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The Abaris Group

The TAG Line

The Abaris Group | *Innovative Solutions for the Emergency Care Field*
700 Ygnacio Valley Rd, Ste. 270 | Walnut Creek, CA 94596
888.EMS.0911 | www.abarisgroup.com

Inside this issue:

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For breaking news, visit EMSNetwork.org.

Final Rules to Recoup Unpaid Emergency Care Costs for Undocumented Immigrants

The Centers for Medicare and Medicaid Services (CMS) announced that it will implement the long-awaited program to help hospitals, certain physicians, and ambulance providers recover the costs of providing emergency medical care to qualified individuals who are uninsured or cannot afford emergency care. The program will provide $1 billion over four years and payments will be made directly to hospitals, certain physicians, and ambulance providers.

According to the Federal Funding of Emergency Health Services Furnished to Undocumented Aliens of the Medicare Prescription Drug, Improvement, and Modernization Act, states will receive payments based on the number of undocumented aliens in the state compared to total residents of the state.

Payments will be available to eligible providers for some or all of their unreimbursed costs of providing emergency health care services required under section 1867 of the Social Security Act (EMTALA) and related hospital inpatient, outpatient and ambulance services.

EMS providers, hospitals and trauma centers will benefit from the new regulations.

State	Undoc'd Alien Pop., Jan. 2000	State Undoc'd Alien Allocations	Final FY 2005 Total Allocation
California	2,209,000	$52,677,852	$70,810,196
Texas	1,041,000	24,824,647	46,048,479
New York	489,000	11,661,145	12,254,399
Florida	337,000	8,036,413	8,683,521
Arizona	283,000	6,748,679	44,979,206
New Mexico	39,000	930,030	5,102,965
Total All States	**7,003,000**	**$167,000,000**	**$250,000,000**

According to an *Oakland Tribune* article, San Francisco area hospitals may decline to accept the federal funding available to them, citing potential "onerous" reporting requirements and the possibility that patients may be deterred from seeking treatment in the EDs. (May 13, 2005)

The new regulations require hospitals to ask patients whether they are eligible for Medicaid, have a border crossing card or if they are foreign-born. However, hospitals cannot ask patients directly if they are undocumented.

CMS Administrator Mark McClellan said that the federal government will not use information obtained from the hospital about an undocumented immigrant's identity for "routine civil immigration proceedings." However, the federal government may obtain information in criminal investigations.

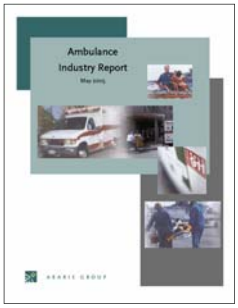
Payments are slated to be disbursed in February or March 2006 for services starting May 10, 2005.

This notice is currently published in the *Federal Register*. CMS' policy notice and related documents can be viewed at www.cms.hhs.gov/providers/section1011.

JUST RELEASED:
Ambulance Industry Report, 2005

This report is the fourth in a series of industry reports that comprehensively analyzes the private sector ambulance industry in the U.S.

Please see page 4 for more details and ordering information.



PART THREE
Implementing New Product Lines in the ED
July 12, 2005
10:00 a.m. – 11:30 a.m. PST

Join our expert panel for a 90-minute highly interactive Webinar. This Webinar will describe product lines that are designed to improve patient flow, increase capacity and customer satisfaction for EDs. You will learn how these product lines work, their volume, cost and revenue implications, and how to get paid.

Key topics to be covered include:

- How to develop a Fast Track & how to make it really "fast"
- What are the benefits and costs of establishing a Clinical Decision Unit
- What is a Rapid Admission Unit & how does it work
- How to design a Discharge Lounge & how to encourage staff to use it
- Why do some of these product lines fail in spite of their high value
- How to develop a business plan to make the business case for these products

Scheduled to Participate:
Trish Carlson, RN, CEN, CFRN, Consultant, The Abaris Group
Mike Williams, MPA/HSA, President, The Abaris Group

Additional details about the series can be found at **www.abarisgroup.com** or by emailing **webinars@abarisgroup.com**.

Top 10 Billing Errors Identified

According to TrailBlazer Health Enterprises, a CMS-contracted intermediary, duplicate claims represent the most common billing error made by healthcare providers. The top billing errors, in ranked order, made by healthcare providers are:

1. Duplicate claims submitted
2. Service bundled into payment for other services
3. Facility information not included on claim
4. Patient not eligible for Medicare
5. Service deemed not medically necessary
6. Provider number missing
7. Medicare is secondary payer
8. Service not covered by Medicare
9. Unique physician identification number (UPIN) missing or invalid
10. Incorrect modifier used

You can find more information by visiting www.trailblazerhealth.com.

