



AMBULANCE SERVICE Journal

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OIG Proposes New Regulation Limiting Excessive Charges to Medicare

By: Darrel J. Grinstead, Esq., Hogan & Hartson L.L.P.

For more than two decades a federal statute has given the Secretary of HHS the authority to sanction suppliers and providers that submit excessive charges to federal health care programs. A supplier or provider who submits a claim to Medicare or a State health care program containing charges for services that are substantially in excess of its usual charges may be excluded from participation in those programs, unless the Secretary finds that there is good cause for the excessive charges.

The Office of the Inspector General (“OIG”) (who has been delegated this authority) has tried twice before to define the terms of this prohibition through regulations, but on both occasions the OIG withdrew the proposal before the regulation became final. Because of the absence of such implementing regulations, the OIG has not been able to enforce this prohibition. Nevertheless, the statute is on the books and it has caused ambulance and other suppliers considerable confusion and doubt about the extent to which they may discount their charges to other payers below the Medicare allowed amount.

On September 15, 2003, the OIG issued a new proposed rule attempting for the third time to define the terms “substantially in excess” and “usual charges” as part of its effort to enforce this provision. The American Ambulance Association and many other

provider groups have sent comments to the Office of Inspector General on the proposed regulation. Unlike most provider groups, the AAA’s comments were partially supportive of the proposed regulation, but contained a number of suggestions for major revisions that would make the regulation clearer and more enforceable. Many other provider groups have objected to the entire regulation, arguing that it would be cumbersome and difficult to administer and would cause substantial disruptions and confusion in the health care industry. The OIG is now considering all comments to the proposed regulation, and, if it decides to move forward, would probably publish a final regulation in the first half of 2004.

In its notice of proposed rulemaking, the OIG proposes to define the term “substantially in excess” as any charge or cost for an item or service submitted to Medicare or Medicaid that is more than 120% of the supplier’s usual charge or cost for that particular item or service. Under the proposed rule “usual charge” would be defined as either the average or the median of a supplier’s or provider’s charges to its customers for that item or service for the previous calendar year or preceding 12-month period. In determining its usual charges a provider would be permitted to exclude

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ODP Funding for Emergency Preparedness

By Klark Staffan, REMSA

The AAA recently provided an educational track at the July meeting in Minneapolis on ODP Funding. This presentation was extremely valuable to all AAA members as it was clarified by ODP that ambulance services are eligible to participate in ODP Grants. This article is intended to outline the key points from the ODP presentation and to highlight what AAA members can do to participate in available funding and preparedness programs at the local level.

Effective March 1st of this year, the Homeland Security Act of 2002 transferred the Office for Domestic Preparedness (ODP) to the Border and Transportation Security Directorate within the Department of Homeland Security. ODP now has the primary responsibility within the executive branch of the Federal Government to develop and administer the preparedness capabilities of the United States to reduce vulnerabilities, respond and recover from acts of terrorism.

In fulfilling the above responsibilities, ODP provides equipment grants, training, exercises, technical assistance, and other resources to State and Local emergency responders. Grant funding is passed through the State Office of Homeland Security (or other similar State Administrative Agency) and then down to the local level for distribution and use based upon approved plans. Being involved as a functional part of a Local Emergency Planning Committee (LEPC), or other well-engaged local planning organization is key for AAA members to participate in local plans and ODP funding.

The Grant planning process works like this. Each State and its local operational areas (counties) conduct hazard assessments to identify areas of need. A State Homeland Security strategy is then created to meet the identified State and Local needs. Each local operational area then submits a grant application to the State level reflecting the local

needs. This process then results in a formal grant request from each State to ODP who in turn allocates the required and approved funding to support the Statewide plans.

As funds flow back through the State level, 20% comes off the top and goes to the State to fund their plan participation. The remaining 80% then goes to the local level and is administered through a Local Emergency Planning Committee or other similar emergency management organization. Unless you are involved in planning and preparedness through your local Emergency Management organization or LEPC, you will not be included in the ODP funding.

As of the July presentation, ODP had made available over \$3.3 billion in grants for equipment acquisitions, training, exercises and planning activities Nation wide. It is now estimated that approximately \$4 billion in grants will be made available in 2004. ODP predicts it is likely that preparedness funding will continue for some time but will decrease in future years.

If your organization is currently not engaged in planning and preparedness at the local level with your Emergency Management organization, and if you currently do not have a designated seat in your local EOC, I urge you to get involved. For more information about the 2004 ODP Grant program, eligible participants and approved grant expenditures, log on to the AAA website and look for the AAA Member Advisory on Homeland Security Grant Program Guidance dated November 7. **ASJ**

Klark Staffan is Vice President of the Regional Emergency Medical Services Authority (REMSA) in Reno, Nevada and is a Certified Emergency Manager. Klark has been an EMS provider, manager and executive in the ambulance industry for over 32 years working in the public, private and Government sectors.

THE HEART OF CUSTOMER SERVICE: Adding Value to Your EMS System while Streamlining the Costs

By Chad A. Williams, EMT-P, EMS Management & Consultants, Inc.

Many EMS Systems today are comprised of either a municipal owned and operated service or several local community volunteer rescue squads or a combination of the two. Either way, many of these systems are fully or partially subsidized by tax dollars. As with all publicly funded services, a higher degree of accountability and responsibility is expected. EMS is no exception. Taxpayers not only expect, but also demand that their tax dollars be spent efficiently and effectively to receive the highest quality service at the lowest possible price. After all, shouldn't this be the primary role of any government? Too often, EMS falls short of this justifiable goal.

The main pitfall in many of our municipal EMS systems is customer service. Most patients of the pre-hospital care system are generally pleased with the level of professional medical care they receive at the time of service. However, this experience is long forgotten when the past due bills and unpaid insurance claims begin to pile up several weeks later. Poor customer service leaves a lasting impression, which is often left unchanged. Unfortunately, this is becoming a bigger and bigger problem each year.

If we continue to think of EMS customer service solely in terms of response times, quality of care and professionalism, we will fall short of the escalating standards of the mainstream healthcare delivery system. Though unintentional, this limited scope approach has undoubtedly contributed to higher costs, lower reimbursement recovery and worse, the criticism of our constituents, the tax paying patient. Just as important as the quality of care rendered is how the customer is served after the transport. Quite often, this is for an extended period of time, lasting several weeks to months or even years for a liability settlement. This "after-the-fact" patient contact time eventually exceeds the actual 10 to 15 minute ambulance ride incurred several months prior.

