

**Written Testimony**  
**Submitted by**  
**Debra M. Gault, National Vice President of Federal Reimbursements & Regulatory Affairs**  
**American Medical Response**

**Committee on Veterans Affairs**  
**Subcommittee on Health**  
**U.S. House of Representatives**

**Assessing VA's Ability to Promptly Pay Non-VA Providers**  
**June 3, 2015**

American Medical Response (AMR) is honored to have this opportunity to submit a written statement to the House Committee on Veterans Affairs' Subcommittee on Health for the hearing on June 3, 2015, entitled "Assessing VA's Ability to Promptly Pay Non-VA Providers." AMR is the nation's largest single ambulance provider with operations in over 2100 communities within 40 States; serving our nation's veterans in every one of our operations. AMR proudly serves our nation's veterans on both an emergency basis, through 911 calls, and a non-emergency basis through contracts with the Department of Veterans Affairs (VA). Like so many other non-VA providers in the country, AMR has had consistent difficulty getting reimbursed by the VA for services we provide to veterans. The current payment backlog at the VA for AMR claims currently totals approximately \$12 million. AMR has been working diligently with the VA for over a year to try to get the backlog resolved. Unfortunately, there has been very little progress. We believe our experience will provide some insight to the Subcommittee as they examine the issue of prompt pay at the VA.

**Background**

AMR has been operating since 1992 and currently provides over 3.3 million transports annually to patients in the communities we serve. Approximately 100,000 of these services are provided to veterans across the nation. AMR has over 19,000 employees nationally and many of them are veterans. We have been diligent in our recruiting efforts to attempt to reach and provide employment to as many veterans as possible and have established recruiting and training programs to provide a career path within AMR for our military heroes who are returning to civilian life. Our objective is for every veteran who desires a career in the world of Emergency Medical Service to be able to attain their goal.

Each of AMR's operations provides clinical ambulance services to our nation's veterans. As a result, AMR works directly with 20 of the VA's Veteran Integrated Service Networks (VISN) when submitting claims and the required documentation as we attempt to secure reimbursement for our services. Unfortunately, as we stated previously, this is not an easy task. While we do everything possible to ensure that veterans' covered services are paid directly by the VA with as little involvement by the veteran as possible, the VA's current lack of consistent processes at the VISN level and the huge problem of inadequate resources to adjudicate submitted claims make this goal extremely difficult, if not impossible.

## **VA is Delinquent in Payment for both Emergency and Non-emergency Claims**

While ambulance services for veterans are virtually all provided by non-VA service providers and are fairly straightforward on the aggregate, attempting to follow the claims processes and regulations put in place by the VA is extremely complicated.

Most non-emergency ambulance services are prior authorized through contractual relationships directly with area VA facilities and claims submission and payment criteria are spelled out within written agreements. Even with these requirements in place, AMR currently has over \$500,000 of contracted claims that are over 90 days old. If we apply the prompt payment regulation, which requires contracted claims to be paid within 30 days, and interest calculation, this amount due increases to over \$2 Million. These are all services that were both prior authorized and requested directly by the local VA facility. As you can imagine, it is frustrating to us that we have abided by our agreements with the VA and have provided contractually obligated services, while the VA has not followed through with its responsibility to provide timely payment.

Emergency or 911 ambulance services are provided by law to patients that require treatment and transport to the hospital when a request for an ambulance response is received within the service area's call center. The request is received from the patient, a family member, a bystander or medical facility personnel. Using nationally standard clinical dispatch protocols, based upon the information provided by the requesting party, ambulance services must send their resources without the ability to observe the actual condition of the patient at the scene until they arrive. Because of the uniqueness of this scenario, payers universally recognize the "Prudent Layperson Standard" for reimbursement to ambulance services. Basically, if an individual without any prior medical training or education perceives that the patient is in need of medical assistance as quickly as possible and that an ambulance should be requested, and if the ambulance service can provide the appropriate documentation that proves this scenario occurred, the emergency response and the level of service required to treat the patient's condition described at the time of the request is reimbursable. While the VA regulations clearly state that their payment policies follow this standard as well, as we'll discuss in more detail later in the testimony, this is not VA practice. Due to the VA's mishandling of emergency claims, the backlog of emergency claims for AMR at the VA totals over \$7.5 million.