Featured Product:
Did you miss our recent Webinar—*Revisiting California ED Nursing Ratios*?

The audio presentation is now available on CD at www.abarisgroup.com on our Products page. For more details, call us at 888-EMS-0911.

Number of ED Visits Increases
CDC Releases 2003 Data

The Centers for Disease Control and Prevention (CDC) recently announced that the number of emergency department (ED) visits increased in 2003, while the number of departments decreased.

According to the report, visits to the nation's EDs reached 114 million, but the number of EDs decreased by 14 percent between 1993 and 2003.

The rise in ED visits has been attributed to increased use by adults, especially those aged 65 years and older. Medicaid patients were four times more likely to seek treatment in an ED (81 visits per 100 people) than those with private insurance.

Additional findings include:

- The waiting time to see a physician was 46.5 minutes, the same as in 2000. The report finds an increase in efficiencies, such as fast tracks, as a reason for the waiting time to remain constant, despite increases in volume.
- 41 percent of injury-related ED visits were the result of motor vehicle traffic incidents. Over 35 percent of ED visits were attributed to injury, poisoning and the adverse effects of medical treatment.
- 14 percent of ED visits arrived by ambulance, representing over 16 million transports.
- X-rays, CT scans or other imaging tests were provided in 43 percent of ED visits.
- A majority of the annual usage (82 percent) was located in metropolitan areas.

For a copy of the full report, visit www.cdc.gov/nchs.

New National EMS Agency?

A report from the George Washington University (GWU) Homeland Security Policy Institute recommends moving the Department of Transportation's (DOT) division of Emergency Medical Services (EMS) to the Department of Homeland Security (DHS). The recommendation suggests that EMS should be placed with the rest of the first responder community in DHS.

A recommendation will be taken to Homeland Security Secretary Michael Chertoff to create a U.S. EMS Administration modeled after the U.S. Fire Administration.

However, other organizations do not think that moving from one federal department to another will solve any problems. The National Association of EMS Physicians (NAEMSP), the National Association of State EMS Directors (NASEMSD), National Association of EMS Educators (NAEMSE) and other national fire organizations are against the creation of a new federal EMS agency.

In a joint letter from the NAEMSP, NASEMSD and NAEMSE, the organizations support the "creation of an EMS office within DHS to provide leadership and support for EMS terrorism preparedness and response, a dedicated program of EMS first responder funding, and the passage of legislation to create a federal Interagency Committee on [EMS] to improve coordination among the many federal agencies that involve EMS, not just NHTSA."

According to a 2004 study in the *Journal of Emergency Medical Services*, almost half of all EMS agencies are attached to fire services.

For more information and a copy of the GWU report, visit www.homelandsecurity.gwu.edu.

Legislative Updates

Final Medicare 2005 Outpatient PPS Update

Medicare outpatient PPS spending on hospitals is projected to be $1.5 million more in 2005 than in 2004. This increase is due to provisions of the rule, expected enrollment, utilization and case mix changes. CMS published the final rule in the Nov. 15, 2004, *Federal Register*.

The impact of the final rule on individual hospitals will depend mostly on service mix and wage index changes. CMS has made numerous APC and CPT changes that require a close review.

The 2005 conversion factor is $56.983, which reflects the 3.3 percent market basket increase for 2005 over 2004, an additional 1.2 percent for funds not required for pass-throughs, and a wage index budget neutrality adjustment of approximately 0.9986.

CMS removed diagnostic testing requirements, but did not expand the conditions that justify payment for observation. Instructions specify that observation care ends at the time the outpatient is actually discharged from the hospital or is admitted as an inpatient. Seven requirements for receiving separate payment for medically-necessary observation services are listed in the final rule.

CMS used claims data from Jan. 1, 2003, through Dec. 31, 2003, in developing the final rule.

For more information, visit the CMS Web site at www.cms.hhs.gov.

2005 Final Outpatient PPS Estimated Effect	
All hospitals	4.0 %
Urban	3.9
Rural	4.5
Major teaching	2.6
Minor teaching	4.1
Proprietary	4.3
Governmental	3.6

Proposed Legislation Focuses on ED Funding

The Los Angeles *Daily News* recently reported that six California lawmakers discussed legislation to increase federal funding for emergency department (ED) physicians. (May 12, 2005) Being seen as temporary measures until a permanent fiscal solution to the ED funding crisis is found, lawmakers intend to stabilize funding for EDs through the proposed legislation. The legislation would:

- Standardize some payment and allocation methods;
- Address regional planning and coordination efforts;
- Exclude patients from billing disputes between physicians and health plans; and
- Require hospitals that close their EDs to notify the public in advance.

Concern over the ED fiscal crisis in California and other states have caused lawmakers to act on behalf of the health system's future financial and provider stability. Communities have raised concern over recent ED closures and want more advanced notice to find alternative solutions to keep ED and hospital doors open.