A major cause for the inadequacies in

EMS customer service today is the lack of a clear definition of customer service itself. Too often, our roles and responsibilities do not equate to the patients expectations. This is where the frustration begins. Most in house billing includes only limited functions such as filing the initial claim, mailing statements and posting payments. Telephone assistance is limited and consists mostly of factual accounting of dates, amounts and so forth. Customer service implies advocacy. Patients want to know you are working for them to get their claim paid. Otherwise, it becomes you, the creditor and them, the debtor. This latter relationship is a source of frustration and leads to lower overall collection of co-pays and deductibles. A patient advocacy centered customer service department should be proactive, responsive and personal. This advocacy approach will ultimately lead to quicker payments and faster claim turn around. The patient is ultimately your best resource for getting a claim paid. Working as a team will ensure better cost recovery and hence, higher customer satisfaction. So what are municipalities and volunteer squads now doing to turn this tide? Is it possible to add higher customer service value and still reduce your overall costs?

The answer to this question is yes! However, take heed before you jump on the customer service bandwagon. It's not always prudent or even appropriate to be in the customer service business. At least not for every service you offer. The Federal Government is a prime example. They outsource thousands of customer service and administrative functions each year, including the one near and dear to our industry – Medicare. Private insurance carriers, who already possessed a knack for customer service, are better equipped to handle the customer service relationship with the beneficiary. And besides, in a competitive market place, customer service is everything.

So before you complete and approve your

budget for next year, take some time to critically analyze your resources and evaluate your ability to provide the highest quality customer service for the lowest possible cost. Are you willing and able to invest in additional labor, training, quality improvement processes, new technologies and assume the liability and risk exposure to federally mandated CMS and HIPAA Compliance? If this would detract time and resources from your main responsibility, i.e. providing public Emergency Medical Services, you may be better served by outsourcing you billing and customer service functions.

The evidence for outsourcing EMS billing is compelling! Outsourcing operates under three assumptions or basic expectations:

1. **Cost Savings.** The economies of scale should certainly be considered. Depending on the size and volume of your agency, the true cost to provide billing and customer service functions may be higher than you think. Here are some questions to ask your department: Are you understaffed due to budget constraints? Are your accounts receivables backing up as a result? Do employee vacations and sick time set your work flow back a few days? Outsourcing may not only save your department money but also provide the required staffing to ensure your billing is current.
2. **Risk Reduction.** Many times the EMS billing office consists of no more than three billing specialists that handle the entire processes of billing: data entry, coding, posting payments, reconciling, refunding, processing attorney requests, managing copies of documents and payment, refilling denials and keeping up with the daily telephone inquires. If one employee should turn in their notice or take time off for a major illness or disability, you'd immediately lose a significant portion of your work force. (Could you

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Insurance Update – Will Premium Increases Ever End?

By: Ron Thackery, AMR

More than two years have passed since the tragedy of September 11, 2001.

Nonetheless, the market for liability insurance in EMS still remains tight. While there have been some reductions in property insurance pricing in the last six months, EMS providers will likely continue to experience renewals in the same cost range as last year. With economic forecasters predicting lower unemployment, investment markets experiencing growth and business outlooks improving, EMS providers might expect premiums to be reduced soon. However, insurance carriers are still trying to make up for losses over the past few years. In addition to the terrorist attacks, several other factors are cited by insurance carriers for the hard market.

The Soft Market

The prolonged soft market preceding the terrorist attacks was reflected by the immense capacity of available insurance to EMS providers. The ability to choose among carriers resulted in a variety of unique program features designed to generate business. Many of these were driven by underwriters that expected funding shortfalls to be recouped in the investment market. Consequently, EMS providers could pay discounted premiums to obtain coverage for anticipated losses and fixed costs. The deficiency in premium was to be earned

through the investment of premium by the carrier.

With the collapse of the investment markets, the ability to earn returns on premiums was severely diminished. At the same time, carriers balance sheets were beginning to reflect the problems associated with business booked during the soft market stretch. The impact of September 11 resulted in a severe psychological blow to the insurance industry. The overlap of losses from workers compensation, life insurance and property were recognized clearly that day. The financial losses to insurers and reinsurers were astounding (\$_____ billion). In response, carriers became extremely conservative as they assessed accounts for renewal by closely scrutinizing employers with concentrations of greater than 100 employees in a location, risky financials and higher than normal loss experience.

Recent Insurance Developments

In the third quarter of 2003, the insurance markets have experienced a return to competitive pricing for certain lines of coverage. Commercial property coverage has flattened and even been declining in some sectors. However, market conditions have not enabled carriers to fully recover so that a rapid decline in insurance costs or a return to the soft market conditions does not appear likely in the near future. Several key

insurance experts doubt we'll see premiums as low as those from the soft market days. Among factors that may prevent declines in the liability markets are the continuing weak economy, low yields on investments and the need for carriers to build reserves as they strengthen their financial condition.

The Council of Insurance Agents and Brokers recently released results from its Commercial Property-Casualty Market Survey. The results analyzed survey responses from 132 agents and brokers throughout the United States that handle small, medium and large accounts. The survey found a marked easing of prices for all sizes of accounts across the country. Approximately 33% of the small and large accounts, and 27% of medium sized accounts, experienced no change in premiums or a drop of up to 10% for renewals and new business. The results also indicated that more than 40% of all types of accounts experienced premium increases between 1 and 10%. Interestingly, 12% of small accounts, 20% of medium accounts and 17% of large accounts still experienced premium increases of 10 – 20% over prior renewals. Fortunately, only a handful of brokers reported premium increases exceeding 20% in the survey.

These results must be carefully analyzed as most respondents indicated premium reductions in property coverage renewals or place-

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Renewal Premium decreases/increases for accounts between July 1, 2003 and September 30, 2003

	Down 20 - 30%	Down 10 - 20%	Down 1 - 10%	No Change	Up 1 - 10%	Up 10 - 20%	Up 20 - 30%	Up 30 - 50%	Up 50 - 100%	Up 100%	N/A
Small Accounts*	1%	3%	5%	25%	44%	12%	4%	0%	0%	0%	5%
Medium Accounts**	0%	1%	9%	18%	48%	20%	2%	0%	0%	0%	2%
Large Accounts***	0%	3%	15%	16%	41%	17%	1%	0%	0%	0%	7%

* Small Accounts generate less than \$25,000 in commissions and fees for agents/brokers

** Medium Accounts generate between \$25,000 - \$100,00 in commissions and fees for agents/brokers

** Large Accounts generate more than \$100,000 in commissions and fees for agents/brokers

Source: Council of Insurance Agents and Brokers. Commercial Property-Casualty Market Survey Third Quarter 2003 Released: October 2003

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charges for services provided to uninsured patients free of charge or at a substantially reduced rate; charges based upon capitated payments or rates offered under risk sharing arrangements; and fees set by Medicare, state health care programs and other federal health care programs (other than TriCare and other federal and state managed care programs whose charges are based on negotiated rates.)

