

# **Report to the City of Columbus Nebraska on it's EMS Service**

**This report is the result of interviews and discussions with City of Columbus officials on the operations and current billing procedures of the EMS service and the tiering concept with surrounding volunteer ambulance services.**

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## Executive Summary

Columbus Fire Department is facing a series of problems not at all unique to the EMS industry nationwide or especially rural EMS. I do believe, however, that the city is cognizant of the issues and is prepared to address them for the betterment of the ambulance service (and thus the city) but, more importantly, the service's patients.

In today's world of complex billing for ambulance service, it is apparent that not only do ambulance services find billing onerous but there is also an inconsistency in interpretation of the laws by the very agencies in charge of overseeing the billing process.

The City of Columbus is exploring ways to implement the tiering process for patients outside of its jurisdiction and I believe it will be done. Much of the important groundwork has already been accomplished but before it should be implemented it is of more importance to ensure that the ambulance service is operating properly.

While not originally part of the my task to review the Columbus EMS program, I think there is an opportunity to not only improve the billing aspect of the ambulance service but also for improving the oversight of the ambulance service in both the day-to-day operations and strategic planning. It is hoped that my suggestions for the management structure are viewed with the thought that they also improve the billing process and will help enhance the tiering concept. I also believe that the suggestions will only enhance the Departments high standards and service to the community.

This report, hopefully, offers suggestions in improving the billing process, management of the EMS Department and for the tiering plan.

## Observations

### Billing Procedures

The current billing process is for the Paramedic, after every call, to fill out an ambulance run report that asks for incident and patient information, the base and mileage charges and a diagnosis code for the patient. This does require the Paramedic to have, at a minimum, a basic understanding of billing procedures and criteria for the different levels of call and diagnosis codes.

Sometime during a week's time, the ambulance run reports are given to the city's finance office and then submitted to the payer. It was indicated during the initial visit with the city officials that, within approximately two weeks, reimbursement is received from payers. This is excellent turn-around time.

It was also indicated that the determination of the charges be submitted to Medicare was made from a combination of interpretations of the Medicare rules, phone questions to the Intermediary (BC/BS of Kansas) and the local EMS protocols. Although this is the most common method for interpreting the rules and charging for the services, it is felt, in this case, that the interpretations put the city at risk for Medicare fraud.

There is little doubt that the billing process was instituted in good faith but the information received from BC/BS of Kansas regarding ALS Assessment was wrong. Additionally, decisions made by a person or persons in the city administration concerning implementing ALS-1 protocols, by initiating an IV on the approximate 90% of the ambulance patients, is of great concern. The standard of care for ambulance services, both in Nebraska and throughout the nation, would indicate that the approximately 90% of the Columbus ambulance patients who receive an IV is extremely high and begs the question of why. If this high percentage of ALS-1 calls is indeed what has occurred, one could easily conclude that it was done for reimbursement reasons only. However, I do not believe that was the case.

### Operations

Columbus Fire Department is staffed by two full-time paid Paramedic/Firefighters on duty at all times and supported by on-call volunteers. For cities the size of Columbus, this is a common model and given the costs of equipment and staffing for a comparable city's fire department this may be one of a few more cost-effective methods for providing both fire and EMS coverage by the city.

According to the Fire Department management structure, there is no one who has intimate knowledge of Advanced Life Support (ALS) protocols or EMS operations with direct oversight of the entire EMS service and the authority to make day-to-day and strategic decisions. The Fire Chief position reports to the City Administrator and does have oversight for EMS. However, because the position is only part-time and an elected position by the Fire Department members, it may not always serve the EMS side as best

as it could. This is by no means intended to reflect badly on the current Fire Chief. My observations deal with what I see as an inherent problem in the position for not only EMS but also for a Fire Department this size.

