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The Treatment in Place Waiver:

What Ground Ambulance Services Must Know

Page Wolfberg & Wirth
The National EMS Industry Law Firm℠

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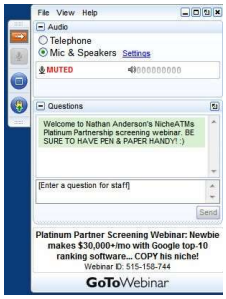

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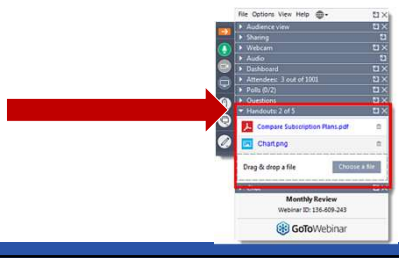

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Not so much a webinar, but more a cautionary tale

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Overview

- History
- The Waiver
- BEWARE
- Scenarios
- Billing
- The Future

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History

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American Rescue Plan Act

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American Rescue Plan Act

- Section 9832 gives the Secretary the authority to waive any requirement under Section 1861(s)(7) or Section 1834(l) of the SSA that an ambulance service include the transport of an individual, to the extent necessary to allow Medicare payment for ground ambulance services during the COVID-19 public health emergency (PHE)

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Two Conditions MUST Be True

1) The ground ambulance service was furnished in response to a 911 call (or the equivalent in areas without a 911 call system)

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Two Conditions MUST Be True

2) The patient would have been transported to a destination permitted under Medicare regulations, but such transport didn't occur as a result of **community-wide emergency medical service (EMS) protocols due to the COVID-19 PHE.**

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911 Call Or The Equivalent

- "The phrase "911 call or the equivalent" is intended to establish the standard that the nature of the call at the time of dispatch is the determining factor. Regardless of the medium by which the call is made"

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911 Call Or The Equivalent

- "An emergency call need not come through 911 even in areas where a 911 call system exists. However, the determination to respond emergently with a BLS or ALS ambulance must be in accord with the local 911 or equivalent service dispatch protocol."

Medicare Benefit Policy Manual, Chapter 10 §30.1.1

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Remember: This Is NOT ET3

- The ET3 demonstration model that began January 1, 2021 has different requirements for treatment in place, and is only applicable to accepted participants
- This waiver would apply to all ambulance providers and suppliers who meet all conditions of the waiver

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Quick Reminder: "CR" Modifier

- "CR" is not used simply to indicate that a transport was COVID-related
- Only applies when coverage is conditioned on a waiver
- ***Prior to this TIP waiver***, use of the COVID-19 staffing waiver was the ***only*** appropriate use for "CR" on an ambulance claim during the PHE

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Quick Reminder: "CR" Modifier

- Because Treatment in Place (TIP), when unrelated to ET3, is only a Medicare covered service if ***all*** of the requirements of this waiver are met, claims submitted for payment under the terms of that very limited coverage ***must*** include the "CR" second modifier

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The TIP Waiver

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TIP Reimbursement

- What it is…

A very specific program that must meet nuanced requirements for payment to occur (i.e., it does NOT apply to all treat-no-transport or "treatment in place" services rendered during the PHE)

- What it is NOT...

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How It Works

- MUST have
  - Community Based EMS Protocol, specific to the COVID-19 PHE (retained in files if needed to prove eligibility under the waiver)
  - 911 (or equivalent) call
  - Medical necessity for transport (had transport occurred)

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What Would the Protocol Look Like?

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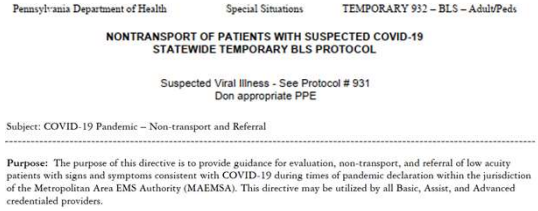
Examples



Pennsylvania Department of Health Special Situations TEMPORARY 932 – BLS – Adult/Peds

NONTRANSPORT OF PATIENTS WITH SUSPECTED COVID-19
STATEWIDE TEMPORARY BLS PROTOCOL

Suspected Viral Illness - See Protocol # 931
Don appropriate PPE

Subject: COVID-19 Pandemic – Non-transport and Referral

Purpose: The purpose of this directive is to provide guidance for evaluation, non-transport, and referral of low acuity patients with signs and symptoms consistent with COVID-19 during times of pandemic declaration within the jurisdiction of the Metropolitan Area EMS Authority (MAEMSA). This directive may be utilized by all Basic, Assist, and Advanced credentialed providers.