In its comments to the Inspector General on this proposed regulation, the AAA took the position that the standards proposed in these definitions are inadequate to accomplish the statutory restriction. AAA maintained that, other than in the exceptional circumstances and the exclusions provided in the regulations, there is no reason why Medicare or a state health care program should pay more for an item or service than the lowest price at which that item or service is provided to a supplier's other customers. The AAA also pointed out that the averaging or median method for calculating usual charges set forth in the proposed regulation would require a huge and burdensome record keeping effort and would present many opportunities for "creative" pricing and accounting practices. The AAA therefore took the position that a provider's usual charges should not be determined on the basis of its average or median charge; rather any price given to a non-excluded payer should be considered the supplier's usual charge and hence the maximum amount that it would be permitted to charge Medicare and Medicaid. The Association emphasized the need to establish a level playing field in order to permit all ambulance suppliers to compete equitably. If subsidized ambulance suppliers choose to provide their service at a lower rate to the community at large, the Association believes the supplier should make the same price available to Medicare and Medicaid.

The Association made a number of other comments intended to clarify and improve the proposed regulation. With respect to the exclusions that should be permitted from the calculation of "usual charge", the AAA noted that all Department of Defense and Department of Veterans Affairs programs,

including TriCare, should be excluded because suppliers have little or no ability to control the prices paid by those programs through negotiations or otherwise. The AAA also pointed out the need for a separate usual charge determination to be made for distinct geographic areas, because different regulatory or competitive circumstances may affect the prices that are charged within a supplier's operating area. The Association also observed that the Medicare ambulance fee is composed of two components, a base rate and a mileage rate. We urged that these two components should be combined for the purpose of determining a supplier's usual charge for the entire service. Finally, the AAA objected to the provision in the proposed regulation that would preclude administrative and judicial review of whether a supplier is entitled to rely on the good clause exception contained in the statute. The Association maintained that this issue should be subject to judicial review along with any other issues that may be raised by a supplier in defense of an action brought by the Inspector General under this provision.

Other provider groups took a more critical stance in opposition to the proposed regulation. In particular the hospital industry has criticized the proposed regulation as cumbersome, burdensome, and impossible to administer, and have asked the OIG to withdraw the proposed regulation. The hospitals point out that their bills may be composed of hundreds of charges, but their Medicare payment is based upon a prospective payment system which provides a single payment amount for each admission. They have argued that the relationship between the Medicare payment and a hospital's charges is a complex financial calculation which is not accounted for in the proposed regulation, nor could it be accounted for given the wide variation among hospitals in their charge practices. The hospitals interpreted the regulation as being the Inspector General's attempt to control hospital charges, which recently have been a matter of investigation by the OIG.

Given the serious criticism of the proposed regulation from many provider groups, it remains to be seen whether and how soon the proposed regulation will be made final. We will keep you apprised of important developments in this area. **ASJ**

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ments. Premiums for business interruption, general liability, surety bonds, workers compensation and umbrella coverage did not soften as consistently as property. For certain lines, errors and omissions, directors and officers and medical malpractice, renewal premiums were still up sharply.

It is also worth noting that as renewal premiums may flatten and become more palatable to buyers, underwriters are scaling back coverage through tighter terms and conditions when writing renewals.

What should you do?

In light of these developments, many EMS providers will continue to experience challenging insurance renewals. The following tips are provided to make that process go smoothly.

1. Keep up to date on the financial condition of carriers and understand the capacity they offer in the insurance lines offered to your company.
2. Work closely with your broker to position your company as a desirable institution for a carrier to insure.
3. Invest in safety in your organization. The easiest loss to afford is the one that doesn't occur. Maintain a good history of loss experience.
4. Provide detailed information on your company, its mission and values, its management team and financial history.
5. Recognize that carriers continue to push for premium increases in certain lines. Review your company's appetite for sharing in the risk of losses. A shared commitment for risk of loss between the company and carrier represents a level of commitment to control losses. **ASJ**

Top Ten Reasons Why Your Ambulance Service Should Have a Personnel Handbook

By Steve Wirth, Esq. and Doug Wolfberg, Esq.

We often get questions about the “pros and cons” of having a personnel handbook for employees who staff EMS organizations, as well as the legal implications of having or not having one. There are some concerns that a handbook could inadvertently create a contract of employment, guaranteeing rights you don’t necessarily want to guarantee. However, these concerns can be addressed with appropriate disclaimers and a legal review of the handbook before implementation.

A proper, up-to-date personnel handbook is an essential element of a good, solid staff communications program. Here are the top ten reasons to have a personnel handbook for your ambulance service:

Reason #10: Communicates the company philosophy

A handbook lets the staff know your company’s philosophy and general management approach. It serves to open communications and provides a “feel good” approach about the organization. At the same time, it sets the tone for the behavior you expect from all personnel in patient care and in interactions with others—a very important aspect of legal compliance activities.

Reason #9: Sets the basic ground rules for behavior

A handbook lets employees know the ground rules and policies they’re expected to follow. It’s critical that staff know what’s expected of them and that they’re informed of these expectations and standards of behavior in advance. “Due process” is absolutely essential in all decisions involving staff, as staff should be made aware of the standard or policy, then given an opportunity to be heard and to correct behavior when it violates those standards. Handbooks help put these rules in the forefront to help make staff aware of the rules and the disciplinary steps that might be involved. This type of up

front notice is the first step in any good staff relations program.

Reason #8: Establishes a guide for supervisors

It’s critical that all supervisors be on the “same page” in understanding your organization’s philosophy and rules. That’s especially hard in the ambulance industry with supervisors who work odd shifts 24/7 and who often don’t have the advantage of walking down the hall and talking to another manager. A handbook helps establish consistency in management conduct and helps avoid inconsistencies in managers’ approach that can occur from shift to shift.

Reason #7: Helps refute claims that employment is other than “at will”

A carefully written handbook can actually help dispel claims that there is a contract for a specific term of employment (which can form the basis of a lawsuit) or that employees can be disciplined for only a particular list of reasons. In many states, an employer can inadvertently create employee rights that it does not want to create, based on statements made in a handbook. The key is to make sure that key areas, especially the rules of conduct, are written with flexibility in mind. Your handbook should be described as a guide book that’s subject to change and not all inclusive of your service’s policies and procedures. Of course, if you have a labor union in place, the “at-will” employment principle won’t apply to the bargaining unit employees. In that case, the collective bargaining agreement will likely govern discipline and termination of employees.

