

I A F F

EMERGENCY MEDICAL SERVICES

Revenue Recovery

Monograph 4



International Association
of Fire Fighters



Emergency Medical Services

Revenue Recovery

Monograph 4



**Department of Emergency Medical Services
International Association of Fire Fighters, AFL-CIO, CLC**

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Foreword

Today more than 80 percent of fire departments perform some level of emergency medical services (EMS), making professional fire fighters the largest group of providers of prehospital emergency care in North America. No other organization – public or private – is capable of providing prehospital emergency response as efficiently and effectively as fire departments. Fire department operations are geared to rapid response, whether it is for EMS or fire suppression. Cross-trained/dual-role fire fighters are trained to aggressively attack their work whether it involves a fire, a rescue, or a medical emergency. It is no surprise that study after study has shown that fire department-based prehospital emergency medical care systems are superior to other provider types.

However, as we look into the future of prehospital emergency medical care, we are called upon to evaluate our role and the possible need for change in the context of a rapidly evolving medical care system. We must look at what we have learned during the past century and create a vision for the future of fire-based EMS. This vision must address necessary legislation for the protection of fire-based systems. It must address public education, prevention, and the possible expansion of the scope of practice for paramedics. This vision must consider the effects of managed care organizations on prehospital EMS, as well as revenue recovery for the services fire fighters perform. It must also protect fire-based systems from the threat of privatization, as well as protect the citizens we serve by preserving the nation's universal emergency access number, 9-1-1. The information in this series of monographs is designed to guide local fire department leaders through the process of developing a vision for the future of a fire-based EMS system. This monograph is the **fourth** in the series and contains information on the concept of billing and collection for the provision of emergency medical services.

The role of the professional fire fighter is constantly changing. We are called upon to act as multi-faceted first responders answering not only fire calls but rescue, hazardous materials, and emergency medical calls. By answering the challenge of change, we can continue to meet the needs of the communities we serve and do what we do best — protect property and save lives.

Harold A. Schaitberger
General President

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EMS Revenue Recovery

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INTRODUCTION

Changes in health care financing, municipal funding, and the emergency response industry challenge traditional approaches to managing prehospital emergency medical systems. Fire department-based EMS system administrators should evaluate how best to organize, manage, and finance prehospital EMS in the future. This monograph deals specifically with financing an EMS system.

Historically, fire departments and fire-based EMS systems have been funded as part of the municipal budget allocation process. Additionally, the majority of fire departments that provide transport services charge fees for those services adding revenue to the budget. More recently, however, municipalities have faced budgeting shortfalls, leading to searches for opportunities to enhance revenue production. Providing emergency medical services and other health and safety related services can generate such revenue. The following information describes various revenue producing services and opportunities for recovering the costs that are available to fire department-based EMS systems.

REVENUE ASSOCIATED WITH PROVIDING EMERGENCY MEDICAL SERVICES

Most reimbursement from health insurance carriers is linked to medically necessary patient transport. According to the 1995 Medicare Part B Reference Manual, transportation by ambulance is a “medical necessity” when “the patient’s condition is such that transportation by any other method is contraindicated.” For Medicare and most health insurers (“third party payers”), medical necessity for ambulance transportation generally can be demonstrated when the information on the claim indicates that the patient can be characterized by any of the following.

- Was unconscious or in shock
- Had to be restrained
- Required oxygen due to the patient’s medical condition
- Required emergency treatment en route
- Was completely bedridden or could only be moved by stretcher
- Was transported in an emergency situation

It is beyond the scope of this manual to detail the chargeable components of each insurance payer’s plan, but various costs associated with BLS transport and ALS transport may be charged to a patient’s account.¹

To obtain reimbursement, the following must be charged in conjunction with one of the above types of transport services.

- Disposable supplies, such as bandages, gloves, or tape
- Specialized disposables, such as IV drug therapy items, oxygen administration, medications, advanced airway items
- Utilization of an extra ambulance attendant; typically, necessity of additional staff is reviewed on a case-by-case basis for payment

-
- MAST trousers
 - Cardiac monitoring
 - Utilization of an ALS intercept, as when private BLS ambulance uses a fire department paramedic during transport. Only the transporting service can bill for the ALS services received in the course of transport, so the ALS portion of the collectibles should be paid to the fire department by the private transport provider.
 - BLS/ALS unit mileage

ESTABLISHING RATES OR FEES-FOR-SERVICE

Ideally, prehospital care rates should strike a balance between service costs and collectibles. Some states set the rates providers are allowed to charge. In areas where the rate or fee structure is established locally, prevailing rates for similar services in surrounding areas serve as the basis for a fire-based EMS system's rates.

