

The Central Line

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Directors Notes: Special Report on Medicare

Submitted By Dave Robie

Medicare and Billing and NorthStar

Many, many years ago, Medicare became the primary payer of health-care benefits for our senior citizens (and now for many others but that is a different story for a later time when you are older). To make sure that they only paid what was right and fair, the government made up rules, lots and lots of rules. I'm going to talk about only two of them today that directly affect whether we (FMH, NorthStar or employees) get paid or not.

First "SNF". Patients who are at Skilled Nursing Facilities receive a level of patient care higher than they would at just a "residence"

nursing home (the term "SNF" can be used for a facility, for a bed type or unit of beds within a nursing home). For that "skilled" care, Medicare pays the nursing home a daily rate based on the



acuity of the patient. Almost everything medically that happens to that patient (including routine ambulance rides and tests like lab) have to come out of that daily reimbursement to the nursing home. Ambulance services and other health providers are forbidden to bill Medicare for these services be-

cause Medicare has already paid the Nursing Home. If they do so, in extreme cases (like if they did it knowingly) it could be considered fraud with many obviously bad ramifications.

Even if they do it unknowingly, Medicare could (and does) require that the provider pay it all back – for years. Nursing Homes are not penalized if the provider bills Medicare so they are

not quick to volunteer that they should be getting the bill. It becomes dependent on the provider (us) to find out if the patient is SNF so that the nursing home can be billed correctly. Medicare has let everyone know that this is a big deal for them and, since it is

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Happy Birthday!!!

April

- *Rudy Davis*
- *Earle Albert*
- *Gini Swan*
- *Ed Strapp*
- *Eric Baker*
- *Steve Grant*
- *Chris French*
- *Apology to Carl Blondell for missing his B-day last month!*

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Operations Manager's Corner

DXA Bone Density Exams

I have been working with HCC for some time to educate individuals on the importance of having Bone Density Exams. To date, I am still waiting for more flyers so that I can distribute them to each base in hopes that you will pass them out to any individuals that display any of the signs listed below.

A DXA (Dual Energy X-ray Absorptiometry) machine uses a weak form of x-ray to scan your bones to measure your bone density.

These scans should be done for all women aged 65 and older, all men aged 70 and older, anyone with a fragility fracture, anyone with a family history of osteoporosis, women with amenorrhea or post menopausal and men with low testosterone.

Submitted by Felicia Harris

The bone density scans are ordered by the patients physician and the patient will go to FMH to have the scan done.

If you suspect any patient that falls within the criteria listed above and is being transported for a fracture (at any age) you should give them a flyer and explain that they may want to ask their physician if he/she feels that they should have a bone density scan.



To Know it, Use it, Teach it...

Submitted by Ed Strapp

Have you ever thought about how you learned what you know? We studied in classes, read our textbooks, listened to our instructor, and crammed for tests and practicals. But what were we all worried about? We often times worried "Am I going to know what to do when the time comes?" Am I going to recognize what my patient is suffering and know when to do this skill? It's the difference of knowing something, knowing it to use it, and even better knowing it enough to explain it (teach it) to someone else.

It's this difference that we all need to recognize and embrace, and use to our advantage in making ourselves better. We all come out of a class/lecture/seminar having gained some knowledge. But very

few of us can go right into the field and apply this new knowledge immediately. We have to think about it, discuss it, review it, and practice it. It's this deeper knowledge that helps us go from knowing something to using it. It's a heightened level of thinking that allows us to take this next step. But how do we get there. It takes time, and effort beyond the class to get to this level. Often times it takes more experienced crew members to help us, guide us, and give us the confidence to apply a new skill before we get there independently. Having recently finished my Intermediate licensure, I got to thinking the other day while starting an IV. I remember my first true field IV, I had a paramedic watching over and giving guidance. I even remember my

first SOLO IV, I knew the patient needed one, Heck LFOM was on the way, and I could not let the flight crew see a patient with NO IVs, not on my watch. But boy was I happy when another Intermediate climbed on board, just for the fact that someone else was there. Yet last week, I was first responding to a chest pain call, with the ambulance slowed by poor roads. I knew he needed an IV, with a BP of 90/60, and having taken 3 Nitro on his own, this patient needed IV access, and I wanted it before he went CTD. It was then that I realized that I not only knew it, but I could use it. I had a higher level of experience with IV's and I was now comfortable that I could recognize when one was needed and I could apply the skill.