Reason #6: Helps emphasize intolerance for unlawful conduct and reduce potential liability

Certain handbook statements can be used to clarify that such things as discriminatory conduct or sexual harassment will not be

tolerated, and to provide an explanation of procedures for reporting alleged unlawful conduct. *Example:* The U.S. Supreme Court recently emphasized the critical importance of communicating and enforcing policies on sexual harassment and conducting a prompt and objective workplace investigation.

Reason #5: Helps reduce risk in government investigations

Handbooks are of significant interest to government investigators researching claims of discrimination, wage/hour violations and the like. It’s often the first place they look to determine the company’s policies. Handbooks can also be an excellent source of evidence in your favor during a government investigation, and shows the investigator you have your act together.

Reason #4: Helps minimize the risk of employee lawsuits

Handbook statements can reduce the risk of lawsuits from wrongful discharge, invasion of privacy and other claims. Handbooks can also increase a feeling of fairness in employee decisions, since procedures can be outlined that establish the rights of both the service and the staff member when it comes to terminations or expulsions. Lawsuits often arise when people feel mistreated or they were not made aware of what the service expects of them and the consequences for not meeting those expectations. Handbooks help make this clear and help staff “accept” adverse decisions when they must be made by the service.

Reason #3: Handbooks can aid in communicating important benefits information

Handbooks can be an adjunct to official plan documents and booklets to summarize the benefits of employment. At the same time, proper disclaimers place employees on

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Conducting The EMS Workplace Investigation: 10 Steps For An Effective Result

by Steve Wirth, Esq. and Doug Wolfberg, Esq.

The increasing volume of employment-related litigation in the ambulance industry has focused on the *response* of the organization to a complaint about unlawful activity, like sexual harassment or age, race, or sex discrimination. (Here courts really do measure “response time!”) A delayed or unfinished investigation and failure to identify and stop unlawful staff member conduct can end with liability to the organization.

Many ambulance organizations are also not well equipped to deal with personnel issues. They may lack the management expertise or fundamental understanding of the laws, since they don’t have the human resources support capability that more traditional health care organizations may have.

How do you prevent employment litigation? Taking fair and proper action in all

remember when conducting a workplace investigation that can help your organization minimize the risk of a lawsuit:

What Prompts an Investigation In The First Place?

It may be a formal complaint in writing from a staff member, or it may be a union grievance if your EMS staff is part of a collective bargaining agreement. Many times it may not be a complaint in writing but simply someone who says, “this isn’t a complaint, BUT I have a concern I want to tell you about...” All of these deserve attention and may require an investigation.

Mistakenly, some EMS managers have taken the position that “it’s not a complaint unless it’s in writing!” Let’s debunk that statement right now. The requirement that a

ed by the EMS organization. Administrative agencies that investigate discrimination, like the Equal Employment Opportunity Commission or state human relations commissions will serve you with a formal “complaint” that will require you to provide an answer to the allegations. This requires that you conduct a good faith investigation of the allegations to determine the truth or falsity of them. Many other laws require that the organization investigate staff member complaints and treat them seriously.

Action Steps to Follow in Any Workplace Investigation

1. Determine the goals of the investigation

Decide what you plan to accomplish—is this an investigation to determine what caused the unexplained loss of supplies or is it an investigation of individual misconduct. The approach may be different and your bottom line goals may vary. If the investigation is to determine the cause of a sudden loss of supplies, then the goal may be to stop the loss and catch the perpetrator. If the investigation is for suspected individual misconduct, then the goal will be to determine if misconduct actually occurred and to make a determination of the extent of disciplinary action that may be imposed.

2. Select the appropriate investigator

The person who conducts the investigation and interviews can make or break the entire process. The person who conducts the investigation must have good people skills and be able to relate well to the witnesses. This person must have the respect of the staff. Thoroughness and good note taking ability are also important skills.

Sometimes the investigation should be

The person who conducts the investigation must have good people skills and be able to relate well to the witnesses.

employment decisions is the key to avoid potential litigation is the first step. Preventive action like policies and procedures on proper staff member conduct, posting the required legal notices on the employee bulletin board, an up to date employee handbook, and training managers and staff members on proper behavior are important steps to keep out of trouble.

But when you do get a complaint about a personnel issue, regardless of where it comes from, it is absolutely imperative that the organization respond promptly and properly, treating every complaint as a possible lawsuit in the works. Even if the complaint does not evolve into litigation (and most don’t) failure to give a workplace complaint proper attention can bring down morale, lower job satisfaction, and eat away at management’s credibility.

Here are some important considerations to

complaint be in writing may actually stifle people from bringing important issues to management’s attention. In some cases, the issues and facts may be so sensitive that the person is afraid to put it in writing. That’s why verbal and written complaints need to be treated the same way when it comes to deciding whether to investigate a complaint.

Other unreported activity unrelated to a complaint against an individual may prompt an investigation. Examples include such as an unexplained change in the conduct of a group of staff members, an unusual loss of supply inventory or a theft of equipment, which may lead to a suspicion of misconduct by a staff member.

When Is a Workplace Investigation Required?

Some laws and regulations put a lot of weight on whether a proper investigation was initiat-

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conducted by the supervisor or line officer who oversees the staff member involved, but that person may be too close to the situation. In services that have a human resources department, this expertise may be helpful and the investigator may be trained in interview techniques. In a more serious situation, it may be helpful to have your attorney conduct that investigation in order to help maximize the “attorney/client privilege” which holds as confidential (and therefore not discoverable in litigation) communications between a client and his attorney.

The attorney’s “work product” such as interview notes and impressions are also protected under this privilege. Otherwise, reports and written documents created in the course of an investigation may be discoverable in litigation. Always consult with legal counsel first before conducting a workplace investigation of an incident that could result in litigation against the company.

3. Identify the potential witnesses

Make a list of the potential witnesses, and the information you would like to seek from them. Usually the person who makes the complaint will be a key source in identifying witnesses. Other staff members not involved in the situation may have information, especially if the incident involves conduct that could have potentially been observed by persons other than the person making the complaint.

Don’t forget to consider outside third parties who may have witnessed something (like the soft drink delivery person), and of course, don’t forget to interview the alleged perpetrator! You may wish to save this interview for last, after you have gained as much information as you can from other potential witnesses and have a framework in your mind as to what may have occurred.