EMS administrators should understand, however, that insurance payers rarely pay 100% of the amount receivable, that is, the billed amount. The unpaid portion is generally left to be billed as a co-insurance amount or otherwise becomes the patient's responsibility. Ultimately, the actual revenue collected is likely to be less than the amount billed. Collection in this context is the dollars collected as a percentage of billed amounts, excluding contractual allowances.² Contractual allowances refer to reductions in billed amounts to which providers have agreed. For example, Medicare actually reimburses providers at specified rates; the difference between billed amounts and Medicare's reimbursement are contractual allowances.

BILLING AND COLLECTION OPTIONS

There are two options for billing available to fire-based EMS systems. The first option is to use in-house billing services with the department actually billing payers or patients directly. Historically, fire department billing systems have had poor returns. With the majority of collection rates ranging from 19% to 60%, few departments have had success stories to present when discussing this issue. According to the 1995 Phoenix Survey, cities report various rates of collection success. For example, Baltimore, Maryland's collection rate was 19%; Pawtucket, Rhode Island's was 40%; and Provo, Utah's was 80%.³ In-house systems that report rates above 60% have adequate personnel trained and dedicated to conduct EMS billing. The lack of success in collection of billables is not a reflection on the fire department or its EMS operations, rather it indicates a lack of expertise in billing for services rendered. In departments without designated personnel responsible for maintaining knowledge of the ever changing laws that govern EMS payment, billing for services should be left to experts in that field.

Fire department billing systems with adequate collection rates have the following components in place.

- An effective and efficient patient information gathering system
- A portion of the staff dedicated to billing/collection tasks
- Staff with current knowledge in the third party payer rules, regulations, and requirements

The second option for billing is to contract with a specialized billing company. The contracted billing agent takes on the responsibility for the entire billing system, including follow-up. The fire department remains responsible for gathering the initial patient data. Services can be

contracted for a portion of the collected amounts. Most billing agency rates are negotiated based on the amount charged for EMS service and the call volume and type.

Three fee structures are common to the EMS billing industry. For example, assume 100 initial bills have been sent by a billing agent on behalf of the provider.

- Flat Fee For Service— A billing company may charge \$7.50 for each bill sent out. If each account requires three bills before actual collection, a total of 300 bills would be sent for a fee of \$2,250.
- Percentage Fees of Collectibles— Using those same 100 initial bills and anticipating that revenue will be received on 60% of the accounts at an average of \$225 per bill, the gross billed amount would be \$22,500. Collecting 60%, net revenue would be \$13,500. At 10% of collectibles, the service fee would equal \$1,350 (10% of \$13,500). A percentage fee may be lower in a system with a high transport volume (6-10%) and higher in a system with a lower transport volume (10-15%).
- Contract Fee— Under the contract fee system, the price for service depends on negotiations between the EMS provider and the billing agent. Once the final price is negotiated, a comparison can be made with the other two billing fee structures. In such an arrangement, the EMS provider must ensure that the contract includes all billing services desired by the provider.

THE BILLING AND COLLECTION PROCESS

The following steps outline the basic process of billing and collecting for EMS services. Both in-house and contracted billing services must develop their own procedures to guide EMS providers in documenting claims to facilitate payment.

- Collection of Source Data — Getting paid for services delivered often depends on field personnel's ability to collect and document billing information. This is the first step for successful collection. The local provider should see that field personnel are properly trained in documentation procedures. Important information may also be obtained from the dispatch/communications center or previous patient records.
- Preparation of Data For Claim Filing — The preparation of billing information is the second step in a successful collection process. The patient report received promptly from the field must be verified and coded. This process will confirm the accuracy of the information received from the field. The data should be entered and charges posted to an accounting system without delay.
- Submission of Claims — Next, an invoice should be prepared and a claim filed with Medicare, Medicaid, or other third party payers as appropriate. Each patient account requires an average of three pieces of correspondence; the original plus two follow-up statements. Many accounts may require additional communication with the insurance carrier. The first invoices and insurance claims should be mailed within 72 hours of service. Quick processing of information, prompt insurance claim filing, and timely invoice mailing have the greatest positive impact on collection rates.⁴ Further, billing personnel

should be well versed in allowable charges under governmental services (Medicare, Medicaid), as well as private insurance company reimbursement plans and managed care plans.

- Account Closing — The best way to “close” an account is with payment in full. However, because each insurance payer may not make payment in full, the account may be closed accepting only what the payer agrees to pay (taking “assignment”). It may also be closed with the receipt of the payer and co-insurance amounts or by “writing off” a portion of the receivable. If further payment is required, the account activity may be refiled with a primary carrier or routed to a secondary insurance carrier, the patient, or to a collection office. Ideally, the accounts closed per day should equal the chargeable events per day to prevent the generation of a backlog of accounts waiting to be closed. All accounts should be cleared within 120 days.