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Director (cont.)

also the right thing to do, we need to do our part to make sure that the correct party is billed for our services. That is why if you pick up a SNF patient, we need to know about it.

“**Medical necessity**” is the other, much bigger rule that Medicare has. This one is a little more complicated so follow me here. Most of what follows deals with transfers of our elderly patients (who have Medicare). Although Medicare generally finds 911 calls medically necessary, sometimes they are clearly not.

Medicare’s rule of Medical Necessity is established when the patient’s condition is such that “use of any method of transportation *other than* an ambulance is contraindicated.” If a means of transportation other than an ambulance could be used without endangering the individual’s health, whether or not such other transportation is actually available, Medicare will likely not pay. The presence (or absence) of a physician’s order for a transport by ambulance does not necessarily prove (or disprove) whether the transport was medically necessary (but it may help make the case). Also the reason for the transport must be medically necessary (i.e., the transport must be to obtain a Medicare covered service or return from such a ser-

vice.) Almost always, transporting a patient by ambulance to a physician’s office is not a covered benefit.

For transfers, medical necessity is *presumed* to be met if the individual was **bed-confined** (or bed-ridden) before and after the ambulance trip. Bed-confinement is defined as: 1) unable to get up from bed without assistance and 2) unable to ambulate and 3) unable to sit in a chair or wheelchair. But even bed confinement, by itself, is only one of the determining factors of medical necessity. The rule for medical necessity is stated above: Is the ambulance necessary for the patient’s health and safety? Good and thorough documentation is critical to explain why *this ambulance ride* is best for the patient.

Furthermore, only “local” transportation by ambulance is covered. Thus, only mileage to the nearest *appropriate* facility equipped to treat the patient is a covered benefit. There is some latitude here but if the destination is not the nearest one, the documentation must be clear as the reason for taking the patient to the alternate destination. When similar hospitals are about the same distance (e.g., CMMC, St. Mary’s, Redington), they can be considered “closest” (unless FMH is significantly closer and can treat the patient).

The *documented* lack of beds for the type of patient (e.g. psych) at the nearer hospital or the *documented* fact that a further away hospital was equipped and staffed for trauma or specific highly specialty care needed for the patient and not available closer are valid reasons for going to a further destination. However, Medicare will not cover bypassing a similarly equipped hospital solely because of facility reputation, patient or physician choice. The excess mileage is the responsibility of the patient. All such alternate destinations must fully documented.

The provider (from the EMT all the way to the biller) is supposed to be aware of all these rules and follow them in every case. Medicare realizes that there may be ambulance trips that are not medically necessary but the patient wants to go anyway. That is where a form called “Notice of Exclusions from Medicare Benefits” (NEMB) comes in (sort of like an ABN for ambulances). When the run is not medically necessary and we cannot bill Medicare, Medicare says you can bill the patient. Unlike an ABN, getting the NEMB is at our discretion. We can bill the patient whether we get the form or not. But we need to make sure that our patient knows that they are getting and bill from us and why. We will

Use it (cont.)

Now, don't get me wrong, I am not saying I am an IV expert. But I have a new level of understanding of IV skills for example.

However, I know how/when, but do I really know why? Sure Carol taught all of us Intermediates WHY we would/should do an IV, but do I understand all the intricacies of this skill. It takes explaining it to someone else or teaching it to a class to get this third level of understanding. This might be helping a classmate out with a skill they struggle with, it might be helping an upcoming student with skills you just learned, or it could be reviewing a skill with fellow crew members. When we understand a skill enough to teach it to someone, we have a 3rd higher power of understanding. We can explain many of the smaller details, we can think thru the physiology, the physical, and the physiological processes of any skill. If its medication administration we have to better understand the pharmacology of the drug, the physical effects of the drug on the body, then understand the 5 Rs, all in a way that we can verbalize to someone in a way clear and conscience that they can learn from it. If it's a physical skill, like traction splinting for example, we have to understand the underlying conditions, the causes of the pain and discomfort, and the reasons that traction will help this pa-

tient. All in a way that we can verbalize to someone so they can learn from it.