4. Identify documents to be reviewed

There may be laws and regulations that apply to the situation, such as federal or state laws that prohibit discrimination.

You need to become acclimated to these laws so you understand the types of questions you need to ask in the investigation. Don’t forget company policies and procedures, as well as local or regional protocols that might be the “law” that applies to the situation. If your organization is unionized, the collective bargaining agreement must be reviewed as that is the contract that governs the terms and conditions of employment for those who are covered by it. If it’s a volunteer organization, make sure you review the bylaws and other policies and procedures that might apply to the situation.

If the investigation involves an individual staff member, a review of that person’s personnel file would be appropriate, as well as the files of employees who may also have been involved in similar incidents. Has the person been disciplined before? How have others been handled who have violated the same rules? These are important questions to be answered.

Other internal documents, such as incident reports, patient care reports, and dispatch logs may also have a bearing on the investigation. Make a list of all the documents you need as you begin to develop the file.

5. Prepare a strategy and timeline for investigation

It is essential to take steps to promptly initiate and complete the investigation. In fact, in sexual harassment litigation, the promptness with which the organization starts and completes the investigation may be a critical element in defense of the case. Establish a logical order of steps that need to be completed, and organize interviews as quickly as possible.

Be flexible and ready to go with the flow a bit, since priorities may change as you get into the investigation. As part of this step, begin to outline the areas you wish to cover with each witness, and begin to prepare a list of questions. You may have a list of standardized questions that would be asked for every situation of that type, and then specific questions that

deal with the particular situation you are investigating.

6. Establish secure files/records

Security of all complaint related documents is a must, to ensure that you maintain confidentiality as much as possible, and to prevent the investigation from becoming a discussion point in the internal rumor mill, or worse yet, outside of the organization.

Organize the documents in various sub-files, such as “interview notes,” “applicable policies and procedures,” “witness statements.” Keep all of the documents in a locked cabinet and only allow those with a bona fide “need to know” reason have access to them. Exercise care before destroying documents (and check with legal counsel) as you may have a legal obligation to preserve these records (now more than ever under the Sarbanes-Oxley Act).

7. Prepare for interviews and gather the facts

This is the meat and potatoes of any workplace investigation and must be handled with extreme care. Before the interview, have your list of interviewees updated with a list of questions you expect to ask each witness.

Consider the timing of the interviews. Think about when you might be able to get the best information possible from the interviewee. For example, it might not be a good idea to interview a paramedic at the end of busy 12 or 24 hour shift when the person is tired and wanting to go home or in direct view of coworkers.

If your organization is covered by a collective bargaining agreement, the staff member who is suspected of wrongdoing may request that he/she have a union representative present for the interview. If the interview is an “investigatory interview” where you may decide what action will be taken as a result of the interview, the right to have a representative present is guaranteed under the National Labor Relations Act. (A recent NLRB decision even extended this right to the non-

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union workplace!) But you only have to allow this if the person asks for one. You don't have a responsibility to let them know of this right, but it may be good to do so in the interest of positive staff relations. And of course, make sure you have a management witness present during the interview wherever possible, not to participate, but to take notes and validate what may or may not have been said during the interview.

In what order should you interview possible witnesses? Usually you will want to start with the "accuser" or the person with the complaint to lay the groundwork for the scope of the investigation. Then you should interview other material witnesses identified by the accuser and those you feel may have helpful information. It is often best to interview the alleged perpetrator after you have most of the facts gathered, so you can be ready with very pointed and direct questions if you have to, and you are in a better position to gauge credibility of this person in comparison to the credibility of others you interviewed.

Based on your knowledge of the individual interviewee, you may wish to prepare for particular witnesses differently. If someone is quiet and with few words in day to day life, you may need to ask questions that will draw the person out a bit more. Take advantage of unscheduled opportunities, like when you are out walking through the garage area and other work areas or the crew lounge to conduct informal "interviews" where the person is not even aware that they are being interviewed. You can usually gain lots of valuable information using this informal approach.

8. Conduct An Objective and Fair Interview

The initial disclosures you should make to the interviewee at the onset of the interview include: Who you are, the purpose and importance of interview, and a general overview of the type of questions

you will be asking. Be careful about giving an assurance that what the person says will be kept confidential, unless you are absolutely certain that it can be.

Otherwise, you may lose considerable trust with the staff if you can't follow up on your promises. It is typically better to let the person know up front that due to the nature of the investigation and the allegations involved, you will do your best to keep the information only to those who needed to have it for decision making, but that you cannot guarantee total confidentiality.

When you begin the interview, make sure you remain objective and consistent in your approach from one witness to the next. Allow the witness to relax, and loosen up a bit before you get into the questions. Make sure you are also prepared and relaxed, and focus on the goals of the interview and in listening carefully to each answer. It is always best to start with "open ended" questions to allow the person to tell the story in their own words. This also helps you develop and organize the facts in your head. Always make sure that the questions and answers cover the basics of "who, what, when, where, why, and how."

Ask for clarification when appropriate. If the interviewee says, "well, you know there is sexual harassment going on here all over the place," probe at this by asking the interviewee to clarify: "Can you give me an example of a specific incident you observed?" or "Why do you say that?" Try to avoid loaded or leading questions that presume facts that you don't know for sure. Example: "OK Will, where were you when you touched Britney on the neck?" may not be a proper question unless Will already admitted that he touched Britney on the neck!

Remember that God gave us two ears and one mouth for a reason! Focus more of your energy on listening carefully and not interrupting the person when they talk. Actually, a period of silence may be good as it will allow you to observe the person's body language and help you tell if they are uncomfortable with the question. It may also be good to ask the same question later in the interview, as you

could get two different answers, which would certainly allow you to draw some conclusions on the credibility of the witness.

Observe non-verbal behavior and eye and body movements when the person is answering the question. Document the interview by taking careful notes of what the person says in response to each question, using quotation marks to note word for word statements. Be careful to avoid mixing up facts and information from the interview with your own opinion. Your opinions and credibility determinations should be kept separate from the actual interview notes or otherwise identified as opinion.

Make sure you date your notes with the time of the interview, a list of who was present, and where it was held. Try to conduct interviews in a quiet and relaxing location where you won't be interrupted and where the interviewed will feel most at ease. You should prepare a summary of the interview and your impressions as soon as possible after the interview while it is still fresh in your mind. In some cases, you may wish to prepare a witness statement for the interviewee to review and sign, but this should only be done after review with legal counsel. The formality of a witness statement may cause the person to give guarded answers in the interview, or it may hinder the flow of informal information that you may receive outside the interview process.

