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Ambulance compliance challenges and the emergence of Lyft in healthcare

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Emergency medical services (EMS) agencies are responsible for adhering to a host of compliance policies—from the Health Insurance Portability and Accountability Act (HIPAA) and Occupational Safety and Health Administration (OSHA) rules, to the latest Centers for Medicare & Medicaid Services (CMS) and Office of Inspector General (OIG) regulations. With so much riding on EMS providers' ability to consistently meet requirements, corporate compliance programs are essential to keep staff in step and up to speed. The problem is that many EMS compliance training initiatives heavily focus on billing, leaving the agency vulnerable to issues that can arise elsewhere and directly affect revenue downstream.

Silos among dispatch, patient care, and billing departments often leave EMS agencies working backward to get required information. Although compliance is a responsibility shared by the entire EMS team, beginning the minute an emergency call is answered, gaps exist in corporate compliance programs. EMS field medics, for example, receive clinical training and limited documentation training, but they are seldom involved in compliance training—which results in recurring points of compliance failure. To mitigate this, compliance training programs should be comprehensive, involve the entire EMS team, and focus on known problem areas.

Overcoming common compliance challenges

Each EMS department plays a pivotal role in meeting various compliance requirements. Dispatch must accurately collect and disseminate patient information to ensure the right resources are sent to the right location. Medics must walk the fine line of capturing all necessary documentation without sacrificing patient care or compliance. Billing teams must tend to the labor-intensive task of claims processing while keeping a watchful eye for documentation inaccuracies and improper coding.

Across the various stages of an EMS encounter, key areas emerge as common points of compliance contention.

Proof of medical necessity

Insufficient medical necessity documentation plagues many EMS agencies. For ambulance services to be reimbursed by Medicare, EMS providers must prove medical necessity for the trip. To circumvent denials, EMS agencies must meet all requirements regarding medical reasonableness and necessity as outlined by CMS.[1]

Proof of medical necessity can make or break reimbursement. Although reimbursement is the primary driver in billing efforts, the paramedics responsible for documenting medical necessity are generally not motivated by money. To reinforce adequate documentation, EMS agencies should appeal to what does matter to field providers—patients and the communities they serve. Encourage crews to approach documentation by addressing why the patient needs an EMT or paramedic at their side. For example, what is it about the patient's condition that

indicates the need for an ambulance rather than a wheelchair van? If those questions are answered, the important issue of medical necessity is adequately demonstrated.

"Working with EMTs and paramedics on call documentation is probably the most impactful training opportunity that we have as managers as it relates to compliance," says Ryan Thorne, CEO of Thorne Ambulance Service. "When a crew understands why we document, the expectations of the documentation, and the way quality documentation improves the overall image of EMS, there is greater team buy-in."[2]

Physician certification statement sign-off

A physician certification statement (PCS) is required for non-emergent transportation reimbursement. Note that the presence or absence of a signed physician's order for ambulance services does not necessarily prove or disprove medical necessity. It is still the EMS provider's job to assess patient's medical necessity.

The ins and outs of PCS sign-off can be confusing. A PCS must be obtained in advance of services for repetitive transport but may be obtained after patient transport for non-repetitive transport. PCSs for scheduled, repetitive transports require physician sign-off. Unscheduled or non-repetitive transports can be signed off by a physician, registered nurse (RN), clinical nurse specialist (CNS), physician assistant (PA), nurse practitioner (NP), or discharge planner. PCS signatures must be legible and include written name and date.

To ensure PCS documentation doesn't fall through the cracks, implement an addendum policy so the occasional miss on a trip report can be addressed. Include deadlines by which documentation must be complete. "Until liability rests with the signing party regarding accuracy and completeness of the PCS, we will continue to receive 'pencil-whipped' and often erroneous documentation," says MedTrust Medical Transport CEO Josh Watts.[3] Making field crews aware of facilities requirements and following up with providers prone to overlooking the importance of PCS sign-offs can help EMS teams be proactive in overcoming this challenge.

"There seems to be a great difference in opinion among facilities. I think this is largely an educational and compliance matter that many of the facilities we work with do not fully understand," adds Thorne. "Ultimately, we developed a letter that we submit to any clinics or facilities that fail to meet the minimal documentation requirements and will ultimately refer them to CMS if they fail to meet the required expectations."

Identification of the closest appropriate facility

EMS providers are required to transport patients to the closest appropriate medical facility for the patient's condition. Determining which facility meets that requirement can be hectic in the rush of emergency care transportation. Compliance with the various Medicare, Medicaid, and commercial payer rules further complicates the issue. Watts points to "the variability of interpretation between Medicare Administrative Contractors and payers regarding coverage, compliance, and process" as a key concern among EMS personnel.

Although Medicare defers to the closest appropriate facility, there is a locality rule whereby Medicare allows for additional travel distance if the patient routinely interacts with multiple local facilities. Note that some states strictly enforce the "closest" facility interpretation for claims. It's imperative that EMS providers document why a patient was transported to a particular facility and why that facility was the most appropriate. And, patient requests for specific facilities should be documented, because this could factor into patient payment liability determinations down the road.

"The right emergency care location can be a complete blur in all but the most acute emergencies," says Watts. "Do we want to manage the care continuum or manage the closest appropriate facility? At this time the ambulance reimbursement methodology, the patient outcome, and overall cost of care are contradictory. In the

age of cost transparency and focus on reduction of redundant medical testing and costs, we need to reshape underlying reimbursement policy."

Emergency, Triage, Treat, and Transport (ET3) is a new ambulance payment model being piloted by CMS starting in 2020. The aim is to reduce avoidable emergency department transports by establishing a medical triage line for low-acuity 911 calls.[4] Thorne points out that in the future, "the ET3 concept could greatly assist providers in transferring patients to the appropriate destination."

Currently Medicare only reimburses for ambulance transportation to hospitals, skilled nursing facilities, and dialysis centers. ET3 will introduce alternative, lower-acuity destinations to the reimbursement model. As Thorne sees it, "The ability to receive reimbursement for these services will assist in gaining compliance with providers and help reshape the mentality of urgent care in our society—reducing costs and improving outcomes."