

Fall 2006 Edition

Welcome to the changing world!

We are happy to release our inaugural issue of MBI Solutions Fire/EMS Billing Newsletter! Our goal is to keep your department abreast of the latest news and trends in Fire and EMS Billing. The last eighteen months have seen a lot of change in the industry. From implementation of the Medicare Ambulance Fee Schedule to electronic fund transfers (EFT), the world of EMS Billing has been ever evolving. Also included in our quarterly newsletter is a clinical article written by one of our many Emergency Department Physicians from our parent company, Premier Health Care Services.

Preparing for the New Year

As 2006 winds down, MBI is gearing up for the beginning of 2007. Marie Goins, our credentialing specialist, is gearing up for our Medicare updates.

Marie will be sending notices out about updating your 2007 Ohio Pharmacy Board License. Medicare requires your department to submit an updated copy of your drug license annually. Once you receive your 2007 drug license, please forward it to Marie as soon as possible. Failing to provide Medicare with the new license will result in all EMS transport to be paid at the BLS base rate, thus reducing your department's revenue.

MBI is eagerly awaiting report of the 2007 Ambulance Inflation Factor (AIF). Sometime throughout late November to early December we expect to receive the CMS announcement. Once the announcement is received we will send your department a Rate Suggestion Sheet for your authorized individual to sign and return to our office. As always these are only suggestions, and your department may elect to accept the rates, maintain your current rates, or set new rates for 2007. MBI advises all departments to take advantage of the AIF and raise your department's rate accordingly.

To allow us to better serve you and to comply with Medicare guidelines we need to know when any of your department information changes. These changes may affect payments processed by Medicare. Changes that need to be reported to our office immediately throughout the year are:

- Department Chief and Contact Information Changes
- Department Physical Address Changes
- Department Pay to Address Changes
- State Pharmacy Board License Changes
- Addition/removal of EMS transport units to your department

For any further information or to report changes please call Marie Goins at 937-619-3064 or 800-875-0136 extension 3064.

Maximizing the Revenue Stream

On October 3, 2006, MBI Solutions Fire/EMS Billing Services kicked off our "Documentation and Revenue Enhancement" initiative. Chiefs, EMS Officers and/or Financial Officers from 28 department joined MBI in Fairborn, Ohio, at our 2006 EMS Billing Conference.

During these times of tight budgets the same question is asked from the smallest of volunteer departments to the largest career department. "How can we maximize our revenue and decrease our write offs?" We have identified areas where your department's input can improve our revenue recovery processes fulfilling your revenue potential.

Patient Signatures

A beneficiary signature to release payment is required to submit Medicare claims. During transport of 911 emergency calls these signatures can be rather difficult to get.

On a "typical" non-emergency call, signatures can be much easier to get from patients. Just ask them to sign on the signature line as required by your department. Always explain why they are signing your run sheet. Many departments will include a statement to cover assignment of benefits, HIPAA Privacy Rights, and permission for treatment. Consult your department Officers for instructions in signatures policies.

Emergency transports are times where it can very difficult or impossible to get a patient signature. Fortunately Medicare allows for situations such as these. Any patient unable to sign due to any mental or physical condition may have a relative, friend, governmental agency providing assistance, or the provider rendering care sign for the patient. This gives you a variety of options to acquire a valid signature. If a friend or relative is present giving patient information, have this individual sign for assignment of benefits. This signature does not make this person responsible for the charges incurred as a result of the transport. If no one is present, a crew member may sign their name and credentials on the signature line. **In either case, you must document the reason the patient was unable to sign.** For departments who have data reporting software, click "signature on file".

Patient Information

Correct and complete patient information is invaluable to the billing process. The EMS crew in the field is the eyes and ears of the billing company.

Of most importance is a correct, full name is essential. Medicare policies and procedures match your patient to their system by the beneficiary's name on file with Medicare. If a patient who is typically known by "Bob" is actually on file with Medicare as "Robert", Medicare may not recognize the patient as a subscriber. A social security and date of birth allows us to locate your patient much more effectively using our electronic insurance queries as well as matching patients to their insurance policies. The patient's correct address and nine-digit telephone number allows us to communicate in writing with that patient. One suggestion is to ask for the patient's driver's license and copy the patient's information directly from the license. Make sure to verify that the information on the license is current.

A full and complete list of procedures, list of medications given and narrative is a must for billing as well as legal purposes. Always remember that if you didn't write it down, you never did it! To assist providers in writing narratives, MBI Solutions has revised the "DocuAid" originally published by Premier Health Care Services. The pocket sized "DocuAid" was developed using the Modified Chart System of documentation. To use the "DocuAid" the provider can quickly refer to a page devoted completely to a particular chief complaint and flow through a series of questions. If the provider can answer all the questions with the narrative then a complete narrative has been written.

For information on patient signatures, you may refer to Medicare Benefit Policy Manual Chapter 10 Section 20.1.2. For any questions about documentation, the "DocuAid", or to schedule an information gathering and documentation training session, contact Andy Cook at 937-619-3003 or 800-875-0136 extension 3003.

The Changing Face of Medicaid in the State of Ohio

The face of Medicare in the State of Ohio will be changing of the next few months. By law the State of Ohio will stop processing transactions and transferring Medicare eligible recipients to one of nine approved Health Management Organizations. This change over is to be completed during the 2007 calendar year.

Each county in the state will chose up-to three of the nine HMO for recipients to enroll by their choosing. If a recipient does not voice a choice the county will place the recipient in the HMO of their own choosing. Most HMO programs are located regionally across the State of Ohio. Plans include Amerigroup (SW, W Central), Buckeye Community (NW, E Central), Care Source (Everywhere except NW), Molina Healthcare (Central, SE, SW, W Central), Paramount (NW), QualChoice (NE), Unison (E Central, NE, Central, SE), and WellPoint (NE, N Central, NW).

