

Quad State Ambulance PET Advisory Committee Minutes

October 4, 2005

Sue Brewer, Co-Chairperson
Mary Muchow, Co-Chairperson
Rochester, MN

Members: Total 18 members

IN PERSON: Paratech Ambulance, Gold Cross/Mayo Medical Transport, MedStar, Superior Ambulance, Illinois Fire Chiefs, Medical Express Ambulance Service, Inc., North Memorial Transportation, Universal Macomb Ambulance, Allina Medical Transportation, Life Link III, Minnesota Ambulance Association.

BY TELECONFERENCE: Bell Ambulance, Gold Cross Ambulance, Paratech Ambulance, Tri-State Ambulance, MedStar, First Care Ambulance Services, Life Care Ambulance, Community EMS, Health East Transportation, WPS Outreach Staff.

Agenda Item	Discussion	Outcome/ Action
Welcome, Roll Call and Introductions	Chairperson: Sue Brewer Sue.Brewer@wps.com introduced Mary. Muchow@wps.com . They will be the co-chairs for this group. Gary Wingrove and Cami Thalacker from Gold Cross Ambulance were thanked for hosting today's meeting. Sue informed the group that Suzanne Johnson is the new Ambulance person at CMS. Suzanne asked Sue to extend her apologies that she was unable to attend in person or on the phone today.	Sending her contact information to the group.

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	<p>Membership List- It is the responsibility of the members to keep their contact information current.</p> <p>Sue did some follow-up from the April Meeting. She pointed out that there was a response from Steve Fradin at CMS regarding the SNF and Medicaid issues. He responded by e-mail dated 5/04/05.</p>	<p>Send any updates to chairperson, Sue Brewer, via e-mail</p> <p>Upon further research, this information was included in the meeting minutes for the April 28, 2005 meeting.</p>
Specialty Care Transports- (SCT)	<p>Sue reminded the group that the new guidelines for SCT transport claims were published in the September CQ. Currently, if the information needed to determine the medical necessity and the SCT level of services are not provided or the information provided is insufficient, a development letter will be sent to obtain the information. Group members stated that they felt it is a lot of extra work to submit an electronic claim and then have to submit the paper documentation, run reports, PCS.</p>	<p>Continue to submit claims with all needed information: Reason for transport, Patient's condition at time of Transport, Reason for transport, Level of training of professional staff. Group was reminded that the claim information /documentation is being reviewed for both medical necessity for the Ambulance Transport and to determine that the level of service provided was at the SCT level.</p>

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	<p>Sue informed the group that they should not be submitting a separate charge for the RN or RT on board. Code A0434 for the Payment for the additional professional crew members is included in the fee for the Base rate A0434 for SCT</p> <p>The reason for development is to determine whether or not the service provided was an SCT level transport. Referred them to the definition of an SCT transport in NCP-AMB-001 found at www.wpsmedicare.com/policies/pol_home.shtml.</p> <p>Referred the group to the September Communiqué article regarding SCT ambulance services at www.wpsmedicare.com/provider/pdfs/0905comm.pdf, page 19.</p> <p>Some wondered if they should go back to submitting paper claims with the documentation attached.</p>	<p>Providers must continue to submit Electronic HIPAA claims. CMS/WPS will be monitoring paper claim submissions to see if the provider meets the exception criteria for not submitting electronic claims.</p>
Condition Codes	<p>There has been no further clarification on the use of the Condition codes since the April meeting. The ICD-9 codes listed in this article can be used to document a patient's condition at the scene. WPS system is set up to recognize the diagnosis codes, but cautioned providers to use the most specific (3-5 digit) diagnosis code to avoid unprocessable denials. No system changes are needed. These ICD-9 codes are not used to make a medical necessity determination determined. <u>Condition codes do not replace the narrative information.</u></p>	<p>WPS will continue to supply the group with any new updates regarding billing for ambulance services as it becomes available.</p>

