assignment would not be an issue. Unfortunately, this is not the case. The means by which reasonable charges are calculated are inherently inequitable. In many cases, the process results in an allowable charge that is far below the cost of the service.

The procedure used by Medicare carriers to determine the reasonable or allowable charge is complex. The carrier is required to pay the lowest of our different amounts for a particular service: the provider's customary charge, the actual charge, the prevailing charge for the locality, or the indexed inflation charge (IIC).

The following is a simplified explanation of how the charges are calculated. Each item charged (such as base rate, oxygen, mileage, bandages, etc.) is calculated separately.

Customary charge

The provider's customary charge for a given procedure is determined by identifying all of that provider's actual charges for a specified procedure during a certain period (for example, a screen year). These charges then are placed in ascending array (from the lowest amount to the highest). To establish a customary charge, this array must contain at least three charges for the procedure. The me-

dian or mid-point charge then is identified (not the average). This median charge is the provider's customary charge for the procedure.

Figure 6.9 contains an example of the customary-charge calculation procedure. In this example, the procedure being determined is the base rate for ALS transport. To calculate the rate, the provider that filed Medicare claims for 12,000 ALS base rates would have an array containing 12,000 charges. For demonstration purposes, the example has the provider only filing 21 ALS base-rate claims to Medicare. The example also shows that the provider had four different charges for the ALS base rate during the year. The charges are placed in an ascending array with the lowest charge ($200) at the bottom and the highest ($500) at the top. The mid-point of the array is at position 11 from the bottom: there are 10 charges above and 10 charges below this point. The charge at this mid-point is $250. This is the provider's customary charge for ALS base rate.

Actual charge

The actual charge is that charge submitted on the claim filed with the Medicare carrier. If the actual charge is less than the other three charges calculated by the carrier, that amount determines the reimbursement.

Figure 6.9: Calculation of Customary Charge

	ALS Base Rate Charges	
	$500	
	$500	
	$500	
	$500	
	$500	
	$500	
	$400	
	$400	
	$400	
	$400	
Median Point »	**$250**	**» Customary Charge**
	$250	
	$250	
	$250	
	$200	
	$200	
	$200	
	$200	
	$200	
	$200	
	$200	

Prevailing charge

The process used to calculate the prevailing charge is the most difficult to understand. To establish the prevailing charge for a particular procedure, the carrier first groups all services into a "locality" for comparison (this locality is not necessarily a geographic region, which most providers would prefer for more uniformity in charges). Again, all charges for the procedure are placed into an ascending array, except this time all charges from every provider in the locality are included. The carrier then determines the 75th percentile: the charge located 75 percent of the way up from the bottom of the array. The charge located at this position is the prevailing charge for all of the services in the locality.

The procedure for calculating the prevailing rate is demonstrated in Figure 6.10, which uses an ALS base rate as an example. The charges presented in the customary-charge calculation can be noted as part of the screen for this exercise. In this example, only 100 charges are listed, while in the actual calculation thousands of charges are likely to be included.

The 100 base-rate charges have been listed in an array with the highest at the top left and the lowest in the bottom right. The prevailing rate can be determined by counting up from the bottom of the array to the 75th percentile. Since there are 100 charges in the example, the position of the 75th percentile would be 75 from the bottom of the array. The charge located at this position ($250) is the prevailing charge for all providers in the locality.

All services that have charged for the procedure in the locality are included in the development of this screen. The reasons for significantly different charges have no effect on the calculations. For example, it makes no difference that many publicly operated services' charges are lower because of local tax subsidization, while their *true cost* for providing the service may be as high as that of any other providers.

Therefore, the service that charges $100 per trip is actually undermining the reimbursement levels for the patients of all the other services in that region—even if those patients are being charged a fee more closely representing the cost to provide the service. The subsidized service that charges significantly less than actual costs is referred to as a "profile-smasher."