The past Physician Medical Director for the ambulance service also does not appear to have been involved as should be as is indicated by the extremely high percentage of patients with IVs initiated in the field. An engaged Physician Medical Director would have questioned this and more than likely changed the protocol or, if the protocol did not call for IV initiation that resulted in that high of a percentage, then he/she would have reinforced the protocol to the EMS staff in order to make the number more in line with standards of care. It is my understanding that Dr. Mark Howerter just started as the Medical Director on October 1, 2006, so this hopefully will change.

At this time, the EMS Department does not have either a quality assurance or performance improvement program.

#### **Tiering with Basic Life Support Services**

The city of Columbus is to be congratulated on the decision to make its ALS service available to volunteer ambulance services bringing patients to Columbus Community Hospital. This is an excellent opportunity to provide specialized care to citizens outside of its current jurisdiction and improve the health care system in the area. These patients will benefit from the ALS care they receive, as a result of the cooperation of the city of Columbus and the volunteer agencies.

Columbus Community Hospital has been designated by the State of Nebraska as a Level III (General) Trauma Center and the tiering concept is a natural extension for the local trauma system.

Tiering will soon be a standard of care for all of Nebraska and, for the most part, already is in communities with a committed and paid ALS service. In fact, the EMS Program of Nebraska's Health and Human Services Systems has made the tiering concept one of the goals for the state EMS System.

## Recommendations

### Billing Procedures

During the visit, there was discussion about using an outside organization or company to provide billing services for the ambulance. There are many billing agencies throughout the nation that specialize in submitting claims for ambulance services and this may be an option. I am not aware that a decision has been made yet, but, regardless of the decision that is decided upon, I recommend the following points be taken into consideration for either decision.

### Contract

- Explore the costs of contracting with an outside billing agency versus continuing to submit claims in-house. Given the number of claims that have been submitted the past two years, it may be more financially advantageous to not contract this out.
- The contract should stipulate that the billing agency will provide the City of Columbus with a complete list of the claims submitted, the amount billed, the amount received, what accounted for the difference, and what claims were denied and for what reason(s).
- The contractor should provide education to the ambulance service whenever there is a change of billing regulations that require knowledge of the rules by the service. Also, education should be provided on an as needed basis when the contractor identifies an area of improvement the ambulance service could provide to them to maximize reimbursement (e.g. documentation). This then would provide the ambulance service with a measurement for their quality improvement program.
- The contract should stipulate that the contractor agrees to be responsible for the appropriate billing that is submitted and that the city will provide the contractor with the demographic information, patient care documentation and any other pertinent billing information. The contractor will then make the determination as to the correct charge based on that information.
- It would be wise for someone within the city's Finance Office to maintain a rudimentary knowledgeable of ambulance reimbursement, in order to monitor how the contractor may be doing.

### Remain In-house

- Specific training in ambulance billing should be given to one or two people within the city's Finance Office who have the responsibility for the billing. This training should be done annually and also with every major change in the reimbursement process.
- This person(s) should have the responsibility for education of the EMS personnel in order that they are familiar with what is needed in providing a "clean claim".

Regardless, if billing is contracted out or retained with the city, I recommend that there be regular training of the Paramedics on what each of the base charges should be based on and what is required for the diagnosis codes. Consistency in billing is of the utmost importance and only by regular and training can billing be consistent.

Beside the question of who should be billing the claims, I would like to present the following points for review to improve the reimbursement.

First, and of much importance, would be to review protocols for applicability and standards of care. This should be accomplished with either all of the Paramedics or a few who could articulate what they see as opportunities for improving patient care. In addition to the Paramedics, the Physician Medical Director must be an active participant in the review and should have the final approval over the protocols. I would also recommend an outside individual with a background in ALS ambulance services protocols and billing knowledge to assist in implementing this concept. This individual would have the task of bringing the ALS protocols and ALS billing into synchronization so there is no question of that patient care always leads the billing process.