9. Develop the record or report.

After you complete the fact gathering process, you may wish to prepare a written report. This is not always going to be the case, but in serious situations it may be necessary to create the proper "paper trail" if the effectiveness of the investigation were ever to be challenged. Before preparing a written report, check with legal counsel as to the format and the manner in which it should be prepared. Your legal counsel may wish to have this report prepared at his direction and sent directly to him to maximize protection

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from discovery if there is a risk of litigation. If so, the report should be stamped “Privileged and Confidential—Prepared At Direction of Legal Counsel in Anticipation of Litigation.”

The report should describe the alleged wrongdoing, summarize the law or policy at issue, provide of the evidence reviewed and compiled (the facts as you know them), summarize your findings, discuss the credibility of the witnesses and make recommendations.

10. Review the investigation results and decide on the action—if any.

This is where the “rubber meets the road.” You will need to take the results of the investigation to the person or persons who need to make a decision. You may find that no action is required, or that you found a serious deficit in your organization that will require comprehensive

retraining of everyone and not just those singled out in the investigation.

Remember that when investigating alleged improper conduct by a staff member, the goal should be to determine first, if improper conduct actually occurred, and then root it out and halt any improper conduct from occurring in the future. When you do this, you need to respect the rights and privacy of all concerned, and conduct the investigation in a professional manner in a way that keeps the dignity of all concerned intact. If you conduct an effective investigation, you will maintain the respect of your staff and be less subject to criticism that you have been heavy handed or unfair in your actions. **ASJ**

Steve Wirth and Doug Wolfberg are founding partners of Page, Wolfberg & Wirth, LLC, a national law firm representing the EMS and medical transportation industry. They are also principals in the medical transportation consulting firm of PWW Consulting, Inc. Doug and

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Visit the firm’s web site at www.pwwemslaw.com for information on the new Spring 2004 EMS Law Audioconference Series and the new must have manual for EMS, “Better Billing: The Ambulance Service Model Compliance Plan.” You can register on-line for the audioconferences and purchase the PWW compliance products through the web site.

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Personnel Handbook

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notice that benefits are subject to change, and can help avoid lawsuits over benefits claims.

Reason #2: Gives you a leg up with an adverse party

It is far better for your service to describe its rules and policies in writing in a personnel handbook than to have an adverse party describe your policies for the first time in litigation in the language that suits them. This also helps avoid conflicting testimony from supervisors who may be witnesses.

Reason #1: There is no practical or legal reason not to have one!

There is minimal legal risk to providing a personnel handbook, as long as it’s reviewed carefully to ensure that the statements are not contractual or discriminatory in nature, or contrary to law. Policy statements in

employee handbooks are generally not considered contractual unless the employer intended it to be a contract and offered it as a binding term of employment. In other words, the employee usually must prove that the employer intended to overcome the at-will employment relationship. With proper disclaimers and the avoidance of language that could be interpreted as modifying the at-will employment relationship, handbooks are effective communication tools that can reduce your service’s liability of a wrongful discharge or other legal claims. **ASJ**

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Calling for 2-1-1

By: Kelly Levy, United Way of America

What is 2-1-1?

2-1-1 is an easy to remember telephone number that, where available, connects people with important health and community services and volunteer opportunities, and is being spearheaded by United Ways and comprehensive and specialized Information and Referral Agencies in states and local communities. United Way of America (UWA) and the Alliance of Information and Referral Systems (AIRS) strongly support federal funding so that every American has access to this essential service.

Every hour of every day, someone in the United States needs essential services – from obtaining medical services to securing adequate care for a child or an aging parent. Faced with a dramatic increase in the number of agencies and help-lines, people often do not know where to turn. In many cases, people end up going without these necessary services because they do not know where to start. 2-1-1 helps people find and give help.

Who Benefits from 2-1-1?

While services that are offered through 2-1-1 vary from community to community, 2-1-1 provides callers with information about and referrals to health and human services for every day needs and in times of crisis. For example, 2-1-1 can offer access to the following types of services:

- Basic human needs resources: food banks, clothing closets, shelters, rent assistance, and utility assistance.
- Physical and mental health resources: health insurance programs, Medicaid and Medicare, maternal health, Children's Health Insurance Program, medical information lines, crisis intervention services, support groups, counseling, and drug or alcohol intervention and rehabilitation.
- Support for children, youth, and families: child care, after school programs, Head Start, family resource centers, summer

camp and recreation programs, mentoring, tutoring, and protective services.

- Employment supports: financial assistance, job training, transportation assistance, and education programs.
- Assistance for older Americans and persons with disabilities.
- Volunteer opportunities and donations.

How Will a National 2-1-1 System Impact Society?

2-1-1 will make some dramatic and much needed changes, including:

- Providing the infrastructure to connect individuals with precise information and social services that address their individual needs.
- Employing personal interaction to analyze callers' needs and impact their lives.
- Empowering the nation to better respond to large-scale emergencies and homeland security needs.
- Providing relied-upon aggregated data from 2-1-1 Systems nationwide to better assess the needs of our communities.

What is the Current Status of 2-1-1?

In 2000, UWA, with its partners on the National 2-1-1 Collaborative, successfully led the effort to get the Federal Communications Commission to assign 2-1-1 for health and human services information and referral. Today, 2-1-1 reaches approximately 65 million Americans – about 23 percent of the U.S. population. The goal of UWA is to ensure that 50 percent of the U.S. population has access to quality community information and referral services



through 2-1-1 by 2005, and 100 percent soon thereafter.

A nationwide 2-1-1 system will not happen without the partnership of the federal government. The Calling for 2-1-1 Act of 2003 (S 1630 and HR 3111), introduced by Senators Elizabeth Dole (R-NC) and Hillary Rodham Clinton (D-NY) and Representatives Richard Burr (R-NC-5) and Anna Eshoo (D-CA-14) with broad bi-partisan support, would authorize \$200 million annually to assist states with implementing and sustaining 2-1-1 statewide. States would have to provide a 50 percent match to the grant, which could come from current 2-1-1 funding in the community, such as United Way funding, funding through other nonprofits, state and local government, foundations, and businesses. Funding would be administered by the U.S. Department of Commerce.

For more information about 2-1-1 and local, state, and national efforts, contact:

Bridget Gavaghan, Director, Public Policy & Partners, United Way of America, 703-836-7112 x497 (local), 800-892-2757 x497, bridget.gavaghan@uwa.unitedway.org or Kelly Levy, Director 2-1-1, United Way of America, 703-836-7112 x211, 800-892-2757 x211, kelly.levy@uwa.unitedway.org.
ASJ

LifeCare Medical Transports, Inc. Continues To Exceed Industry Standards By Sticking With Basic Core Values

By: Sara Lindley, LifeCare Medical Transports, Inc.