I encourage you to think about the skills you know, and understand the level that you know them! Do you know it, can you effectively use it, and could you teach it. The more you can explain it to someone else, the higher your level of understanding. Use your time to discuss protocols with your partner, helping to explain something they are not familiar or comfortable with, and learning from them about things you need help with. It's not about putting someone down or putting yourself on a pedestal saying I know something you don't know. It all comes from experience.

At one skills fair, I was there to go thru stations, and ended up helping a few very experienced crew members work thru the Kendrick traction splint. Its not that I am smarter then they are, its just I have a bit more experience with that device. But for me, it was a great review; it made me think through how the splint is designed and how that makes things work. It is this kind of interaction that helps them learn the skills and maybe get to a point they can use it, and helps me stay more comfortable with the skills to better understand them.

So think about you skills, and understand where you are in the chain of understanding, and work to get more skills to that higher level of thinking!

(Now my disclaimer: When I say teach them, it does not need to be a formal class, just being able to explain something to someone in almost any environment is beneficial to you in understanding that skill at a higher level of thinking.)

So don't just sit around watching baseball on your next Saturday shift, pull out some equipment, review it, brain storm about its uses, indications contraindications, and make yourself a better provider.



Check out the all new NorthStar Bike Medic Team webpage:
<http://www.fchn.org/northstar/biketeam/>

Team member info, events and contact info for our busiest team!



NorthStar is affiliated with Franklin Memorial Hospital and is part of the FCHN family.

Director (cont.)

likely be introducing this form later in April.

Medicare recently looked at several of our claims and found that, yes, we have done some transports that may have not been medically necessary according to Medicare rules. And yes, there may be a recoupment. Along with some education, we will be implementing various new procedures: among them probably a new transfer/physician certification form and the requirement of a completed NEMB for any (Medicare) situation where:

- ♦ The patient (or physician) requests a destination beyond the closest appropriate facility
- ♦ The patient's condition would allow them to be transported by a means other than ambulance

(whether or not the other transportation is available).

Above all and no matter what, the whys and wherefores need to be documented. Was the patient bed ridden according to the above definition? Then document it (e.g., "could not get out of bed, could not ambulate, could not sit"). Was the patient moved from the bed directly to the stretcher because xxxxx? Then document it (e.g., "85yo patient moved directly from bed to stretcher to ambulance due to extreme weakness secondary to open heart surgery 2 days ago, hematoma in both legs and COPD"). Could the patient sit for only 5 minutes at a time or is seizure prone requiring monitoring or

weighs 400 pounds and thus could not take other transportation?

Then document it (e.g., "patient had decubitus ulcers over 75% of posterior and weighed 400 lbs preventing any other mode of transportation"). What are all the reasons why the ambulance was the right vehicle for the patient?

Document it. Or if there is a question in your mind, be clear about the patient's current status and record any mitigating circumstances that you feel are appropriate?

Document it. Or if it was not medically necessary, be clear why not and the steps you took to discuss this with the patient and/or family. Document it.

So, there you have it. Go now and document it. And be safe. ❄



Honey, why don't we skip church this week?



At Least They're Honest...

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The Back Page

Last but not Least...

I hate Rhododendrons. Despite the fact they're a sure sign of Spring/summer (where's your global warming now, AI? Or did you invent that too just like you invented the internet?), and they look nice with their whites and purples and all. But I gotta say, I hate them now.

A few weeks ago, five of us left the not-so-warm State of Maine for the Appalachian Mountain region of North Carolina (no banjo music, please) for a Search and Rescue exercise. After the 1000 mile journey, we were tired but ready to go. The next morning, after a hearty break-

fast (all meals were hearty), we were split into two teams. Our



gear was checked by our team leaders and we were given our missions: To check a creek bed for signs of the lost persons. Each mission was around 2.5 miles long.

**We're on the web! Check us out
at www.fchn.org/NorthStar**

Little did we know that the creek beds had steep (STEEP) grades of 200+ feet on each side. The bottom 100' of steepness was the thickest jungle of Rhododendron. Heck, Mike fell and never hit the ground.

Those few miles took each team 6 HOURS to trek.

And the boys from N.C. *laughed* at me when I told them I bought the Rhododendrons I had on my lawn at Home Depot. Good thing the hospitality quickly erased the hurt.

More on the N.C. trip next month. I'm taking orders for Rhododendrons for next year. It'll be much less expensive than the garden center...