Indexed inflation charge (IIC)

The IIC is a relatively recent development arising from government's attempt to limit Medicare expenditures; it limits increases in a particular provider's Medicare reimbursement. Each year, a percentage increase is calculated that may or may not correspond to the inflation rate. This allowable increase, which may

Figure 6.10: Calculation of Prevailing Charge

Base Rate Charges	Cumulative # of Base Rates	Base Rate Charges	Cumulative # of Base Rates	Base Rate Charges	Cumulative # of Base Rates
$600	100	$225	65	$150	30
$600		$225		$150	
$600		$225		$150	
$550		$225		$150	
$550		$225		$150	
$550	95	$200	60	$150	25
$550		$200		$150	
$500		$200		$150	
$500		$200		$150	
$500		$200		$100	
$500	90	$200	55	$100	20
$500		$200		$100	
$500		$200		$100	
$475		$200		$100	
$475		$200		$100	
$475	85	$200	50	$100	15
$400		$200		$100	
$400		$175		$100	
$400		$175		$100	
$400		$175		$100	
$400	80	$175	45	$100	10
$275		$175		$100	
$275		$175		$100	
$275		$175		$100	
$250		$175		$100	
$250	**75**	$175	40	$100	5
$250		$175		$100	
$250		$175		$100	
$250		$175		$100	
$250		$175		$100	
$250	70	$175	35		
$250		$175			
$225		$175			
$225		$175			
$225		$150			

75th Percentile » Prevailing Rate

be (and has been) zero, is applied to the charges previously discussed. The easiest way to understand this is to demonstrate by example. Consider a provider with a customary charge of $100, and a prevailing charge of $200. The provider may believe that, by doubling the service's charges, reimbursement would be based on the $200 figure after a year, since the customary rate will now be the same as the prevailing rate. The IIC, however, would only allow reimbursement to be increased by the set percentage, say 4 percent. If this were the case, the provider's IIC charge would be $104, and reimbursement would be based on that amount.

After determining all four of the above charges, the Medicare carrier will select the lowest one as its basis for reimbursement. This lowest charge will be the amount determined to be reasonable and will be described as the allowable charge for the given procedure. The carrier then reimburses the provider 80 percent of this amount.

The federal government has occasionally reduced reimbursement below the 80-percent level by sequestering funds. They do this by deducting a small percentage (1 to 2 percent) directly from the reimbursement. The provider is then unable to bill the patient for the reduced amount because of the Medicare sequestration.

In summary, deciding whether or not to accept assignment should be done with attention to costs and the amount the service receives from Medicare. Several activities will aid the manager in understanding the service's position and reimbursement performance before making this decision. This information will also be helpful in justifying rate increases and determining how to structure charges.

Specific information can be obtained from the provider's Medicare carrier. One particularly helpful item is a printout of a service's charge mix and the customary rate for each charge. This shows exactly how much the carrier allows for each item, and what reimbursement levels are. If charges are to be raised, it is important to remember that the carrier will only re-evaluate charges once a year. A second document is a list of current prevailing charges for a particular region. This list will help the manager identify reimbursement levels for each procedure and will aid in the comparison of other services' charges.

Another useful strategy is to review what items or services are charged for separately, and which ones are included in the base rate. If the carrier allows a charge for defibrillation, for example, and the service does not charge for that procedure, a change can be considered.

Interhospital Transfers

Transportation from hospital to hospital or to another free-standing medical facility, and return for specialized diagnostic or therapeutic services not available in the inpatient's hospital, must be billed to the sending hospital. Simply stated, if the Medicare beneficiary remains an inpatient at one hospital and is transported

somewhere else for tests or treatment and returned, the hospital, not the patient, must be billed. Hospitals billed for these services are required to pay the provider of the service. It is acceptable to set a discounted rate with hospitals for these transports, and it is generally in the service's best interest to establish contractual relationships with medical facilities. This policy does *not* cover transports for admission, transfers between a hospital and the patient's home or transfers between hospitals and SNFs.

Documenting Medical Necessity

It is impossible to detail how to fill out each type of claim form and the specific codings used. A manual for ambulance providers is available from the carrier with step-by-step instructions.

The *critical* aspect of submitting a claim, which determines whether or not the claim will be paid, is the presumptive medical diagnostic information and presenting conditions of the patient as documented by the field technicians. It proves to the carrier that the patient could not have traveled by other means because of the need for medical care.

Many times claims are denied solely because of semantics. For example, a heart condition does not, by itself, justify ambulance transportation, while an acute myocardial infraction (AMI) does. The wording and completeness of the diagnostic information, then, is essential in determining payment.

Some acceptable and unacceptable examples of diagnoses are listed below. They are presented here to illustrate why ambulance personnel must fill out the patient-care report completely and accurately. Although field employees should not be allowed to write creative reports to artificially increase reimbursement for services rendered, many services claim that when employees are trained in accurate report writing, and when documentation improves, there is a significant positive effect on reimbursements.

Some acceptable diagnoses of patient conditions include unconsciousness, shock or coma, cardiac arrest, acute or complete stroke (CVA), AMI and convulsions. Also acceptable to carriers are the need for oxygen, IV maintenance, ECG monitoring or other emergency care or treatment. A patient confined to a bed, unable to walk and movable only by a stretcher, with a spinal or back injury or who needs restraining en route is also considered acceptable.