We have provided information regarding the claims backlog that AMR has at the VA to the Subcommittee. The claims are categorized by contracted services and non-contracted services and also by age of the claim. We are also able to break this information down by VISN. The data show the bulk of the AMR's outstanding claims have been backlogged at the VA for well over 30 days. 30 percent of our emergency claims and 13 percent of our contracted claims are over 90 days past due. Some claims have been outstanding for as long as over a year. We have provided this, and other information, to the VA at their request and would be happy to answer any questions the Subcommittee may have about the data.

## **Discussions with the VA have not Resulted in Resolution**

Receiving prompt payment from the VA has been an ongoing problem for years. However, as we indicated above, clearly the problem has begun to reach critical mass. AMR has established and nurtured relationships with management level personnel at each of the VISNs we interact with, however, over many years, we have seen little or no progress toward any type of consistent resolution. A year ago, when we had tried everything we could think of to resolve the problem internally, AMR reached out to Congressman Mike Coffman (R-CO), the Member of Congress for AMR's headquarters in Greenwood Village, Colorado and a member of this Subcommittee. Through Congressman Coffman's assistance, AMR began attending weekly conference calls with representatives of VA management from the Central Business Office (CBO) who oversee VA transportation benefits to discuss the delays in processing our claims. These calls are still ongoing today.

We have also received contact information for each of the VISNs, so that we can deal with them directly. We have been working with each of the contacts provided to us but none have been able to produce consistent solutions and resolve the payment issues that have caused the current backlogs. AMR has been asked to schedule weekly calls with several of the VISN management and we have done so, only to sit on the calls at the scheduled times without any participation whatsoever from the local VISN. This is a regular occurrence. While we continue to try everything at our disposal to work directly with the VISNs to address and resolve the problems and the payment backlog, we do not see any sense of urgency on the part of the VA personnel to truly address the issue.

In August 2014, representatives of the VA CBO agreed to meet with AMR and our colleagues from Acadian Ambulance based in Louisiana in person at their Atlanta facility. Most of the VISN managers AMR and Acadian interact with also participated in this meeting by phone. At the meeting in Atlanta, AMR worked with the VA to identify the problems the VA encounters during claims processing. We also made several recommendations for resolving these issues and streamlining claims processing overall. The VA did not follow up on our recommendations or offers of collaboration and the problem of outstanding claims has continued to grow.

## **Several Problems Contribute to VA's Delinquency in Claims Processing**

As a result of our discussions with the VA, AMR has been successful in identifying several problems that we believe are contributing to the claims backlog at the VA.

### *VISNs Claim Lack of Funding*

When AMR discusses the backlog of claims with the individual VISNs, we are often told that they are out of funds appropriated for ambulance services in their budgets, and we will have to wait until the next fiscal year to be paid for our claim. This can occur as early as the first quarter of the year and would require us to wait until after October 1 of that year, or even the following year in some cases, to obtain payment for our services. When AMR raised this issue at the meeting in Atlanta, VA management personnel from the VA CBO were actually surprised to hear about it, but the VISN participants admitted that they budget for ambulance usage based upon prior year volumes. AMR pointed out that if this was

the methodology they used annually to budget for outgoing years, the cycle of under-budgeting would continue, especially if the previous year's claims were still unpaid. The VA CBO personnel informed the VISNs that there were sufficient funds at the national level and if they required additional funding to pay for the ambulance claims they had received, they should contact the CBO and funds would be released immediately to allow the claims to be paid. This apparently did not occur as we continue to hear unavailable funds as a reason claims cannot be paid.

AMR offered our resources to review the VA's budgeted data annually to assist them with getting as accurate of an estimate as possible for the following year's payment requirements. While the CBO personnel agreed it would be beneficial to work in partnership with the industry when the budgeting process occurred this year, this has not transpired, despite reminders and outreach from AMR to the VA. Unless the budgeting process is addressed, the VISNs will continue to improperly calculate the amount of funding necessary for ambulance services in a given year.