TYPES OF PAYERS FOR EMERGENCY MEDICAL SERVICES

MEDICARE

The Medicare program provides medical insurance coverage for people 65 and older, for certain disabled people, and for some people with end stage renal disease (ESRD). In 1996, there were over 37 million beneficiaries throughout the United States.⁵ Medicare has two parts: hospital insurance (Part A) and supplemental medical insurance (Part B). Medicare Part A coverage pays for inpatient hospital care, some inpatient care in a skilled nursing facility, some home health care, and hospice care. Hospitals usually submit claims to a designated Medicare Part A intermediary for payment. Medicare Part B pays for covered “medically necessary” services rendered by physicians, suppliers, independent laboratories, clinical psychologists, social workers, physician assistants, nurse practitioners, and ambulance services. Medicare Part B is administered by organizations known as Medicare carriers. They are health insurance organizations under contract with the Health Care Financing Administration (HCFA), the federal agency responsible for the national administration of Medicare Parts A and B.

Medicare Part B Assignment and Participation: Under the Medicare program, an eligible service provider or supplier may enter into a participation agreement and accept assignment for all services rendered to Medicare patients. Accepting assignment means agreeing to accept the Medicare approved amount as payment in full for the service. The approved amount consists of the Medicare Part B payment and the applicable deductible and co-insurance. Medicare customarily pays 80% of the allowed charges for ambulance services. The allowed charges for ambulance service is determined by a complex formula and limited by prevailing rates in a designated region. The remaining 20% may be billed to a patient’s co-insurance or to the patient directly as a deductible. A

participating provider or supplier may not ordinarily collect from the beneficiary more than the applicable deductible and co-insurance for covered services. Current Medicare regulations also require that patients **must** be billed for the difference between the total charges and the Medicare contribution. However, the provider may decide the extent to which collection from individual patients will be pursued.

All providers and suppliers eligible to receive payments under Part B of the Medicare program may enter into a participation agreement. The term of the agreement is one year. All non-participating providers and suppliers receive copies of the agreement during the open enrollment period every December.

EMS transport providers should recognize that participation Medicare does not mean guaranteed payment. Payment for services may be denied as not being reasonable or medically necessary. Also, injections that can be self-administered are not covered.

Medicare and Ambulance Billing: The majority of ambulance services are billed to Medicare Part B. Medicare Part B ambulance guidelines identify terms and list covered and non-covered services. The following guidelines are particularly important to EMS providers.

- Vehicle and Crew Requirements For Basic Life Support (BLS) — A basic life support ambulance is one that provides transportation as well as the equipment and staff needed for basic services, such as controlling bleeding, splinting fractures, treatment for shock, delivery of babies, and CPR. The BLS provider's vehicles must be certified as ambulances and have a minimum crew of two persons, one of whom must have completed standard and advanced first aid classes.
- Vehicle and Crew Requirements For Advanced Life Support (ALS) — An ALS ambulance has specialized life sustaining equipment and ordinarily, equipment for radio-telephone contact with a physician or

hospital. This includes mobile coronary care units and other ambulance vehicles that are appropriately equipped and staffed by personnel trained and authorized to administer intravenous therapy, provide anti-shock trousers, establish and maintain airway, defibrillate the heart, relieve pneumothorax conditions, and perform other ALS procedures or services. These skills are considered to be an integral part of the ALS service and will not be reimbursed when reported separately. **These services can be reimbursed only when the patient is transported.**

- Emergency service is almost always covered— Here “**emergency**” means a service provided after the sudden onset of a medical condition manifesting itself by acute symptoms of such severity (including severe pain) that the absence of immediate medical attention could reasonably be expected to result in any of the following.
 - Placing the patient’s health in serious jeopardy
 - Serious impairment to bodily functions
 - Serious dysfunction of any bodily organ or part
- Non-emergency transports may not be covered — Here “**non-emergency**” is any trip that does not meet the “emergency” definition, including all scheduled runs, as well as transports to nursing homes, dialysis centers, or to a patient’s residence. Claims for these services should be submitted with the appropriate non-emergency code. Transports to end-stage renal dialysis facilities for patients experiencing acute renal failure would be considered emergency ambulance services.
- Destination Requirements— Only local transportation by ambulance is covered. This means the patient must be transported to a hospital or skilled nursing facility with a locality encompassing the place where the ambulance transportation of the patient began and which would ordinarily be expected to have the appropriate facilities for the

treatment of the injury or illness involved. Locality refers to the service area surrounding an institution from which patients normally come or are expected to come for hospital or skilled nursing services. Appropriate facilities means that the institution is generally equipped to provide the hospital or skilled nursing care for the illness or injury involved. Medicare will pay for ambulance services outside the locality only if there is no institution within the locality having appropriate facilities. Medicare will not pay for transportation from one institution to another unless the discharging institution did not have appropriate facilities for treating the patient, and the admitting institution was the nearest one with appropriate facilities.