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"Verbal" Protocols

- Example: "From a hospital in a remote area"
- CMS assumes these will later be reduced to writing
- If not, MUST be "fully documented"
- MUST be community wide, specific to the PHE

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Very Limited Application

- ***All*** criteria must be met to qualify for billing under the waiver
- This does NOT open the door for all Treat-No-Transport situations
- BUT both COVID and non-COVID related patient encounters ***might*** qualify – depends on the language of your protocol

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REMEMBER

- The protocol must be specific to the COVID-19 PHE
- The protocol must exist at the time of the transport AND
- You must maintain a copy of that protocol to be able to produce in the event of an audit

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So How do we Bill?

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It's not that simple…

Remember there are very specific requirements that must be met in order to bill TIP

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Scenarios

Let's assess a few fact patterns, to show you how nuanced this really is

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Scenario #1

- COVID non-transport protocol exists on DOS
- 911 (or equivalent) call
- Patient treated - transport *is* recommended
- Patient meets medical necessity for transport
- Patient REFUSES transport AMA (or RMA)
  - Against Medical Advice (Refused Medical Assistance)

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NOT Billable under TIP

The patient *refused* on their own, AMA, where crew recommended transport occur

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The Distinction

- Under TIP, your "medical advice" is that the Pt. NOT be transported
- If the Pt. ***agrees*** with that recommendation, it is NOT "AMA" (it's what you advised)
- The patient might "refuse" transport, but they are not refusing "AMA" - they are agreeing with your recommendation

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The Distinction

- Under Scenario #1, "refusing AMA" would mean that your crew is telling the patient that this COVID TIP protocol does ***not*** apply to their situation, and they *need* to be transported, but the patient refuses to be transported anyway
- In that case, the TNT is ***not*** billable to Medicare as TIP

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Scenario #2

- COVID related Protocol exists, but language does not discuss non-transport
- 911 (or equivalent) call
- Patient treated on scene
- Crew and patient decide not to transport
- Medical necessity is met

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NOT Billable under TIP

Protocol does ***not*** adequately address non-transport

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Scenario #3

- COVID non-transport protocol exists as of DOS
- 911 (or equivalent) call
- Patient treated on scene
- Transport not warranted (under the protocol)
- Medical necessity is ***not*** met (had transport been appropriate)

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NOT Billable under TIP

Patient did ***not*** meet medical necessity requirements (had transport been warranted, but for the protocol)

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Scenario #4

- COVID non-transport protocol exists as of DOS
- 911 (or equivalent) call
- Patient DOA (obvious death) on scene and ultimately is pronounced dead after dispatch (no transport)

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NOT Billable under TIP

There is already a mechanism for Medicare reimbursement (QL modifier)

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But Now For a Twist . . .

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Scenario #5

- COVID non-transport protocol exists as of DOS
- 911 (or equivalent) call
- Patient treated on scene for witnessed cardiac arrest but is ultimately pronounced dead (no transport)
- Medical necessity for transport would have existed but for protocol and/or death

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POSSIBLY BILLABLE under TIP

Depends on protocol.

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Why Does It Matter?

- If, for example, COVID-19 specific protocol specified that with no ROSC on scene during PHE, do not transport: All criteria have been satisfied
- Assuming ALS Emergency dispatch, difference is ALS1 Emergency (A0247) reimbursement (under TIP) vs. BLS Emergency (A0429) (using QL)

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Could It Be ALS2?