Nevada Bill Targets Emergency Room Waits

A Nevada Senate bill won approval in April to require Las Vegas area hospital emergency rooms to provide care to emergency patients within half an hour of arrival by ambulance. Endorsed by the Senate Human Resources and Education Committee, Senate Bill 458 would impose no penalties or liability for not meeting the deadline, but the waits will be tracked and included in a study showing where emergency care is slow.

Hospitals, emergency service providers and others worked together on the bill and Clark County health district will oversee the tracking.

Proponents of SB458 think the legislation is a move in the right direction in developing standards for emergency patients and improving emergency room care.

New Medicare Appeal Rules

New regulations have been published in the *Federal Register* that are important to ambulance services. Beginning May 1, 2005, the new regulations make the appeals process similar both for Medicare's Part A and Part B claims. These include new filing deadlines and timeframes for decisions.

The new rules limit the amount of time that hearing officials have to issue decisions. The ambulance service has the right to take the appeal to the next level if the decision is not issued on schedule.

However, the rules require that providers present all of the evidence before the QIC appeal level. If not followed, favorable evidence may be difficult to find at a later stage in the process.

Also, administrative law judges (ALJs) will be moved from within the Social Security Administration to Medicare-specific ALJs within the Department of Health and Human Services, a move that has been viewed unfavorably by certain providers.

The new rules will be implemented by CMS in various stages through Jan. 1, 2006.

Ambulance providers will benefit to be familiar with the regulations. You can learn more about the new Medicare appeal rules by searching the Federal Register, volume 70, number 44, March 8, 2005, at www.gpoaccess.gov.

The Abaris Group releases

Ambulance Industry Report, 2005

This report is the fourth in a series of industry reports since 1999 that comprehensively analyze the private sector ambulance industry in the U.S. This 27-page report broadens its analysis of the evolution, key pressure points and success factors that affect the ambulance industry across the spectrum of provider types – private, public, volunteer and others. The report provides a detailed evaluation of the industry's two largest providers, as well as the latest trends of market share gain, contemporary delivery models and the "private vs. public" debate. Key financial performance and commentary of these two providers are provided.

Price: $340

For more information and to order, contact The Abaris Group at 888-EMS-0911 or email us at dmendes@abarisgroup.com.

The first three reports can also be purchased by contacting The Abaris Group or visiting www.abarisgroup.com.

CMS Confirms Long EMS Off-loads are EMTALA Violations

A recent article found in the May 2005 *EMS Insider* brought to light that several hospitals in the Dallas region were preventing EMS staff from transferring patients from the ambulance to a hospital bed or gurney.

In a letter to CMS Region VI hospitals, David Wright, special assistant to the Region VI administrator, cautioned hospitals that delaying care and forcing a patient to wait with EMS staff is a violation of the Emergency Treatment and Active Labor Act (EMTALA). "Under EMTALA, a patient is considered to have 'presented' to a hospital when a patient arrives on hospital grounds," wrote Wright. "A hospital's refusal to 'accept responsibility' for a patient in the hospital or on hospital grounds could be a violation of EMTALA."

The same rules hold true for patients transferred by ambulance from one facility to another.

Although EDs today are crowded and strained, Wright urged, "'Parking' patients in hospitals and refusing to release EMS equipment or personnel jeopardizes patient health and impacts the ability of the community to provide emergency services by forcing EMS personnel off the street."

For a copy of the letter, email david.wright@cms.hhs.gov.

Reducing ED Burden via Phone

A Dallas-based group has launched a "fast, low-cost" answer to the "time-crunched" patient waiting to meet with a physician via the telephone.

For both the insured and uninsured, TelaDoc provides doctors to respond to phone calls instead of urgent care clinics or the emergency room.

The service costs $18 to join and $4.25 per month for each individual. Each call to a doctor is $35. Physicians will respond to all member calls within three hours or the $35 fee is waived. (*USA Today*, May 24, 2005)

TelaDoc joins a new generation of health care providers hoping to make the service convenient for the patient. TelaDoc estimates that it will respond to three-fourths of the calls, which will include complaints related to allergies, colds, recurring urinary tract infections and sprains. The physicians do not prescribe narcotic painkillers or treat patients under the age of 12.

According to the *USA Today* article, the launch of TelaDoc and other convenient health care outlets is derived from a Center for Studying Health System Change report that found insured patients drove most of the 16 percent rise in hospital ED visits between 1996 and 1997, and 2001 and 2001.

"There is a whole move toward consumer-oriented health care: Your time, your place, your way," says Jonathan Weiner, a professor of health policy at Johns Hopkins.

If the "TelaDoc system has a market, it signals that people are having a difficult time accessing their primary care physicians," said a researcher at the Center.

