EMS Innovation and Reimbursement Opportunities

The Future of Ambulance Reimbursements and the Effect on Fire-Based EMS Delivery

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The days of transporting a patient to the appropriate destination and then submitting a claim for reimbursement are becoming a dated practice.
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• The impact of the Patient Protection and Affordable Care Act (PPACA) on reimbursements will continue to grow over the next 3 years.
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- The Patient Protection and Affordable Care Act will impact the field of EMS.
- What we can control is our preparedness for the change.*

* International Association of Fire Chiefs
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• New health care payment and delivery system models that aspire to achieve Triple Aim objectives—better patient care, improved population health, and lower per capita cost.

• Target high-risk/high-cost patients and newly diagnosed chronic disease patients.
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• Delivering appropriate care at the right time in the most cost-effective setting

• The capability to evaluate program effectiveness is necessary to gauge its impact on improving patient health and experience, community and population health.
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YOU MEAN TO TELL ME

AMBULANCES AND TAXIS AREN'T THE SAME THING?
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• “Reduce overall health care costs by reducing duplicate services, increasing health care delivery efficiency, and promoting the best use of clinical and nonclinical services that help people achieve their health goals.”*

*Rural Policy Research Institute Care Coordination Report, June 2015
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Quality and Affordability:
Improve the quality of care while lowering costs – the essence of “pay-for performance”.
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• “85% of Medicare “fee-for-service” payments should be tied to quality or value by 2016”

• “30% of Medicare payments should be tied to quality or value through alternative payment models by 2016, and 50% by 2018”

Sylvia Burwell, Secretary, HHS
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Pay-for performance:

• Limited data currently

• Key Performance Indicators (KPIs)

• Value-based purchasing – hospitals now, transport services in the future
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- CMS will develop KPI’s – we must align our services to meet/exceed these benchmarks
- Our financial benefits will be based on quality measures and performance improvement measured against a baseline standard.
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- As CMS goes, other payers follow.
- Expect the insurance industry to use CMS reimbursement criteria to set their own minimum standards.
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• Data is an integral component in demonstrating effective and appropriate patient care
• Does your electronic data meet national standards and regulations? Buyer beware!!!
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• Alternative Destinations - A.R.S §§ 36-2205(D) and 36-2232(F) and R9-25-504 address the protocol for selection of a health care institution for transport.
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Community Paramedicine:

- Predominately fire-based programs in AZ
- Community needs assessment
- Preventative healthcare – underserved and at-risk populations
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• Reimbursement obstacles:
  Lack of billing codes to allow fee-for-service payments.
  Lack of data to show “value” of services provided.
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• Federal – CMS
• State – Medicaid (AHCCCS)

Both require legislative changes to allow for billing/reimbursement.

Only one state currently successful in accomplishing legal status for billing/reimbursement of community paramedicine services.
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- Per Member per Month (PMPM) fee structure is being used in some states that are reorganizing care delivery for Medicaid beneficiaries. This financing method uses a single payment per beneficiary per month paid either directly to the organization that is providing the care or through Medicaid MCO contracts that pay a set fee to the entities delivering the care.
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• Multi-Payer Payment for Shared Capacity is the financing mechanism where all insurers (commercial and public) share the cost.
• The capacity payment is meant to establish the community-based care support infrastructure available to primary care practices and the general populations they serve.
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- Data collected from six states, including Arizona, shows that nearly 20% of all hospital discharges come back to a hospital ED within 30 days, and 28% of those patients are readmitted at a different facility.
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• 8% of patients revisited a hospital within 3 days. Of these:
  - 29% were readmitted
  - 32% of those readmission took place at a different location than the initial visit.
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• Patients 65 and older were most likely to be readmitted after a revisit.
• Patients between the ages of 18 and 44 had a higher number of ED revisits, and these were more often at a different location than their initial ED visit.
• 89% of revisits had the same primary diagnosis as the initial ED visit.
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• EMS Compass hosted a series of town-hall style webinars June 15-18, 2015 as a forum for members of the EMS community and other stakeholders to provide feedback on the quality and performance measures topics under consideration for further development and testing.
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• Throughout the month of May 2015, EMS Compass held an open “Call for Measures,” and more than 400 measures were submitted through the initiative website. These webinars were the public’s chance to discuss the measures that were proposed and within the context of the 10 domains, provide input that will help the EMS Compass team prioritize the clinical areas and topics addressed.
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- This input will be used by the initiative to evaluate the measures based on criteria such as their importance for EMS to measure and report to their communities and patients, the ability of EMS systems to collect and analyze the data, and the evidence supporting the validity of the measure.
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• The ten webinars were organized by type of performance measure domain, or related area of interest. Members of the EMS Compass Initiative led the webinars, which focused on discussing the types of measures that have been proposed and receiving community input.

http://emscompass.org/webinars/
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- Patient and Family Engagement
- Patient Safety
- Care Coordination
- Population/Public Health
- Efficient Use of Healthcare Resources
- Clinical Process/Effectiveness
- EMS Workforce
- EMS Fleet
- EMS Data
- EMS Finance
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Today’s Ambulance providers face an environment that is in constant & increasing change

- Increasing Medical Necessity requirements
- Review of Claims
- Audit threats
- Decreased revenues
- And now better documentation....why??
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• The use of ICD-10 on all ambulance claims is mandated to start on 10/1/2015

• ICD-10 codes include greater detail and changes in terminology to align with current medical practices.