- No. CMS addressed this in their COVID-19 FAQ document, updated 5/6/2021
- "CMS will not permit payment of claims that request payment at the ALS2 level of service."

https://www.cms.gov/files/document/03092020-covid-19-faqs-508.pdf

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Scenario #6

- COVID non-transport protocol implemented May 10, 2021, made retroactive to March 1, 2020
- 911 (or equivalent) call for DOS of April 5, 2020
- Patient treated on scene
- Patient and crew decide transport is not appropriate due to COVID-19
- Medical necessity met

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NOT Billable under TIP

Protocol was ***not*** in place at the time of the original transport (Protocol *cannot* be made retroactive)

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Scenario #7

- COVID non-transport protocol exists as of DOS
- 911 (or equivalent) call
- Patient treated on scene but asks to be transported anyway (despite protocol)
- Medical necessity met

50

NOT Billable under TIP

BUT, still a *covered transport* so long as all Medicare coverage criteria were met

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Scenario #8

- Alternative destination protocol exists as of DOS
- 911 (or equivalent) call
- Patient transported to physician's office instead of hospital
- Medical necessity met

52

NOT Billable under TIP

But possibly billable to Medicare as "alternative destination" expanded regulatory definition

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Scenario #9

- COVID non-transport protocol exists as of DOS
- Direct dial to ambulance service requesting *non-emergency interfacility transfer* from SNF to Hospital for evaluation of abnormal vitals
- Patient and crew decide not to transport pursuant to protocol
- Medical necessity met

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NOT Billable under TIP

No 911 call (or equivalent)

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Scenario #10

- COVID non-transport protocol exists
- 911 (or equivalent) call
- Patient treated on scene
- Patient and crew decide transport is not warranted pursuant to protocol
- Medical necessity for transport met

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BILLABLE under TIP

All criteria have been satisfied

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Billing

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When ALL Criteria are Met

- Bill A0429 or A0427 (depending on services rendered on scene); NOT A0433
- Do **not** bill A0425 (subcharges)
- Origin/destination modifiers: A valid modifier combination that would have been appropriate if you transported the patient
- Use CR second modifier

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Origin and Destination Modifiers

- Origin modifier will be "normal"
- Destination modifier will reflect the destination the Pt. ***would have been*** transported to had the COVID-19 community wide protocol not prevented this medically necessary transport
- "CR" second modifier authorizes use of destination modifier as described above for TIP

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Time Frame

- All dates of service that meet all coverage criteria from March 1, 2020 until the end of the PHE can be billed
- All claims for services from March 1, 2020 – May 5, 2021 must be submitted by May 5, 2022 (extra few months for claim submission for the older services)

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MUST Understand

TIP is now a Medicare covered service, effective March 1, 2020 through the end of the PHE

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New Benefit, So CMS Rules Apply

- Mandatory claims submission rules
- Mandatory assignment
- But all coverage criteria specific to this waiver **MUST** be met for it to be a covered service

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Mandatory Claim Submission

- **Q.** Do mandatory claims submission rules apply?
- **A.** Yes. **Unless** ambulance providers and suppliers choose to furnish treatment in place services covered under the waiver without charge (that is, neither the individual furnished such items, **nor anyone else**, has a legal obligation to pay), they must submit claims to Medicare on behalf of the beneficiary.

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Mandatory Assignment

- **Q.** Does mandatory assignment apply to services covered under the waiver?
- **A.** Yes. Ambulance providers and suppliers must accept the Medicare allowed amount as payment in full and may not bill or collect from the beneficiary any amount other than the unmet deductible and coinsurance.

https://www.cms.gov/files/document/03092020-covid-19-faqs-508.pdf

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What about the co-pay/ deductible?

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Special OIG Consideration

- Billing pursuant to this waiver does not require billing the patient for cost-sharing . . . Probably
- Middle ground – you can probably discount the cost-sharing amount
- You are not obligated to waive or discount co-pays

https://oig.hhs.gov/coronavirus/authorities-faq.asp

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Conflicting Messages?

- On the one hand, OIG guidance mentions "surprise bills" and suggests that retroactive billing of cost-sharing may fall into that category
- "OIG believes it would represent a sufficiently low risk of fraud and abuse for ground ambulance providers and suppliers to waive or discount beneficiary cost sharing obligations for claims billed in accordance with the Waiver."

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Conflicting Messages?