- Round Trip Ambulance Service — Coverage is limited to inpatients of participating skilled nursing facilities who are transported to the nearest facility to obtain necessary diagnostic or therapeutic services if those services are not available at the institution where the beneficiary is an inpatient. This type of transport is billed to Medicare Part A by the skilled nursing facility where the patient remains admitted.
- Documentation — Ambulance suppliers are required to retain documentation on file supporting ambulance services billed to Medicare. Documentation must include a permanent record of each patient's medical condition and reason for transport. This information must meet medical necessity criteria for ambulance transport. In the event of a round trip, separate trip sheets should be completed for each leg of the transport.
- Billing for Supplies or Procedures — Depending on the billing method used by an area, supplies, advanced procedures, or mileage may be billed as separate items, or under one comprehensive charge.
- Ground Ambulance Transportation Services — Reporting codes for BLS and ALS services are grouped according to the four billing

methods established by HCFA. Within each group are separate billing codes for various services. For example, there are separate codes for BLS or ALS vehicles providing emergency and non-emergency services and for ALS specialized disposables. You must adhere to the billing method that has been determined to be your state's billing pattern.

Method 1 uses a single, all-inclusive charge reflecting all services, supplies and mileage. Method 2 uses one charge reflecting all services and supplies, with separate charge for mileage. Method 3 uses one charge for all services and mileage, with separate charge for supplies. Method 4 uses separate charges for services, mileage, and supplies.

A useful source of information about the Medicare program is the "Medicare Handbook." This booklet explains how the Medicare program works. To order a free copy, write to: Health Care Financing Administration, Publications, N1-26-27, 7500 Security Blvd., Baltimore, MD 21244-1850. Other sources of Medicare information include local Social Security offices or HCFA'S Medicare Hotline at 1-800-638-6833.

MEDICAID

Medicaid, established with Medicare in 1965, provides health care coverage to a number of economically disadvantaged groups. It is a joint effort between the individual states and the federal government (except for Arizona, which has its own program to provide health services to the indigent), with the federal government matching from 50-79 percent of the state's medical service and administrative costs.⁶ States' contributions to the program vary according to per capita income, and each state establishes its own criteria for Medicaid eligibility and benefit levels.

Each state administers its own separate and distinct Medicaid program. In 1996, all state programs combined provided coverage to 13.8% of the U.S. civilian population.⁷ Since each state has responsibility for setting coverage levels, there is substantial variation among states with regard to covered services. In contrast to Medicare and other third-party payers, the terms under which states receive federal funds for Medicaid programs forbid requiring co-payments or deductibles of beneficiaries.⁸

There appears to be a great deal of diversity in cost-containment efforts among the 50 states. Only a few states are still using retrospective reimbursement. The majority of the states use prospective reimbursement, and California and Arizona use competitive, selective bidding. Managed care appears to be an integral part of many cost-containment efforts. It is unclear why different states have elected to use different levels of competition and regulation, although studies have suggested that increases in costs have engendered increases in cost-containment measures.⁹

Currently, 49 states offer some form of managed care in their Medicaid program. Additionally, at least 38 states are mainstreaming Medicaid-eligible citizens into HMOs and PPOs.¹⁰ Capitation programs, in which states contract with private or municipally-run health plans to provide a full range of services to Medicaid beneficiaries, are now the fastest growing type of Medicaid managed care programs.¹¹ However, the transition to Medicaid managed care plans has reportedly yielded mixed results in

improving access to care, assuring the quality of care and saving money.¹² The Medicaid billing process varies only slightly from the Medicare billing process. Again, it is essential to establish medical necessity, and patient transportation is required for prehospital care reimbursement. Other aspects of the Medicare billing process include the following.¹³

- 42 CFR 43.53 stipulates that state plans must “specify that the Medicaid agency ensure necessary transportation for recipients to and from providers and describe the methods to be used to meet this requirement.
- States are obligated to utilize all available sources of free transportation services (such as relatives and friends) before authorizing Medicaid payment. When multiple methods of transportation exist, states are required to use the least costly means available.
- Transportation costs can be covered as an optional medical service (440.70[a]) or as an administrative expense (43.53).
 - **Optional Medical Service** — 42 CFR 440.70(a) defines the coverage of transportation services which includes “expenses for transportation and other related travel expenses determined necessary by the agency to secure medical examinations and treatment for the recipient.” States that choose to cover transportation as optional medical service would receive reimbursement at the Federal Matching Assistance Percentage (FMAP) rate.

In order for states to provide transportation as an optional medical service, it must be provided by a vendor to whom direct payment can be made by the state Medicaid agency. Freedom-of-choice principles apply, unless the state is granted a freedom-of-choice waiver. This means that the recipient must have the freedom to choose among all qualified providers.

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- **Administrative Expense** — Under 42 CFR 43.53, states may choose this option, and thus receive Federal Financial Participation (FFP) at the 50% administrative rate. The state has more flexibility in covering transportation under this method. Arrangements may include the use of vendors or other transportation alternatives, such as direct reimbursement to the recipient. Freedom-of-choice principles do not apply, which allows the state to restrict the providers from which the recipient can obtain transportation or the type of transportation provided.