Currently every one participates as an enrolled provider with Ohio Medicaid. There are advantages of participating and even not participating with your local Medicaid HMO. Participating as a provider will allow MBI to access eligibility and claim status information more efficiently through each respective HMO website. Not participating as a provider will allow MBI to potentially collect a slightly more revenue per claim once we receive the information required to submit the claim. MBI currently recommends participating with at least the three local HMO programs for your respective county. Over the next very short weeks, MBI will be contacting each county's Medicaid program to ascertain their choice of Medicaid HMO. During this fourth quarter of 2006, your department will be receiving by mail paperwork to be reviewed, signed, and returned to MBI as quickly as possible.

For additional information on the Ohio Medicaid HMO system, contact Andy Cook at 937-619-3003 or 800-875-0136 extension 3003.

High Deductibles and Health Savings Accounts Causing a Stir in Medical Reimbursement

If you talk any individual with commercial insurance, you may have heard the same statement repeated over the past year. "My deductible has gone up or is going up next year." 2003 saw the introduction of Health Savings Accounts (HSA). Employees may elect to carry only catastrophic coverage and contribute to an HSA. By the end of 2003 only 438,000 individuals were covered by an HSA according to the American Health Insurance Providers (AHIP). By the end of 2005 that number rose to 3.2 million individuals and is expected to rise to 40-45 million individuals. Contributions to an HSA range from \$1,050 for single coverage to \$6,000 for family coverage. Kiplinger's *Your Money* newsletter's October issue says "In 2004, fewer than 10% of midsize and larger firms offered a high-deductible option...In 2007, more than 60% will."

What do high deductibles translate to your revenue? In short your department could see a possible reduction in revenue, especially during the first and half of the insurance policy year. Most plans do begin in January, but there are plan years form July to June.

Combating the EMS Billing issues related to these high deductible plans is not going to be easy. Utilizing policies with in the Department of Health and Human Services Office of the Inspector General, most departments have sought billing policies that preclude their residents from any type of revenue collection. The only notice these residents receive may be a request for information fro MBI or an Explanation of Benefits (EOB) from their insurance carrier.

For questions regarding High Deductible Plans or Health Savings Accounts, contact Tom Steuer at 937-619-3027 or 800-875-0136 extension 3027.

It's Just the Flu...or Maybe NOT!

Recognizing alcohol and narcotic withdrawal syndromes

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A 53 year old male who is a well-known alcoholic was found unresponsive by his family. He was covered in emesis and incontinent of urine and stool. EMS noted a GCS of 10. Family reported that he had been “trying to stop drinking” and has had no alcohol for about 72 hours. There is an odor of ketones on his breath, but no ethanol can be detected.

A 26 year old female presents with nausea, vomiting, and diarrhea for 24 hours. She has a history of chronic back pain and is on a Fentanyl patch. She also takes Vicodin “whenever I can get hold of it”, but has had none in three days. She lost her job last week and ran out of medication, including Fentanyl, three days ago. This is her second transport to the emergency department in 24 hours. Yesterday she received an injection of Toradol (Ketorolac) for pain and a prescription for Phenergan tablets.

Not all vomiting associated with substance abuse relates to excess. In fact, in the cases above both patients had toxicology screens which were negative for alcohol, narcotics, and other substances of abuse. The metabolic consequences of withdrawal can be severe, even life threatening, and treatment requires aggressive intervention that goes beyond re-hydration.

Early symptoms of narcotic withdrawal include yawning, excessive tearing, runny nose, sweating, and restless sleep. This progresses over 12 to 24 hours to nausea, muscle twitching, and abdominal cramps. After about 36 hours patients become restless, anorexic and begin having profuse vomiting and diarrhea. Fever and hypertension may occur. The exact timing of symptoms depends on the opiate. Although narcotic abstinence symptoms are unpleasant, narcotic withdrawal is rarely life-threatening.

The alcohol withdrawal syndrome develops 6 to 24 hours after last ethanol intake and lasts 2 to 7 days. Mild symptoms include insomnia and irritability, to fever, vomiting and diarrhea, disorientation, seizures, and hallucination. Signs include tremor, tachycardia, hypoglycemia, hypertension, reduced seizure threshold, visual and auditory hallucinations, and finally delirium. Delirium tremens usually appears the third post-abstinence day and is characterized by severe tremors, confusions, fever, and hallucinations. Hepatic encephalopathy may be irreversible. Mortality associated with DTs is about 15 to 20%. Remember that chronic alcoholics are also at increased risk of occult trauma and bleeding, such as subarachnoid bleeds.

Initial management of both types of withdrawal patients begins with assessment of the ABC's. A good history may or may not include a known period of abstinence. A carefully performed neurological exam is essential. Anti-nausea medicines are helpful along with IV fluids to treat and prevent dehydration and correct metabolic abnormalities. It is tempting to give IV narcotics to opiate addicts to rescue them from withdrawal syndrome, but long term this does little to help them with their addiction recovery. Be alert for occult trauma, especially in alcoholic patients who are at increased risk for bleeding. Check for hypoglycemia, especially in patients who have experienced seizures.

We have been trained to recognize acute intoxication, and we often know well the patient who is addicted, but we are less attuned to recognized withdrawal syndromes. When you are tempted to treat nausea, vomiting, and diarrhea as "just the flu" think about the possibility of withdrawal syndromes. Early recognition, evaluation, and stabilization result in improved long term outcome for the patients.

For more information on this or other clinical topics or EMS Education opportunities, call Wanda Blackford at 937- 312-3640. Premier Health Care Services is a Dayton, Ohio based emergency department physician group staffing forty hospital emergency departments in seven states.