- Yet it is interesting that CMS does not give a clear yes/no answer, but links to an OIG page that says, "any favorable answer will not result in prospective immunity or protection from OIG administrative sanctions or prospective immunity or protection under Federal criminal law."

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Our Thoughts . . .

- If you never billed for these services at all and are now able to recover 80% of the Medicare allowed amount, you may want to think about the repercussions from billing patients for the 20% on trips that happened over a year ago, during the height of the pandemic.

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Our Thoughts . . .

- If you billed the patient for these services and were paid, they will likely be thrilled to get back everything except 20% of the Medicare allowed amount.
- See how you went to bat for them!!
- At the end of the day, it is a business decision

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BUT…

- Billing under the TIP waiver for current DOS would allow for (and require) billing the patient for applicable cost-sharing amounts
- Consider letting patients know that Medicare may pay for TIP and there would then be co-payment obligations that are significantly less than their non-covered service obligations

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What About Medicare Advantage?

- Medicare Advantage (MA) plans must provide coverage of all benefits that are covered under Part A and Part B in the FFS Medicare program.

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What About Medicare Advantage?

- In order to fulfill its obligations under section 1852(a)(1) of the Act and §§ 422.100 and 422.101, an MA plan may not deny coverage based on the requirement that an ambulance service include the transport of the enrollee in situations where that requirement has been waived by CMS.

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What About Medicare Advantage?

- MA plans may continue to make appropriate medical necessity determinations using their own medical necessity criteria that are no more restrictive than original Medicare's national and, as applicable, local coverage policies.

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What About ET3?

- **Q.** Does this provision affect participation in the ET3 model?
- **A.** No. An ET3 Model participant is not prohibited from exercising the flexibility made available by the waiver, regardless of whether it elected to implement the ET3 model treatment in place intervention.

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Now That We Understand The Issues

What Are My Options?

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Depends On Where You're At

- Did/do you have a qualifying protocol in place?
- Have you billed anyone (including ***any*** payer) for the TNT responses that now qualify for TIP under your COVID-19 specific protocol?

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Qualifying Protocol In Place?

- If No:
  - Since the qualifying protocol can not be made retroactive, this will not affect any past responses for you
  - You may put a protocol in place now to allow for reimbursement of future qualifying TIP services during the PHE if you think that will be helpful

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Qualifying Protocol In Place?

- If Yes:
  - Have you previously billed anyone as a TNT for what would now be a Medicare covered TIP service?

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Charged For Any Qualifying TIP?

- If No:
  - If you would like to receive compensation for qualifying TIP services, you may now bill for dates of service retroactive to either March 1, 2020, or the effective date your qualifying protocol, whichever is later
- If Yes:

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Medicare Beneficiaries

- If you have billed any Medicare Beneficiary for TNT (likely A0998), for services that would now be a Medicare covered service under TIP, you would need to bill Medicare for the TIP, and ***refund the patient*** any amount paid in excess of the patient's cost-sharing responsibility

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Caveat On This One

- If the beneficiary has a supplemental plan that is responsible for Medicare cost-sharing amounts, once that supplemental plan pays, your refund to the patient would be everything the patient paid less any patient responsible amounts left after both (all) payers pay

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Commercial Insurance Plans

- Have you billed any Commercial Insurance Plans as supplemental coverage of a Medicare non-covered TNT (A0998), for services provided to a Medicare Beneficiary, that would now be a Medicare covered service under TIP?

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Commercial Insurance Plans

- Remember, if you want to be paid ***from any source*** for the Medicare covered service provided, you must bill Medicare for the TIP
- When Medicare pays as primary, you would then need to refund any amount paid by the commercial payer in excess of the cost-sharing amount they are responsible for.

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Future

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Audit Bait

- Easy Medicare edits for CR and/or no mileage being billed
- Black and white criteria for auditing (presence of protocol, and whether protocol was produced)
- Potential for overpayment liability if TIP services were incorrectly billed

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What about patient complaints?

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Example

- Patient was billed and paid for TNT
- Service does NOT meet TIP criteria
- Patient complains to Medicare thinking that they should not be personally responsible, because the service is covered under TIP
- Will have to defend your decision to NOT bill TIP and maintain A0998 billing to patient

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Thanks, again!

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