LifeCare Medical Transports, Inc. began operations in 1994 in Fredericksburg, Virginia (USA) and has grown from a local service to one of Virginia's largest health care transportation providers. We contribute our growth to maintaining our core values: Quality patient care, positive and active involvement in the communities we service, customer services, and quality assurance (QA).

Corporate Offices and a Centralized Communications Center are maintained in Fredericksburg where dispatch, billing services and administrative functions are completed. Licensed at the highest level of service recognized by the Commonwealth of Virginia - Office of Emergency Medical Services, LifeCare functions at the Advanced Life Support (ALS) level to ensure a broad and complete range of services to our customers.

LifeCare provides essential emergency, non-emergency, Basic Life Support (BLS), Advanced Life Support (ALS), Specialty Care Transport (SCT), Wheelchair Van and other varied services throughout the Commonwealth of Virginia. LifeCare employs over 250 employees with both health care and business training with locations in Northern Virginia, Charlottesville, Richmond, Northern Neck, Middle Peninsula, Newport News and Fredericksburg.

We have found at LifeCare that common

sense and a few simple things to do will save you time and make the accounting office smile. Here are just a few suggestions.

Plan Ahead. It Saves Time, Produces Efficiency and Saves Lives.

With an innovative approach to many processes, LifeCare incorporates modern technology with the day-to-day operations. Developing and implementing process improvements (PI) created by a team based environment represents our desire to not only stay on the cutting edge of patient care, but to be part of development.

An Inventory Officer with a Detailed Check Sheet is a Big Plus.

Inventory control is a vital function of an EMS system. The manner in which inventory is established, maintained and distributed is critical to the mission of all agencies. LifeCare developed and implemented an Inventory Seal System for all vehicles. The system works well with a positive comfort factor that all vehicles maintain the minimum supplies and equipment requirements.

The system is implemented in the following manner:

- A master inventory list of required supplies and equipment is developed
- A seal tracking section is located on the daily vehicle check sheet with a notation of the status of seals and the beginning and end of each shift.

- Compartment stocking, arrangements and numbering is arranged in consistent manner on each vehicle
- Specific compartments are arranged in numeric order
- Specific compartments are stocked with specific supplies
- Compartments are labeled with the compartment number, contents and required number of items
- Loop Fasteners are installed on each compartment
- Standard Blue health care seals with tracking numbers are utilized
- Vehicles are fully stocked as outlined on the master inventory lists
- Utilizing the installed loop fastener, seals are placed on each compartment
- When needed, providers break the seals and utilize the equipment and/or supply
- At the end of each shift, items used are replaced and a new seal is installed
- Seal numbers are recorded on the daily vehicle check sheet and tracked to the provider, date, time and items replaced.

These steps have succeeded in not only meeting industry standard, but also exceeding them. Proving that just a few common sense process improvements properly placed makes a world of difference to the Supply Officer, the Station Supervisor, the crew running the call and ultimately, the patients. **ASJ**

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survive a massive loss of paramedic personnel and still provide adequate service to the community?). Hiring a temp or training a new employee takes time. It takes even more time to regain your original knowledge and workflow effi-

ciency base.

You may also want to consider the potential risks and costs of trying to keep up with current billing technologies, supporting software applications, new billing processes and federal legislation. All of which are an added risk and cost to your billing office.

3. **Performance Improvement.** An expe-

rienced and reputable billing company exclusively dedicated to EMS billing with a proven track record, will undoubtedly, provide a higher level of performance when it comes to collections. However, performance comes with a price. Billing companies are contracted on a contingency fee of net collections. While it ini-

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Southwest Ambulance Named Best of the Best

Arizona-based Southwest Ambulance was named National Ambulance Provider of the Year at the AAA National Convention/ EMS Expo Opening Keynote in Las Vegas this past September. EMS Magazine's 9th Annual Gold Award named Southwest the paid and Lockridge Emergency Response of Lockridge, Iowa the volunteer service of the year.

"This award is a great honor and credit to our employees," said Southwest Ambulance Senior Vice President Roy Ryals upon learning of the award.

Nancy Perry, Publisher of EMS Magazine told the East Valley Tribune, "We look for agencies who excel in terms of education for their paramedics and EMTs, the way they're involved in the community and just the way they deliver care. Southwest Ambulance was an easy choice to make. They really did stand out from the crowd because they're a private business and they've gone above and beyond the call of duty. They're really done some innovative things over there."

Some of the Southwest Ambulance innovations include:

- Became the first private provider in the Country to offer its field employees a 20-year pension similar to what municipal EMS workers receive.
- Launched three Bariatric Care Units (ambulances for the obese) that uses a ramp and winch system to help load a patient into the ambulance. To help other providers facing similar obese patient issues create their own units, Southwest created a "How To Build a Bariatric Unit" guide sharing what its Fleet mechanics learned in

creating their units (see the Southwest Ambulance website or the December issue of JEMS Magazine).

- Created Kidzulance Ambulances, units for children complete with toys, stuffed animals and video games to make the ride less scary for kids. To launch their third unit, Southwest held an art contest with students of the Thomas J. Pappas School for the Homeless with the winners' art appearing on the outside of the ambulance.
- A Paramedic Academy where Southwest trains its EMTs in-house at no cost to them to become Paramedics in a 3-month intensive course while receiving pay and benefits.
- An EMT Academy where civilians go through an in-house EMT course to become Southwest Ambulance employees.

In addition to these innovations, what sets Southwest Ambulance apart is its community involvement and their ability to follow through on customer service.

One example of their community involvement is the Pool Pack Program. A regional issue in Arizona is the number of children who drown as a result of so many backyard swimming pools. Area Fire Departments have done a fantastic job educating parents about pool fences and watching their kids around water. Unfortunately, accidents still occasionally happen. Southwest Ambulance decided to tackle the problem from another angle, by providing free swim lessons in partnership with local community aquatic centers. The idea is that as more kids learn to swim, the

number of children who drown will decrease. Last year, Southwest donated \$37,000 in free swim lessons in high-risk areas.

Ryals credits the growth of Southwest into one of the nation's largest medical transport providers is that they are easy to work with, and ensure the highest level of customer service.

For example, Southwest's customer relationship policy requires that for every inquiry a call will be returned from a Southwest Ambulance customer advocate or manager

within 10 minutes. If the issue is not resolved immediately, the facility or individual receives a visit from a manager within one hour. All of the requests are kept in a customer inquiry database to ensure the highest quality services are maintained for our clients.