If a state covers transportation as an administrative expense, the principles of OMB circular A-87 are followed in claiming reimbursement. OMB A-87 contains the cost principles for determining allowable costs of programs administered by the state and local governments. Among other requirements, OMB circular A-87 requires that costs be “necessary and reasonable” and “allowable” to the Medicaid program for Medicaid payment to be available. Principles of OMB A-87 would require Medicaid reimbursement as an administrative expense according to cost allocation to ensure that the Medicaid program only pays for the portion of transportation that would be necessary for the medical service.

For specifics on Medicaid eligibility and the health services covered, contact your state Medicaid program office. For general information on the Medicaid program, see “Medicaid Fact Sheet.” For a free copy, write to Health Care Financing Administration, Publications, N1-26-27, 7500 Security Blvd., Baltimore, MD 21244-1850.

**MANAGED CARE
ORGANIZATIONS-
CAPITATED
REIMBURSEMENT**

Managed care organizations deliver medical care through contracts with selected providers for a predetermined monthly or annual premium. Enrollees receive services from designated providers for a prepaid or capitated amount, thereby limiting out-of-pocket expenses.¹⁴ Managed

care payers include preferred provider organizations (PPOs); health maintenance organizations (HMOs), and self-insured employer plans.¹⁵ Also, medical groups, hospitals, and multi-facility integrated delivery systems are becoming involved in transport services and are becoming payers themselves.¹⁶

Revenue from managed care organizations is arranged by contract, often based on covered “lives” transported per month, known as capitation. Capitation is a pre-determined amount paid per enrollee without regard to the amount, type, or frequency of service rendered to the enrollee. Many health care experts expect prospective capitated reimbursement to providers to become the primary method of reimbursement — with or without health care reform.¹⁷

“Medical necessity” takes on new meaning when a provider enters into a capitated agreement with an MCO. The MCO often acts as or delegates a “gatekeeper” to restrict a patient’s access to care based on necessity. Transporting costs for patients who, for example, are transported without necessity or without pre-authorization may not be reimbursed. However, the revenue from **approved** transports that occur under a capitated agreement is guaranteed. (See also Monograph 5 for details on Managed Care Contracting.)

OTHER THIRD PARTY PAYERS

There are more than 1,200 possible payers for emergency medical services, including managed care organizations, Blue Cross/Blue Shield, and other commercial health insurers.¹⁸ Commercial health insurers do business in each of the 50 states, although not every firm sells in every state. Nearly all of the large firms, such as Travelers, Prudential, and Metropolitan Life have substantial business in property, automobile, and life insurance, as well as health insurance.¹⁹ Commercial insurers typically reimburse providers on a fee-for-service basis, although many insurers have shifted to HMOs and PPOs. Commercial carriers generally reimburse patients directly and have larger deductibles and higher co-payments than do Blue Cross and Blue shield plans.²⁰

**Auto
Insurance**

Medical necessity or pre-authorization is again the basis of third-party payer reimbursement. Restricted access to reimbursement for expenses is a method of cost-containment even for non-MCO insurers. Many third-party insurers use the Medicare rates and necessity guidelines as the foundation for their own reimbursement standards. Providers and billing staff need to be aware of the reimbursement criteria and procedures for each third-party payer in their area. Complete documentation is a must, as unfavorable retrospective review of an “unjustified” claim may result in reduced reimbursement and revenue recovery.

Every state motor vehicle department requires vehicle registrants to hold automobile insurance. Some of these insurance carriers allow for fire departments to charge for services rendered at the scenes of auto accidents. The charges permitted vary depending on the type of service provided.

For example, the fire department may respond to a motor vehicle accident where there is an access problem in addition to a medical problem. If the fire department transports, either the patient’s medical insurance or the medical portion of the auto insurance could reimburse the fire department, subject to any deductibles. Even if the fire department does not transport, the patient could be billed for the rescue services, and then make a claim to his or her auto insurance company. If the claim is accepted, the fire department could be reimbursed by the patient’s reparations portion of the policy, which is usually not subject to any deductible. A minor access rescue would be billed at a lesser amount than a major access solution. Charges could be based on equipment, staff, or time used to perform the rescue. For example, the Scranton, Pennsylvania Fire Department bills individual vehicle owners \$175 after responding to a motor vehicle accident where rescuers used hydraulic rescue tools for extrication. The bill goes to the person’s auto insurance company.²¹

PATIENT SELF-PAY

Patient self-pay is one other area of cost recovery. The collection rate has been low for many departments, not always because of financial hardship on the part of the patient, but because of the scope of billing expertise needed to effectively collect. Many departments are having to write off between 40 and 60 percent of potential billings for these reasons. Increasing billing and collections effectiveness could be achieved by considering alternate sources of payment such as cash discount incentive or credit. Closure of the account as soon as possible, even with a discount, can produce much needed revenue for transport systems. One as yet untapped and innovative method is to offer the availability of a credit card charge for service. Traditional credit cards have only been used for about 10% of the health care related self-pay expenses on a national level. No figures are available at this point segregating the credit card payment method strictly for ambulance services and transport. Often the available credit on traditional cards will not withstand a large medical charge. A relatively recent phenomenon is being developed that would enable the uninsured or underinsured person to obtain a credit card dedicated solely to health care related charges.