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	Jerry Miller stated that he has tested the condition codes. Everything seemed to work with the exception of some small issues with some other insurers. He found no problems with Medicare or crossover claims.	CMS is looking at the modifier issues to be sure they are not duplicative. At this time, there is no new information available regarding this topic.
SNF- Consolidated Billing	MMA 3933 article Referred to this article and informed the group to be sure to bill their claims correctly. If the claims are paid in error, the carrier will recoup the overpayments.	See articles. Also refer to MMA 3427 and 3676 on the CMS website. CB code lists are found at www.cms.hhs.gov .
Ambulance Fee Schedule (AFS)	The national AFS is scheduled to be fully implemented on January 1, 2006.	Additional information on final implementation will be addressed in the Communiqué and on the WPS Medicare Website. The most recent information will be sent to PET members via e-mail.
Rural Air Ambulance	MMA – 3571 Personnel determine need for rural air ambulance transport. Local Protocol. Each supplier needs to submit a copy of their Local Protocol to WPS for CMD review. Coverage will be based on the CMS Online Manual.	Each supplier needs to submit a copy of the local protocol. The procedures on how to send in the protocol are listed in the August 2005, page 5 CQ article.

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		WPS will check into posting the article on the WPS website-Provider Education section as an additional reference site.
Medicare Part D	<p>The new Drug Part D benefit begins on January 1, 2006. CMS is asking that ambulance suppliers keep the new benefit in mind when dealing with beneficiaries at the time of an ambulance transport. There may be times when pointing out this benefit to patients or their family members may be very helpful to them. Remind them to call 1-800-MEDICARE with questions and help regarding their Medicare benefits. It is CMS' intent to keep all providers informed about the Prescription Drug Benefit.</p> <p>CMS just announced the names of the Part D plans for each state. They are listed on the CMS website. There will be a separate premium, deductible and co-pays for the drug benefit per each plan. There are beneficiary assistance programs available to help with the premium, deductible and co-payments for those eligible. There is also assistance with selecting a plan. Refer the patient to 1-800-MEDICARE or www.Medicare.gov for assistance in finding trained staff to help with the Part D benefits.</p>	Providers should refer patients with Part D questions to 1-800-Medicare or www.Medicare.gov .
Incarceration Issues	<p>Paula Bliemeister from Paratech is still having problems with transporting patients that are still listed as incarcerated on the CWF by Medicare based on SSA records. These patients cannot or will not go to SSA to get their records corrected. Claims are denied based on the SSA records at CWF.</p> <p>CMS is aware of these issues. To date, there is no additional information from CMS</p>	Suppliers will need to have the patient contact their SSO and get those SSA records updated. These are SSA records to maintain.
Hospital to Hospital Transports beyond 50 miles	This issue was discussed at length. Concerns were brought up that in some rural areas the nearest appropriate facility is often more than 50 miles away from the sending facility. The claims are paid for the first 50 miles and then a review must be requested for the remaining mileage, thus adding additional time and expense to all involved.	HH transports beyond 50 miles, claims for transports for more than 50 miles providers will need to submit

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		<p>the medical necessity documentation for these transports for review. It is the provider's responsibility to provide the documentation. It is <i>not</i> the Carrier's responsibility to develop on these cases.</p> <p>This issue was also addressed at the AAA Conference in Chicago. Suzanne Johnson, from CMS, again agreed that the provider must supply the required documentation in order to determine medical necessity for the transport beyond the nearest appropriate facility. WPS staff will need claim examples to research these claim denials. She has been working with MN appeals staff on these claims.</p>

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	<p>Paula from Health East also stated they have been seeing denials for transports for patients that have been discharged from a hospital to a NH, rehab facility or home. Denials stated that the claim was denied because the transport was not to the closest facility. Some of these are for BLS transports as well as SCT or ALS level transports.</p>	
<p>Change in Appeals</p>	<p>The last step in the Carrier appeals process, a Fair Hearing will be changed to a Reconsideration as of January 1, 2006. A Qualified Independent Contractor (QIC) will render decisions on this level of appeal. To date, for claim re-determinations that are rendered by 12/31/05, the provider will submit a written Fair Hearing request to the carrier. For re-determinations rendered as of Jan 1, 2006, the provider will submit a written request to the QIC for a reconsideration.</p>	<p>As more information becomes available, the group will be notified. Watch the WPS and CMS websites as well as the Communiqué for more information as it becomes available. This change will affect all providers.</p>
<p>Use of WPS and CMS websites to access information regarding ambulance services</p>	<p>Reminded the group that CMS offers an Open Door Forum (ODF) call on ambulance issues. CMS CO and RO staffs participate in these calls. They are held every other month. Almost everyone present in the room has participated in an ODF call. If you are unable to attend the call, there is an encore feature on these calls. You can still listen to the call, after the call date by using that feature. The recording is available for 3 business days.</p> <p>There is a wealth of information available on the CMS and WPS websites. Be sure you are signed up for the WPS Medicare website ListServ to receive the most current</p>	<p>Register for Notification of upcoming Open Door Forums on the CMS website.</p> <p>Sign up for List-Serv messages on both websites.</p>