Every employee, including senior management, has participated in a specially designed and internationally recognized customer service training. Ensuring that every patient, caller, fellow EMS or Health Care worker and peer receives the company's best every day.

"Our service is our product," said Ryals. "Providing adequate medical care is easy, providing a relationship takes teamwork."

With more than 1000 employees, Southwest Ambulance provides emergency and pre-scheduled transportation services to more than 20 communities in Arizona and New Mexico. In the past year Southwest Ambulance received more than 275,000 calls and conducted more than 200,000 transports.

For more visit www.swambulance.com. **ASJ**



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tially may appear to be costly, this performance driven incentive drives billing companies to achieve better results. They are further driven to reinvest their capital into better technologies that will improve their collection efforts while at the same

time, increase their efficiencies and reduce their costs. And you guessed it - the client EMS agency becomes the ultimate beneficiary in this process.

In the end, each EMS agency must continuously evaluate all components of its system to improve the quality of patient care. Unfortunately, we often overlook customer service during the time period after the

patient has been transported. However, customer service should be considered an inseparable part of the total patient care process. In addition to funding your operations, the billing and reimbursement office is a key area for PR and for patient advocacy. In short, the quality and efficiency of your customer service is the ultimate measuring stick of your organization's billing office. **ASJ**

Online CMS Manual System

By: David M. Werfel, Esq.

Effective October 1, 2003, CMS changed from paper Medicare manuals (e.g. Carriers Manual, Intermediary Manual, etc.) to a web-based system. Under the new system, CMS will no longer issue program memoranda. CMS will issue four new templates to communicate program instructions:

- manual revisions
- one-time notification
- business requirement
- confidential requirement

The new CMS Manual System will be organized by functional areas, e.g. eligibility, entitlement, claims processing, benefit policy, program integrity, etc. CMS estimates this will eliminate significant redundancy and will streamline the updating process.

This new Online CMS Manual System can be downloaded from <http://www.cms.hhs.gov/manuals>.

The CMS Manual System is divided into different publications by functional areas, as follows:

- Pub. 100—Introduction
- Pub. 100-1—Medicare General Information, Eligibility, and Entitlement
- Pub. 100-2—Medicare Benefit Policy
- Pub. 100-3—Medicare National Coverage Determinations
- Pub. 100-4—Medicare Claims Processing
- Pub. 100-5—Medicare Secondary Payer
- Pub. 100-6—Medicare Financial Management
- Pub. 100-7—Medicare State Operations
- Pub. 100-8—Medicare Program Integrity
- Pub. 100-9—Medicare Contractor Beneficiary and Provider Communications
- Pub. 100-10—Medicare Quality Improvement Organization
- Pub. 100-11—Reserved
- Pub. 100-12—State Medicaid
- Pub. 100-13—Medicaid State Children's Health Insurance Program
- Pub. 100-14—Medicare End Stage Renal Disease Network Organization
- Pub. 100-15—Medicare State Buy-In
- Pub. 100-16—Medicare Managed Care

- Pub. 100-17—Medicare Business Partners Systems Security
- Pub. 100-18—Medicare Business Partners Security Oversight
- Pub. 100-19—Demonstrations
- Pub. 100-20—One-Time Notification

Ambulance is primarily listed in Publication 100-2, the Medicare Benefit Policy Manual, Chapter 10 and in Publication 100-4, the Claims Processing Manual, Chapter 15. It is also listed 163 other times in other manuals.

It is interesting to note that several issues have been clarified in these new manuals, including:

- **Q-Codes** – Q-codes (Q3019, Q3020) may be used, during the phase-in period, when BLS is not available (Chapter 10, Benefit Policy Manual, section 10.2.2 and in Chapter 15, Claims Processing Manual, section 20.1.3).
- **Bed Confined** – Carriers may presume the medical necessity requirement is met when the beneficiary is bed confined (Benefit Policy Manual, section 10.2.3). Interestingly, they still refer to “bed confined”, as “before and after”.
- **Hospital ER to in-patient hospital, same ID#** – If the patient is being transported from a hospital ER (they have not been admitted as an in-patient) to another hospital, to be admitted as an in-patient, Part B can be billed, even if the two hospitals have the same ID number (Benefit Policy Manual, section 10.3.3)
- **Intra-Campus, Different Buildings** – Intra-hospital transports, same campus, same ID numbers should be billed to the first hospital (same section as above).
- **Medical Necessity** – The previous list of 9 conditions has been expanded to 10 conditions by adding acute respiratory distress, cardiac distress, shortness of breath or chest pain. More importantly, they have added “signs or symptoms” to the acute conditions (Benefit Policy Manual, section 20(2)(a)).
- **ALS Assessment** – Where dispatch is

inconsistent with the dispatch protocol in the state, including where no dispatch protocol was used, the patient's condition at the scene determines the appropriate level of payment (Claims Processing Manual, Chapter 15, section 10.3).

- **PEG Tubes** – Removal, replacement or insertion of PEG tubes is specifically excluded from SNF Consolidated Billing and should be billed to Part B Carriers (Claims Processing Manual, Chapter 15, section 30.2.3).

There are also numerous errors in these manuals. For example, “bed confined” is listed as being “before and after”, when CMS has agreed that it is based on the time of service (Benefit Policy Manual, Chapter 10, Sections 10.2.3 and 20). Another example is in their descriptions of the procedure codes for the base rates in the Claims Processing Manual, Chapter 15, section 30. For A0426, A0427, Q3019 and Q3020 they have listed “Specialized (or not Specialized) ALS Service” when this is no longer the language used for any procedure code. There are also numerous errors in cross references that were made to the former Medicare Carriers Manual and other Manuals, dates that are incorrectly listed, items missing when procedure codes and modifiers are listed, etc.

The AAA is compiling a list of these errors to bring to the attention of CMS. If you spot any errors that you feel need to be corrected, please send them to me care of the AAA at the following address: [JULIE – TRISTAN WILL FILL THIS IN] ASJ

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2004 AAA Calendar of Events

Mark your calendars for next year's events!

January 28-31, 2004

Winter Healthcare
Reimbursement and Professional
Education Conference
Miami Beach, FL
Windham Miami Beach

May 2-5, 2004

Stars of Life Celebration
Washington, DC
Omni Shoreham Hotel

July 22-25, 2004

Summer Healthcare
Reimbursement and Professional
Education Conference
Boston, MA- Copley Marriott

Location and Dates TBD

Annual Convention and
Tradeshow

Visit www.the-aaa.org for more information.



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