Charges for Ambulance Services - DRAFT

Purpose:    To establish ambulance service charges, define ambulance service charges for members of Fitch-Rona and family members of district emergency medical technicians (EMTs), and no-transport fee guidelines.

Policy:

Billing for ambulance service is based on four service categories. The categories are Base Rate, Mileage, Supplies/Procedures, and EMS Standby. The EMS Commission is responsible for setting the Base Rate to be charged for each ambulance call, the Mileage Charge, and Standby Rates. The EMS Chief is responsible for setting the cost for Supplies/Procedures.  All costs are reviewed annually to ensure competitive rates within the local medical community.

**Base Rate:** These fees are divided into two categories: Residents of the Fitch-Rona EMS District and non-residents. Resident fees are less than a non-resident fee with the premise that a resident’s taxes already contribute to the funding of EMS in the municipality. The Base Rate fee is meant to cover costs for labor, general supply and equipment use, and other costs of operating the service.

**Mileage:** These fees are intended to contribute to the cost of fuel, routine maintenance, and repairs on vehicles.

**Supplies:** Supply costs are reviewed annually and adjusted to cover purchase costs of supplies equipment utilized on calls for service and contribute to covering the cost of supplies and equipment that is stocked, but due to low frequency, but critical use, may expire, or require replacement.

**EMS Standby:** There are organizations that request an ambulance to be present, and dedicated to the support of their event. The District does their best to provide the equipment and staffing to support these events, but because the crew and resources are dedicated to the event, they are not available for general 911-calls, which is the primary use, and tax-supported use of EMS. For this reason, the standby fee covers 100% of the cost of crew and resources that are dedicated to the event and generally includes a “Mobilization Fee” to cover the administrative time and fuel utilized to coordinate the support.

Some circumstances dictate unique billing rates:

**1.    Intercept Charges**- When Fitch-Rona EMS intercepts with another EMS service:

a.    Fitch-Rona EMS District will make every attempt to put into place an Intercept Billing Agreement with outlying agencies.  The language for the agreement is provided by our billing agency and conforms to Medicare requirements.  These agreements typically will include flat rate costs for all Medicaid/Medicare patients.

    i.    If such an agreement is in place, a pre-determined amount will be billed for all Medicare/Medicaid or other federal entity recipients directly to the Ambulance Service requesting the intercept. They in turn will bill Medicare/Medicaid or other federal entity recipients using ALS coding. Payment by the Ambulance Service that requested the intercept will be expected within 30 days.

ii.    If the patient has other insurance or is a self-pay, Fitch-Rona will bill either the patient’s insurance company or the patient directly for the care based on standard billing categories.

b.    If there is not a Billing Agreement in place with the outlying agency, Fitch-Rona will do the following:

i.    If the patient has insurance other than Medicare, Medicaid, or other federal insurances, the patient or their health coverage plan will be billed using standard billing categories.

ii.    If the patient has Medicare, Medicaid, or other Federal entity insurance, the requesting EMS service will be charged standard billing categories for Non-Residents

2.   **Volunteers and Paid Staff Waivers**- Volunteers in good standing and paid staff will not be personally liable for the ambulance base rate, mileage, and supplies used after an invoice is submitted to their insurance agency.

3.   **No- Transports** – Both residents and non-residents will be charged a fee for no-transports. This no transport fee will be a rate determined by the EMS Commission on an annual basis. In addition, patients will be charged for all supplies used by Fitch-Rona.

Calls involving patient assessment or on-scene care will be considered for the no-transport fee.  Following are examples of calls that may or may not be billed:

**No-transport fee charged:**

a.    When a patient or their family member calls due to an illness/injury and a physical assessment or treatment is performed.

b.    When a patient has an altered level of consciousness for any reason, i.e. use of drugs, alcohol, or medical condition and a physical assessment or treatment is performed.

c.    When a medical assessment is requested by police or fire for any reason and a physical assessment or treatment is performed.

d.    In the case of diabetics or asthmatics, where definitive treatment is administered and the patient is still not transported, an ALS no transport fee along with supplies used will be charged.

e.    When local health care facilities call for EMS services and there is no obvious injury to a patient, but lifting assistance is requested, the facility may be charged the no transport fee.

f.    At the discretion of the EMS Chief, a no transport fee may be charged if we are called often to provide lift assistance for the same person. When a patient repeatedly calls for lifting assists or other non-emergent reasons, the patient will begin to be charged after a set number of responses are made.  The responses are based on a lifetime. The tiered charges are as follows:

    Five responses – no transport assessment fee

    Six and above responses – ALS no-transport assessment fee

**No- transport fee not charged:**

a.    When a person calls for assistance getting up and no physical assessment or treatment is performed. As referenced above, less than 5 calls for assistance, patients will not be charged, but after the fourth response, they will receive a notice that future responses will be charged.

b.    When bystanders call without first checking for injuries/medical need and no physical assessment or treatment is performed.

c.    When responding to a fire or law enforcement stand-by and no patient contact is made.

**Ambulance fee write-offs :**

a.    Medicare and Medicaid Health plans remaining balances after payment by Medicare/Medicaid and supplemental insurance, as required by law.

b.    Remaining balances for Worker’s Compensation payments, as required by law.

c.    Any remaining balance after payment by a health care plan less than the annual pre-determined amount approved by the district.

d.    Any account that was to be sent to our designated Collection Agency, unless the patient has multiple accounts which add up to a sum greater than the annual pre-determined amount approved by the district.

e.    Deceased patients without insurance balances are written off.

f.    Deceased patients with insurance that have remaining balances due are written off after insurance payments are complete.

**Non-Sufficient Funds (NSF) Fee –**

**If the district receives a check with insufficient funds to cover the amount of the check, a NSF fee will be added to the cost of the ambulance service invoice, not to exceed what is charged by the banking institution.**

**Financial hardship requests:**

    The Fitch Rona EMS District may reduce or eliminate the patient's financial responsibility for EMS transport services, when requested, on a case-by-case basis where the patient qualifies under our financial hardship guidelines. The determination of financial hardship is based upon a percentage of established Federal Poverty Guidelines in relation to     household income.  (NOTE: Insured patients who choose not to have their claim filed     with their insurance company are not eligible for our financial hardship assistance     program.)

a.    To apply for financial assistance, the patient or responsible party will need to complete an Ambulance Fee Waiver request and submit the completed information to Fitch Rona EMS for verification of financial information.

b.    Fitch Rona will use 200% of the most current National Poverty Guidelines in assessing possible waiver of charges.  (https://aspe.hhs.gov/)

c.    Patients who fall at, or below the above guidelines may have up to 100% of their ambulance fees waived.

d.    Payment plans may be arranged for charges due based on a review of circumstances and approval by the EMS Chief or designee.

e.    The determination of financial hardship applies to the current EMS transport only. To waive or reduce future payments, the patient must again prove hardship.

f.    Reductions cannot be applied to deductibles or co-pays as determined by a patient’s health insurance plan.