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	updates to Medicare changes.	
Open Discussion	Allina Medical Staff questioned whether or not the address of the person signing on behalf of the beneficiary was necessary as stated in the Ambulance handbook 2003 on the WPS website.	WPS staff researched. The address is required. Please refer to the Medicare Claims Processing Manual, Pub. 100-4, Chapter 26, Section 10.3, #12.
Open Discussion	<p>Subject of Limited ALS services was brought up. In Michigan, BLS providers have staff that can provide Limited ALS services. Michigan provider has been working with CMS regarding clarification on this issue.</p> <p>CMS recently responded to Jan at Accu-med billing stating:</p> <p>“ALS ambulance providers/suppliers must meet all state credentialing requirements for ALS in order to bill for ALS HealthCare Common Procedure Coding System (HCPCS) codes. Medicare contractors, such as WPS, review the BLS and ALS state licensure documentation furnished by ambulance suppliers to determine and validate, among other Medicare/State requirements, the level of care credentials of suppliers' ambulance personnel. WPS has made the determination that the level of care services performed by the State of Michigan's "EMT-Specialist" licensed personnel is not equivalent to advanced life support level of care services.</p> <p>CMS agrees with WPS’s determination. For Medicare to pay a medically necessary ambulance transport at the ALS level of service, the ambulance crew must meet the definition of an ALS-level transport. The ambulance fee schedule levels are either Basic Life Support (BLS) or Advanced Life Support, nothing in between. CMS' Program Memorandum AB-02-130 defines the ALS level of service for either Level 1 or Level 2. In addition, Federal Regulations at 42 Code of Federal Regulations, Section</p>	WPS reviews the BLS and ALS state licensure information supplied by ambulance suppliers to determine and validate the level of care credentials of ambulance supplier’s personnel.

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	410.41 requires that vehicle staff must consist of at least two people - one must be certified as an Emergency Medical Technician (EMT) by the State or local authority where the services are furnished, and the other, at a minimum, must be certified as a Paramedic or an Emergency Medical Technician (EMT), by the State or local authority where the services are being furnished, to perform one or more ALS services.”	
	Question as to when to bill procedure code A0888 for the excess miles for transports from Hospital to Hospital (HH) or Nursing Home to Nursing Home (NH) when the destination is determined not to be the closest appropriate facility?	Use A0888 for the excess miles beyond the nearest appropriate facility.
	GY Modifier usage. Problems with Customer Service staff telling beneficiary/family that the ambulance company is billing incorrectly and telling them to call the ambulance company to tell them to resubmit the claim without the GY modifier. This presents a credibility issue for the ambulance company.	WPS staff will meet with CS staff regarding responses to beneficiary questions.
Ambulance Association Meetings	If you attend any of these meetings, please be sure to share any information you get at the AMB PET meetings with these associations. We want to be sure that all ambulance providers receive this information.	
HIPAA Contingency	Members were asked to refer to Medlearn Matters Article Number MM3856 which was sent out with the meeting agenda for additional information concerning the end of the HIPAA contingency plan for claims submission. As of October 1, 2005, all providers must use the HIPAA compliant format for claims submitted to Medicare. Non-compliant claims submitted to Medicare on or after October 1, 2005 will be rejected and returned to the provider.	
National Provider Identifier (NPI)	Information about the NPI was shared with members. Among the topics discussed were the definition of the NPI, important dates, requirements for the NPI, the benefits of NPI, who needs an NPI, the National Plan and Provider Enumeration System (NPES), how covered health provider can get an NPI, NPI resources, and where to apply for an NPI.	