Unacceptable diagnoses, on the other hand, include intoxication, behaviorally disturbed, possible bleeding (sometimes acceptable depending on severity), fractured arm, nausea or vomiting or a heart condition with no further explanation. Other diagnoses in this category are doctor-ordered ambulance transports, if the patient is dead prior to a call for an ambulance (this is an acceptable claim if the patient dies en route to hospital); severe illness with no further explanation; patient too sick to walk with no further explanation; and a patient requiring dialysis treatment (unless significant diagnostic information is supplied that proves ambulance transport is medically necessary in each case).

Accurate and complete diagnostic and treatment information results in fewer claims being denied as medically unnecessary.

Medicaid

Since Medicaid is administered by individual states; the rules and regulations are not universal. What is universal is that, as with Medicare, the service must apply to the state for approval as a provider. Medicaid forms are unique to each state, and the state may require various supporting forms of documentation, including copies of patient-care forms, physician's medical-necessity statements, pre-authorizations and other documents.

The amount of money that Medicaid programs reimburse providers varies widely from one program to another. The amount may be fixed, such as $50 per transport, or it may be tied to what is allowed by Medicare. Medicaid programs are often more restrictive than Medicare regarding which transports are approved, and reimbursement may be limited to only life-threatening emergencies or other specific criteria.

For example, in the state of Missouri, the reimbursement from Medicaid only applies to emergency transports. A fixed amount is paid for each call, and a limited number of add-on procedures or supplies are covered. A copy of the Missouri state ambulance run report must accompany each Medicaid claim form, and each Medicaid claim is reviewed by a physician to determine the medical necessity of ambulance transportation. This clearly shows that documentation and the completeness of the patient diagnostic and treatment information is of utmost importance.

Even though Medicaid may pay only a small portion of ambulance service costs, it should not be overlooked as a source of revenue. Participants in Medicaid programs have already met requirements that determine they are unable to pay for medical care. This pre-screening should indicate to the manager that Medicaid may be the only option by which the service can collect available funds to help cover its costs.

By filing a Medicaid claim, the ambulance service agrees to accept the Medicaid reimbursement as payment in full for services provided. The provider is not allowed to bill the patient if it is known that the patient is a Medicaid recipient. Only in a situation in which a Medicaid claim is denied or the person is not covered by Medicaid can the patient be billed for the full charges. However, the collection percentage on these accounts will be low. Because the Medicaid patient is poor, collecting money on this account should be handled with compassion. Many of these accounts will eventually be written off to charity.

Filing a Claim

Honest claim filing: Many doctors and health care providers have been charged with Medicare or Medicaid fraud. To counteract such practices, agencies have established programs and procedures to prevent and discover fraud. An EMS manager must establish procedures to ensure that intentional wrongdoings are not allowed, and to make sure the service eliminates accidental errors or oversights.

Medicare can only be filed with permission from the beneficiary, for either assignment or non-assignment. This is why it is necessary for the patient to sign either a Medicare form or another appropriate release form. The EMS manager must ensure that signatures are collected before filing Medicare or other insurance claims.

Other insurance: Insurance companies can be billed directly for services rendered to their clients. Most hospitals file insurance claims for patients and generally are paid directly by the companies. Ambulance services can also follow this policy, but there are numerous insurance companies, and many require individual forms. Even though this policy can increase collections and reduce the time required to receive reimbursement, the amount of time and the number of personnel required to process insurance claims in-house may offset the additional income. The benefits or downfalls should be evaluated carefully before deciding which procedure to use.

Instead of filing directly with the insurance company, the ambulance service can send an itemized bill directly to the patient. It is then the patient's responsibility to file with the proper insurance company or companies.

Crossover: Many Medicare carriers have developed a crossover system with other insurance companies such as Medicaid or Blue Shield. In such cases, only one claim is filed, probably to Medicare or Blue Shield, but the information and account numbers for the crossover insurance companies are included on the claim. After the primary carrier acts on the claim, it is transferred to the appropriate reimbursement agencies for consideration. This process eliminates the necessity of filing multiple claims. It is important to determine which crossovers, if any, are available with the carrier.

Third-party reimbursement is complicated, but an efficient system of handling insurance claims can dramatically increase the revenue generated from patient services. All aspects of the billing and collection system should be thoroughly evaluated to make sure needed dollars are not slipping through the cracks.