#### *Electronic Claims Transmission is not Available for Submission of All Ambulance Claims*

At the VA, Electronic Claims Transmission (ECT) is not available for ambulance claims submission for most services provided to veterans. At the time of our meeting in Atlanta, most VISNs had not repaired a problem that was prohibiting most ambulance services (including AMR) from submitting even contracted, prior authorized claims via ECT. This problem has since been rectified and contracted claims can be submitted via the OB-10 format. Emergency ambulance claims created a much more complicated process. The claim must be designated as a non-VA provider situation and then separated into a service or non-service related transport prior to processing. AMR's Las Vegas operation has been working directly with the Information Technology team at the VA to attempt to develop an ECT process for submission of these claims. Through the diligent efforts of our AMR team, significant progress has been made in this area and we recently have submitted some test batches of claims through a third-party claims processing intermediary to the VA. We hope to learn that all problems and bugs are worked through and that this option will be released to the ambulance industry at large very soon.

#### *VA is Requiring External Records from other Health Care Providers before Paying Emergency Claims*

As we discussed briefly earlier in the testimony, the VA is holding emergency ambulance claims prior to processing or payment until medical records are received for the veteran's entire episode of care on the day of the ambulance transport. Even if the veteran meets the additional requirements established within the VA's payment regulations (e.g., whether the incident is service or non-service related, whether the patient has been seen within a specified period of time prior to the current date of service), the VA does not truly utilize the prudent layperson standard to establish payment for emergency medical services. In addition to the ambulance service's documentation, the VA claims that it also requires documentation from all other medical providers that are involved with the patient's care on the date in question before the VA can pay any of the claims received. Putting these criteria in the ambulance service's context, the ambulance provider's claim cannot be reimbursed until all medical records from the hospital and other clinicians that see the veteran on the day of their ambulance transport are received and reviewed by the VISN. This means that even though the ambulance service

personnel are not even present and the ambulance service has absolutely nothing to do with the care that is rendered once the patient is transferred to the receiving facility, the ambulance provider's claim is delayed until all other claims are received and evaluated to determine whether the entire incident can satisfy the need for medical care on that date.

For example, the ambulance service may be told that a patient with chest pain requires an ambulance response. The paramedics arrive on scene and after assessing the patient and evaluation of an EKG and other medical treatments they utilize on scene, they establish that the patient is complaining of chest pain and treat the patient as such. Upon arrival at the hospital, the patient then receives further assessment and diagnostic testing and the final diagnosis is an anxiety reaction or possible heartburn or epigastric pain. After reviewing the hospital records (which the ambulance service neither has control over or is privy to the patient's treatment after their clinical service to the patient has been completed), the VA determines that the patient's episode of care that day does not meet medical necessity standards and all claims for payment should be denied. This is a very common scenario and while we appeal these claims on a standard basis, the VA continues to merge the ambulance claim into the care rendered after the ambulance service is no longer even involved with the patient when determining whether the veteran's episode of care should be paid. If VA regulations state that the Prudent Layperson is the standard by which the VA will reimburse emergency medical services, then that is the standard that should be used. Unfortunately, that is not the case.

Recently, Congressman Coffman contacted the VA about this issue on our behalf. Acadian Ambulance also asked Congressman Boustany (R-LA) to write to the VA regarding this issue. It is our understanding that in the response that Congressman Boustany received from the VA, the VA stated: ". . . VA does not require an ambulance provider to submit all clinical notes related to the emergent episode of care. In response to your constituent's comment that it does not need to submit medical documentation from the receiving facility, we agree that emergency transportation claims typically only include the ambulance company's notes related to the transport of the eligible Veteran to the non-VA emergency facility." While we appreciate that the VA agrees with our interpretation of the requirements for documentation, in practice VISNs are requiring ambulance companies to submit this external documentation. As a result, ambulance claims are delayed and many are ultimately erroneously denied.

#### *There are not Enough Resources within the VISNs to Process Ambulance Claims*

Another problem discussed openly at the August meeting is that there are not enough resources within the VISNs to process ambulance claims. The VISNs were actually very honest that this is absolutely true. We are always told by VISN personnel that the reason there is such a backlog of our claims is that they simply do not have enough people working on them. We also discussed the fact that when one of the dedicated personnel at the VISN is not working for a period of time, there is no process to accommodate any backfill of that person's work. So, they leave a backlog when they go on vacation or medical/personal leave and come back to a backlog that is exponentially worse because no one has been processing any of these claims in the meantime. The VA CBO stated that they would discuss this problem with the management level personnel on their monthly VISN call and report back with a

solution. This has never occurred and we continue to face the problem that there are never enough VISN employees to process the volume of ambulance claims that are regularly submitted.