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	<p>Enrollment for an NPI does not mean that providers will not need to enroll with their local Medicare carrier(s).</p> <p>An NPI will replace the UPIN. There are concerns that providers will not be able to obtain referring provider NPIs like the current UPIN registry. Per CMS, there are no current plans to provide a database to look up NPIs. A suggestion was made to ask referring providers to place their NPI on the referral form.</p>	
<p>Electronic Funds Transfer (EFT)</p>	<p>Providers can have their Medicare Part B payments deposited electronically into their back account with Electronic Funds Transfer (EFT). This is the preferred method of payment by the Centers for Medicare & Medicaid Services (CMS).</p> <p>Providers are not required to receive ERAs in order to take advantage of EFT. Each transaction is handled separately.</p> <p>Benefits include –</p> <ul style="list-style-type: none"> ✓ Faster communication and payment notification/receipt ✓ Faster account reconciliation through electronic posting ✓ Automation of follow-up action ✓ Paperwork Reduction ✓ Detailed information ✓ No waiting on the mail ✓ Elimination of lost checks and Standard Paper Remittances <p>Please contact our EDI department at 877-567-7261 for Wisconsin, Illinois, and Michigan or 866-380-4742 for Minnesota (ask for EDI) to request the ERA and/or cancel the SPR.</p> <p>Providers may download the authorization agreement for EFT at http://www.wpsic.com/edi/pdf/edi_medb_eft.pdf</p>	

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Electronic Remittance Advice (ERA)	If you are currently receiving the Standard Paper Remittance Advice (SPR), consider utilizing the technology available to increase productivity by switching to the Electronic Remittance Advice (ERA). Take advantage of faster communication, payment information and reduction of paperwork by receiving the ERA. If you are receiving both a SPR and ERA, consider canceling the SPR.	
Communiqué	The Communiqué is the WPS Medicare Part B monthly newsletter. WPS publishes both on a monthly and quarterly basis and providers can access it free from the WPS Medicare Website at www.wpsmedicare.com/provider/pub_home.shtml . For those providers that are unable to receive electronic newsletters, the quarterly Communiqué is available for a subscription cost.	
Listserv	The WPS Medicare Listserv allows you to receive e-News messages and is free of charge. Messages are typically sent once per week. It is easy to subscribe and/or unsubscribe. You can also check on what Listservs you have subscribed to, some are specialty and/or state specific. To access the Listserv signup, refer to: http://corp-ws.wpsic.com/www-ag/listserv/SilverStream/Pages/signonPage.html	
CD-ROM	The 2006 Physician Fee Schedule CD-ROM contains a variety of information in addition to Fee Schedules and will be available this November.	
Computer Based Training (CBT)	WPS currently offers on-line tutorials or CBT modules on our Website. These allow you the convenience of learning at the office or in your home. Continuing Education Units may be available.	
Internet Demo	WPS is currently offering an iLinc program which details instruction on navigating Medicare's Website for optimal effectiveness. Of particular interest, is the Internet Search Techniques.	
Technology Packet (E-Medicare & You)	Created as an initiative for education to small providers, this product offers novice computer users a guide to computers, electronic billing, and the Internet. E-Medicare & You packets will be sent to all Ambulance PET members that are participating via teleconference. If you are unable to benefit from the information provided, we ask that	Send E-Medicare & You packets to phone Attendees.

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	you give the packet to someone that may benefit from it. Please consider sharing this information with other providers or an association that may be able to promote the product and get it into the hands of those providers that will be able to use it. Telephone numbers and an e-mail address are provided on the back of the packet, should you need to request more copies.	
2006 Premium and Annual Deductible	The Medicare Part B monthly premium will be \$88.50 in 2006, an increase of \$10.30 from the current \$78.20 premium. The deductible will be \$124 in 2006.	
Next Meeting	Paula Bliemeister, Paratech Ambulance, volunteered to host the meeting to be held in April, 2006 in Wisconsin.	
Meeting Minutes	Prepared by Sue Brewer and Mary Muchow	