The current practice of billing for mileage only when the call is outside of the city limits of Columbus should be reviewed for current Medicare rules. Specifically, all Medicare patients are to be billed the same. Not billing mileage for patients contacted within the city limits sets a different standard than those outside the limits. Medicare is clear that mileage can be charged for all calls even those that are less than one mile. The amount of reimbursement that may be gained by this will, obviously, be minimal but the point is to be in compliance with current Medicare rules, which calls for consistency.

Lastly, instead of waiting for a certain date and/or time to submit claims for payment, I would recommend doing them on a daily basis in order to ensure that reimbursement occurs as timely as possible and some claims are not lost.

### Operations

It is noted that there does not seem to be a clear chain-of-command for the ambulance service and, thus, the management structure for EMS may have opportunity for improvement.

Because the Fire Chief position not a full-time paid one and with the current Fire Chief's basic clinical knowledge of an ALS service, it would appear that this would invite some problems regarding oversight of interpersonal and clinical interactions of the paid, full-time EMS staff. Additionally, this type of management structure does not routinely result in providing support and a voice for the ambulance service with the city administration.

Traditional city ambulance/fire departments are not always in the best interests of either the two services or population they serve. There are ways of separating the two in order to maximize each and, in this case, I would recommend having someone in charge of the ambulance service who has a background and knowledge of ALS ambulance operations and with a history of managing people, budgets and operations. This could occur by keeping the present fire department structure but separating the EMS operations from it. The same personnel could still serve in both departments but by taking EMS out of the fire department, I think there would be better overall efficiencies in operations. If one looks at both Columbus Fire Department and Columbus EMS, it is obvious that the EMS

side is much busier and, because of that, should require more oversight and attention than does the Fire Department. City fire departments became responsible for EMS simply because they were already staffed for 24-hour emergency response operations but I don't think that should be the reason for keeping Columbus EMS in the current Fire Department operational structure.

A robust quality assurance and performance improvement plan for EMS should be implemented in partnership with Dr. Howerter and the city. A quality assurance plan could measure response times, scene times, completion of certain high risk and low volume skills (e.g. intubations, chest decompressions, cardiac or trauma arrests, etc.) and a performance improvement plan would look at ways of improving patient care by doing things differently (i.e. protocol changes, shift changes, operational improvements, etc.). Even a mediocre QA and/or PI plan will allow the service to become better and will always benefit the patients.

### Tiering

Before implementing any tiering agreements, I think it is important to reach a decision about what is to be the future for the ambulance billing – contract or in-house. When that has been determined, the next step should be to know the correct billing criteria and educated both the Columbus Paramedics and the volunteer services. Particular attention has to be paid to the proper method of billing when contacting with the volunteer services who do and those who do not bill.

Review of the tiering process should be done on a regular basis and determined by the services involved. It is imperative that everyone involved understands the tiering concept and is clear on how it should operate and regular meetings to review past calls will help to reinforce this. Tiering review will also provide opportunities for improving patient care and allow a better communication between the Paramedics and BLS providers, and allow a collaboration of all services in quality improvement activities. Involvement by Dr. Howerter and the Physician Medical Directors of the other services is absolutely essential for tiering to be successful.

Since Columbus Community Hospital has been designated as a Trauma Center, tiering will lend itself very nicely into the area's trauma system and its quality improvement plan.

## Conclusion

At the meeting held October 19 at city offices and through the ongoing communications with city staff, I have been impressed with the desire to improve what is being done (i.e. tiering, review of the billing process). You are to be applauded for recognizing that some things need to be changed and are taking steps to do just that.

Paramedic ambulance service is relatively new to Columbus and with all new operations this service is experiencing growing pains and problems, and concerns are becoming visible. This is not unique, of course, but it can be frustrating. However, this visibility and the desire to overcome the problems does provide a chance to review what is occurring and to perhaps implement different and better ways to provide services.

I certainly have appreciated everyone's openness and willingness to share for the betterment of the service and would hope that I have provided some insight into existing operations and offered some alternatives.

Thank you,

Dale Gibbs