You can view the *USA Today* article online by visiting www.usatoday.com.

Two Studies Focus on Uninsured Workers

A recent study released by the Robert Wood Johnson Foundation found that 20 million working adults do not have healthcare coverage. According to the data analyzed from the CDC, at least one in five working adults does not have healthcare coverage in eight states. At least one working adult in every 10 is uninsured in 39 other states.

The study also reported that between one-fourth and one-half of all uninsured adults nationwide were unable to see a physician when needed in the past year because of cost.

Another report from The Commonwealth Fund (CWF) revealed that most state-level, federal-funded pilot projects to expand coverage to the uninsured have focused on reforms that build on employer-sponsored insurance. Pilot project planning grantees found that a majority of the uninsured are workers, therefore exploring employment-based coverage through publicly-funded premium assistance and tax credits to subsidize employee and employer premium shares.

The Health Resources and Services Administration (HRSA) provides state planning and pilot project planning grants to help states with their uninsured populations.

The Robert Wood Johnson and CWF reports can be found by visiting covertheuninsuredweek.org and www.cmwf.org.

The Abaris Group continues

Webinar Series on Improving ED and Trauma Services

The Abaris Group is conducting a Webinar series throughout the year designed to assist emergency, trauma and other healthcare providers with effective strategies to use in the hospital and out-of-hospital environments. Led by experts in the field, the Webinars will provide participants with tools and tactics to use in the everyday healthcare setting.

Webinar Series Timeline

Implementing New Product Lines in the ED
July 12, 2005

Enhancing Medical Staff Coverage for the ED and Trauma Center
September 7, 2005

Developing New ED Revenue
November 2, 2005

For more details and to register, visit www.abarisgroup.com. Educate your entire staff for one low cost. Pay only **$295** per site for one Webinar or learn about our special discounts when you register for two or more Webinars.

If you've missed our previous Webinars, visit www.abarisgroup.com to purchase a recorded version on CD.

News Briefs

The Texas department of health and the American College of Surgeons (ACS) have verified the **Children's Medical Center Dallas** as a Level I pediatric trauma center, becoming the first hospital in Texas to receive the designation. According to the *Dallas Business Journal*, there are 14 Level I pediatric trauma centers in the nation, and the two facilities closest to Texas are located in Denver and Indianapolis. (Feb. 21, 2005)

Alleghany County, Penn., is making efforts to expand six of its 20 emergency rooms in a move to look less like "bus stations and more like hotel lobbies," according to the *Pittsburg Post-Gazette.* (April 22, 2005) Patient experience is the focus of the expansions.

According to Los Angeles County officials, no deaths or cases of serious harm to patients have been attributed to the closer of **Martin Luther King Jr./Drew Medical Center** in Dec. 2004. (*Los Angeles Times*, May 8, 2005) Patients are being treated at three nearby hospitals.

A survey conducted by the ***Annals of Emergency Medicine*** found that 76 percent of 171 ED physicians experienced at lease one violent act over the previous 12 months. Seventy-five percent of the respondents reported that they had encountered verbal threats, 28 percent said they were victims of physical assaults, 11 percent indicated they were confronted outside the ED, and 3.5 percent have experienced stalking events. In spite of the survey findings, only 27 percent of ED physicians report ED-assigned permanent security officers at their hospitals.

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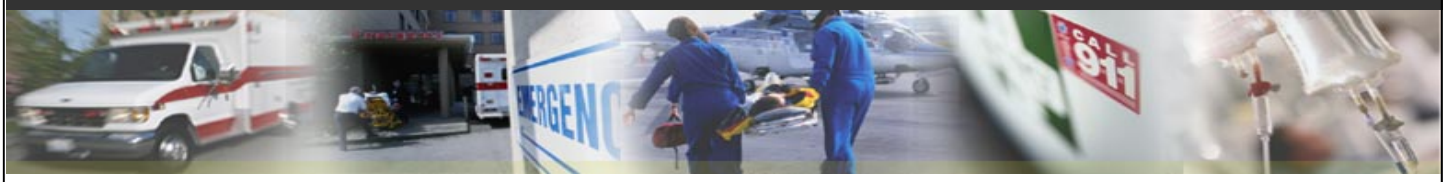

About Us

The Abaris Group is a consulting firm that specializes in emergency and outpatient services. We provide clients with help on a wide range of topics, including strategic planning, operational improvement, and financial enhancement, to help them achieve their goals.

We pride ourselves on delivering value to our clients in the form of quality recommendations and strategies that work. To achieve this, we conduct detailed analyses, blending insight and experience from all spectrums of the healthcare and emergency care fields to meet our client's unique needs.

Whether it is evaluation of new programs, studies of existing ones or assistance with implementation, we will extend this superior level of service to you and your organization.

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