This unique concept benefits the transport provider because once the person is approved and the card used, the providers of services receives payment for services rendered within two days. The amount reimbursed to the provider would vary, depending on the credit score of the card user — anywhere from 65% to 95% of charges. Although discounted, the advantages are many: the provider never has to do further billing; the credit card is a revolving one and can be used for repeat instances and with other medical providers who accept the card; there is no risk to the provider on collections because the underwriting bank does the billing and credit collection. The consumer can make low monthly payments and receives 90 days same as cash upon their initial charge, it strengthens or establishes their credit history and offers them the security of an alternate payment method that is reserved only for health care. The application opportunity could be offered through the consumer bill so that the consumer

has the option of paying the city in full or applying for the credit card.

Some companies may offer credit only to the “A” credit tier, and some may offer multi-tiered layers of credit risk with varying discount rates. Depending on the terms, ambulance transport services could begin recovering a significant portion of their self-pay that is now lost. If for example, an additional 10% could be collected on an annual budget of 1.5 million, it could mean another \$150,000 in revenue available for improvement of services via staffing, new programs and capital outlay. This alternative is a new and viable option to improve much needed revenue for ambulance transport. The caveat of course, as in all transport collections, would be the need for public relations sensitivity to the marketing of such a concept and to the resulting collections procedures.

SUBSCRIPTION SYSTEMS

Highly successful ambulance subscription programs have been established by several urban systems. Federal law permits two kinds of programs: offering ambulance services for sale, and offering contract in which a provider sets prices and customers prepay uninsured portions of medically necessary ambulance services. Under the first type of program, the provider may not bill third-party payers for services rendered. Under the second type of program, the provider can bill and collect from third-party payers.²²

The following features are common to successful subscription programs.

- The program covers both emergency and non-emergency transport as a full-service program
- Renewals of subscriptions are dependent on the reputation of the provider
- The program focuses on providing the highest quality service
- The program is marketed through a concentrated advertising effort, and members can join within a limited window of opportunity (typically 30 to 60 days annually)

- High transport rates and aggressive collection efforts which provide incentives for residents to buy into an ambulance subscription program
- The income from each subscription is viewed as a stream of income over a period of years, with the payoff being realized in a series of renewals

An example of a such a program is the Orange City, California Fire Department Paramedic Subscription Program. This program provides medical treatment, along with transportation, for emergency 9-1-1 calls. A subscription allows coverage for any person at a subscribing address, whether a residence or a business. The fire department publishes a color brochure to advertise the rates of the various subscription fee schedules, as well as the more expensive non-subscriber treatment and transport rates. The brochure also explains that if the 9-1-1 service is used, the subscriber's insurance is billed and the patient does not have any out-of-pocket expenses. In fact, regardless of the subscriber's insurance, the subscription fee assures no out-of-pocket expenses. The department established an open enrollment period, and late fees are charged for enrollments after the annual enrollment deadline.

**ALS INTERCEPTS
FOR PRIVATE
AMBULANCE
COMPANIES**

ALS intercepts are another source of cost-recovery. By establishing an ALS intercept agreement with a private ambulance, the private ambulance service becomes a payer for ALS service. For example, if a fire department paramedic provides ALS services on the BLS transport vehicle operated by a private company, the BLS service may charge ALS rates if there is an intercept agreement. A properly structured intercept agreement would require the BLS service to reimburse the ALS intercept provider for the difference between ALS rates and BLS rates.

OPPORTUNITIES BEYOND THE TRADITIONAL EMS CHARGES

ANCILLARY SERVICES

The most common ancillary services include special events coverage, hospital contracts for inter-facility patient transport, specialized mobile intensive care transport services, regular long-distance transfer service, joint ventures with air transport services, and government contracts (for example, Veteran’s Administration hospital contracts). Unless state and local laws prohibit, fire departments may contract with other entities to provide these services. Most contracts are negotiated on a per patient or per event rate schedule.

PRIVATE COMPANY AGREEMENT

When a fire department provides initial emergency medical response and transport is provided by a private company, a contract may be established between the fire department and the private company. The private ambulance company may be billed for supplies used prior to the ambulance’s arrival and for any assistance provided by the fire department (for example, a fire fighter riding in as an extra person on the ambulance). An example of this contract exists between the Rancho Cucamonga Fire District (California) and MedTrans, a subsidiary of Laidlaw Medical Transport (AMR). Relevant sections of this contract follow.