• Providers are responsible to make sure their billing company is in compliance with ICD-10 standards.
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- A major change included in the ICD-10 implementation is the requirement of greater specificity in the code(s) selected for claims that are filed to all payers including Medicare claims. Due to this change, the documentation of the patient assessment in the patient care report will become more important.
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• Specificity: Describing in more detail the types of injuries or complaints the patient has suffered, accurate anatomical locations for each, onset time and a history of the present illness.

• Laterality: Accurately describing which side of the body or which limb has been impacted by the injury (left, right, bilateral, lateral, inferior, etc).

(*Graphic courtesy of Intermedix)
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- Detailed documented patient assessments will allow coders to obtain the specificity that is needed, particularly with patients who have trauma or pain (medical or trauma related) type complaints.
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Breaking down a ICD-10 code..........

S 8 6

↓ Category

S = Injuries, Poisoning and certain episode other consequences of external causes S86 = Injury of muscle, fascia and tendon at lower leg

↓ Etiology, Anatomic Site, Severity

S86.0 = Injury of Achilles tendon
S86.01 = Strain of Achilles tendon
S86.011 = Strain of right Achilles tendon

↓ Extension

A = Initial encounter
Primarily used to document of care for injuries and with external causes.

D = Subsequent encounter
S = Sequela

In ICD-9.......It’s 845.09.... Other sprains and strains of ankle

(*Info courtesy of Intermedix)
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- EMS providers will be required to provide more thorough documentation about how the patient is moved to the gurney and to and from the ambulance.
- Signatures must be obtained from the patient, responsible party, receiving facility staff, and EMS personnel caring for and transporting the patient.
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• Documenting a clear, concise & accurate HPI in the narrative is important and key for determining medical necessity decisions.

• Ensure pain scale, which is often left out and is used to support medical necessity, is documented.
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• Weakness complaints are frowned upon by payers, and the claims often not paid. Documentation must thoroughly explain the complaint and document the severity of it.
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Not Enough Detail

Upon arrival, found the 85 y/o patient lying supine on the ground. Patient tripped and fell while walking out of Walmart's front door, striking it and is now complaining of left leg pain and a laceration to the left leg. Patient is AXOX4. Pt denies LOC, neck and back pain as well as any other complaints at this time. Patient able to stand and ambulate with assistance. Bleeding controlled at this time. Loaded patient into the unit and transported patient to ABC Hospital with report given to staff.

(*Documentation courtesy of Intermedix)
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- Good Detailed Documentation

Upon arrival found the 85 y/o patient lying supine on the ground, bystanders present. The patient tripped and fell while walking out Walmart’s front door, striking it and is now complaining of left leg pain and a laceration to the left leg. Patient is AXOX4, GCS of 15 and denying LOC, neck/back pain as well as any other complaints. DCAP-BTLS is negative on a head to toe exam with the exception of a open 3 inch jagged laceration to the lateral left lower leg, distal to the knee. Wound presents with no active hemorrhaging at this time with a total blood loss estimated at 50ccs or less before stopping. Patient's pain is centered around the area of the laceration, and rates it a 5 on a scale of 1-10. Leg wound was dressed with an adaptic dressing and cling. Patient able to stand and ambulate with assistance to the stretcher. Vitals obtained and monitored during transport. Loaded patient into the unit and transported patient to ABC Hospital with no change in the patient’s status during route. Upon arrival at the ED, patient was transferred to room 6 and a full report provided to RN Sally Jones.

(*Documentation courtesy of Intermedix)
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Documentation for a PCR should include:

• All treatment modalities performed on the patient
• Noting any, all or no improvement in the patient’s status during the call and upon arrival at the destination
• Noting how the patient was moved at the various times during the call including to the EMS stretcher and ER bed
• Documenting the transfer of patient care and to whom the specific ER receiving person is as well
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• For all providers, it comes down to the same thing - maintain quality documentation that allows billing personnel to make good decisions on who to bill.
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• Whether emergency or non-emergency, it is not the job of a field provider to be a biller. But it is the job of the field provider to document objectively all aspects of the transport, from arrival to treatment and transport and eventual handover at the destination.
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"Commitment is doing the thing you said you were going to do long after the mood you said it in has left you."

- Unknown
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QUESTIONS?

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