PUBLIC/PRIVATE FIRST-RESPONDER AGREEMENT

This agreement is made between the RANCHO CUCOMONGA FIRE PROTECTION DISTRICT, hereinafter referred to as “DISTRICT”, the CITY OF RANCHO CUCOMONGA, hereinafter referred to as “CITY”, and MEDTRANS, a subsidiary of Laidlaw Medical Transport, Inc., a Delaware corporation, d.b.a. MERCY, hereinafter referred to as “MERCY”, to assist in the financing and the provision of improved prehospital emergency medical services within the areas served by the DISTRICT.

3. Responsibilities of Parties.

a. Responsibilities of MERCY

(1) Upon the commencement of DISTRICT'S ALS service, MERCY shall pay to DISTRICT, on or before the fifth day of each month, the sum of \$17,500 each month for the first twelve (2) months in return for receiving service support from DISTRICT'S ALS First Response System. The monthly payment amount shall be adjusted at the beginning of each subsequent year from the date of commencement of DISTRICT ALS services.

(2) Commencing with the second year of the term of this Agreement, and at the beginning of each subsequent year thereafter, MERCY's monthly payment to DISTRICT shall be adjusted in accordance with the percentage change in the prior year's total number of emergency ambulance responses. Calendar year 1994 shall be the base year for purposes of this adjustment. The total monthly payment shall be computed by dividing the prior year's total number of emergency ambulance responses by the total number of emergency ambulance responses in the base year (1994), then multiplying the resulting quotient by the initial monthly payment (\$17,500).

The adjusted monthly payment, established by use of the formula set forth above, shall be subject to a further adjustment, commencing with the second year of the term of this Agreement and annually thereafter, based upon the percentage change in the Consumer Price Index, published by the U.S. Department of Labor Bureau of Labor Statistics, for the Los Angeles-Anaheim-Riverside statistical area (1982-84=00) for all urban consumers. The formula for adjusting the monthly payment to be made to DISTRICT, in mathematical terms, shall be as follows:

$$\text{Adjusted monthly payment} = \frac{\text{prior year's responses}}{1994 \text{ responses}} \times \$17,500 \times \% \text{ change in CPI}$$

(4) MERCY shall comply with all applicable city, county, state and federal statutes, ordinances, regulations, policies and procedures related to the provision of emergency ambulance service. Billing, collection and reimbursement for services shall be subject to the limits imposed under San Bernardino County rate setting procedures.

(5) Following MERCY's provision of EMS at the scene of any incident, MERCY shall promptly return DISTRICT personnel to DISTRICT fire stations, by MERCY's

vehicles, taxicab, or otherwise, when DISTRICT personnel have, in the opinion of MERCY's personnel, been required to accompany MERCY personnel during patient transport. Further, MERCY shall replace any and all disposable medical supplies, including drugs and other medications normally supplied by receiving emergency care facilities, as may be utilized by DISTRICT's personnel as part of their provision of emergency medical services.

**HAZARDOUS
MATERIAL
INCIDENT
REIMBURSEMENT**

If a hazardous material was involved in the incident, the cost of any materials used and any equipment damaged at the scene due to hazardous materials, can be billed to the responsible party. The state or regional environmental protective office can help fire departments identify responsible parties where responsibility for the incident is disputed.

STATUTORY REVENUE

Some states have enacted laws. In New Hampshire, state statute provides that up to \$10,000 may be recovered in the court system from a subject found guilty of a criminal offense which caused the utilization of fire or EMS services.²³ A list of services provided at the scene of such emergencies and their associated costs is furnished to the court by a fire department through the prosecuting agency. The court may decide to make restitution in whole or in part and that monetary relief is then designated to be paid to the fire department as part of the sentence. The types of incidents that are recoverable include aggravated DWI, attempted suicide, drug overdose, or a hostage situation. Keep in mind that judgment against an individual does not guarantee that an EMS provider can collect, as the individual may not be able to pay restitution.

WHY WOULDN'T A FIRE DEPARTMENT BE ABLE TO BILL?

Medicare and Medicaid will only reimburse services delivered and documented by Medicare or Medicaid “providers.” EMS providers must apply for provider status and submit proof that they meet state standards for ambulance services. If a service is operating with any exemptions from state prehospital care standards, all Medicare and Medicaid provider applications and claims will be rejected. Other third-party payers may also limit reimbursements for services that do not meet state EMS standards.

Finally, local government charters or constitutions may include language limiting the ability of the fire department to recover costs. The language may hold the charges at a given amount or prohibit any fee-for-service system from being established. Before initiating any cost-recovery system, fire department officials should thoroughly research local regulations for any such limitations.

CONCLUSION

Taxpayer funding of a fire-based EMS system may be supplemented by cost-recovery programs. Medicare, Medicaid, and private health insurance payers pay for medical care and this includes prehospital EMS. Effective billing and collection systems are designed by administrators with working knowledge of various payer policies and procedures and are maintained by staff assigned exclusively to the task of handling the extra workload. A well designed billing and collecting system, whether in house or contracted out, can provide a substantial source of revenue to a fire department-based EMS system.

ENDNOTES

- 1 MANY THIRD-PARTY PAYER ALLOWANCES PARALLEL MEDICARE REGULATIONS.
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- 3 PHOENIX FIRE DEPARTMENT, "NATIONAL SURVEY: FIRE DEPARTMENT OPERATIONS IN THE UNITED STATES AND CANADA," 1995.
- 4 KELLER, R., "THE ABC'S OF EMS BILLING AND COLLECTION," EMERGENCY, MARCH 1994.
- 5 HCFA MEDICARE MANAGED CARE CONTRACT REPORT, JANUARY 1997.
- 6 THE GEORGE WASHINGTON UNIVERSITY COMMITTEE ON HEALTH POLICY, REFORM WATCH, FALL 1995, P.2.
- 7 HCFA "1996 STATISTICS AT A GLANCE" PAGE.
- 8 GREENBERG, W., "COMPETITION, REGULATION, AND RATIONING IN HEALTH CARE," HEALTH ADMINISTRATION PRESS, 1991, P. 87.
- 9 FANARA, P., GREENBERG, W., "FACTORS AFFECTING THE ADOPTION OF PROSPECTIVE REIMBURSEMENT PROGRAMS BY STATE GOVERNMENTS, INCENTIVES V. CONTROLS IN HEALTH POLICY," AMERICAN ENTERPRISE INSTITUTE, 1985, PP. 144-156.
- 10 "MANAGED CARE IMPACTS EMS," EMERGENCY, DECEMBER 1996, P. 30.
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- 12 U.S. GOVERNMENT ACCOUNTING OFFICE, MEDICAID: STATES TURN TO MANAGED CARE TO IMPROVE ACCESS AND CONTROL COSTS, WASHINGTON, DC, GAO/HRD-93-46, MARCH 17, 1993.
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- 16 ACTUARY - BNA HEALTH CARE POLICY.
- 17 JONES D., "PREPARING FOR CAPITATED PAYMENT AND INTEGRATED DELIVERY SYSTEMS, PREHOSPITAL CARE ADMINISTRATION, JEMS COMMUNICATION, 1995, P. 426.
- 18 KELLER R., "DEALING WITH THIRD-PARTY PAYERS," PREHOSPITAL CARE ADMINISTRATION, JEMS COMMUNICATIONS, 1995, P. 422.
- 19 GREENBERG, W., "COMPETITION, REGULATION, AND RATIONING IN HEALTH CARE," HEALTH ADMINISTRATION PRESS, 1991, P. 48.
- 20 FRECH, H., GINSBURG, P., "COMPETITION AMONG HEALTH INSURERS, COMPETITION THE HEALTH CARE SECTOR: PAST, PRESENT AND FUTURE," ASPEN SYSTEM CORPORATION, 1978, P. 50.
- 21 "DISPATCHES," RESCUE, SEPTEMBER/OCTOBER 1996, P.15.

ENDNOTES
(CONT'D)

²²ROUSH, W., PRINCIPLES OF EMS SYSTEM, AMERICAN COLLEGE OF EMERGENCY PHYSICIANS, 1994, P. 470.

²³NEW HAMPSHIRE REVISED STATUTE ANNOTATED 151-B:21.

GLOSSARY

Advanced Life Support (ALS)— All basic life support measures, plus invasive medical procedures including intravenous therapy, cardiac defibrillation, administration of medications and solutions, use of adjunctive ventilation devices, and other procedures which may be authorized by state law and performed under medical control.

Amount Billed (billables) — The dollar amount of the bill sent to the insurance company or patient directly.

Amount Collected (collectibles) — The actual dollar amount received in response to the amount billed to the insurance company or patient.

Basic Life Support (BLS)— Generally limited to airway maintenance, ventilation (breathing) support, CPR, hemorrhage control, splinting of fractures, management of spinal injury, protection and transportation of the patient with accepted procedures.

Billing Agent — The third party responsible for handling all components of EMS service billing , except the information gathered during patient contact. This includes billing, claims submission, and billing follow up.

Capitation — A method of payment for services in which, based on a pre negotiated contract, a health care provider is paid a fixed amount per person per month, regardless of whether the individual actually uses the health care system. This system transfers the risk from the insurance payer to the health care provider.

Cost — The dollar amount expended in order to provide a service.

Cost-Recovery — The process of recuperating the amount expended as a result of the provision of a service.

Medically Necessary — Medical necessity is demonstrated when patient records indicate the patient's condition was such that transportation by any other method was contraindicated. This term may vary according to a specific payer's criteria.

Payer — The entity that reimburses the provider on behalf of the patient , for services rendered. (Medicare, Blue Cross/Blue Shield, Aetna)

Revenue Producing — Services or products that are billable and can be reimbursed beyond the cost of providing those services or products.

Revenue Recovery — The process of obtaining reimbursements from payers for services rendered.