### *The VA 30 Day Timely Filing Timeframe for Claims is Totally Inadequate*

Respectfully, we believe the VA 30 day timely filing deadline for claims is unworkable. Ambulance services are only with the patient for a very short time and often in situations where they can obtain very little information about the patient or their insurance coverage. As a result, much of the patient information must be obtained after the patient leaves our direct care. We often hear from the patient after they receive their invoice or even the second invoice notice that they are veterans which is often already past the 30 day claims filing requirement. Because of the uniqueness of our service, it is sometimes impossible to discuss potential third party coverage with our patients and family members. Expecting a 30 day turnaround on emergency ambulance claims is truly not reasonable. While we try as hard as possible to meet that deadline, we must often rely on the veteran after the date our service was rendered to contact us to let us know that we should be submitting a claim to the VA. If the veteran is in the hospital for any length of time after our service is rendered, the situation is exacerbated as a request for third party insurance coverage notice is most likely waiting at home for them when they are discharged. While the veteran may contact us as quickly as they can, often they are too late to allow us to meet the unreasonable 30 day filing requirement.

The problem we described above regarding the VISN waiting to obtain all medical records for the episode of care before they will pay the ambulance claim is also causing denials for untimely filing which often results in the veteran becoming financially responsible. If the VISN receives the ambulance claim timely, staff will still state that they require the other provider medical records which may not come at all, or they may be received well after the filing deadline has past. Because the VISN considers these external medical records as a part of the "incident" and must have all of them to consider making payment, the timely filing deadline requirement is often missed due to no fault of the ambulance provider at all.

We have also found that despite the fact that we file manual claims within the 30 day filing deadline and we send the claims via certified mail so that we can be certain to have proof that the claims were received timely, the VISN will state that they either never received our claim (even with the signed receipt) or the claim was not received within the filing deadline. We must then appeal the decision with the VISN. The appeal process is a very tedious and long process. Even with the proof of receipt, we often receive "untimely filing" denials as the VA's final decision.

### **When VA does not Pay Claims, Veterans are Affected**

When the VA does not pay claims, veterans can be held responsible. AMR does everything possible to hold claims until they receive notification directly from the VA that the claim is either not covered or is paid. As you can see on the data we have provided, there are claims that are over a year old that we are holding as we are hoping that we do not have to hold the veteran financially responsible if the VA should cover their service. We will notify the veteran in the revenue billing cycle that we are submitting their claim to the VA for payment and request their help in trying to resolve the debt by asking them to reach

out to the VA personally, but if there is any chance at all that we may receive payment for the service, we do everything we possibly can to work through issues or delays with the VISN. Ultimately, however, if we are unable to obtain a definitive response from the VISN, the veteran may become financially responsible for payment. When that occurs, AMR will work directly with the veteran to establish a monthly payment plan, and we also will submit the claim to any other third party payer that may cover the service on their behalf. If, however, the veteran simply has no financial means to cover the cost of the service, the claim unfortunately may ultimately be referred to external collections. Once again, AMR does everything we can to avoid this from occurring, but other providers may have fewer options.

While many large ambulance companies are able to operate despite the VA's delinquent payments, for small ambulance companies, it is much more difficult to hold claims open without payment for long periods of time. Because large companies can normally establish policies for veterans that allow them to work much longer on obtaining payment from the VA and other third party payers before holding veterans personally responsible, they will show accounts that remain open on their data for sometimes over a year while they try to find a payment resolution. Small companies – particularly those that are in rural areas with a low volume of calls but the large overhead costs of maintaining an ambulance ready for response when needed – are in a much different situation. Because they have far smaller volumes, accounts cannot be held open for long periods of time or they will simply not be able to maintain their ability to stay in business. In these cases, companies may have no choice but to hold the veteran responsible much earlier in the billing cycle and provide them with a smaller number of choices or a shorter monthly payment plan period to resolve their debt. In many cases in these areas, veterans' claims are being referred to outside collection agencies much faster. This occurs even when the VA should be responsible for payment but simply does not respond in a timely manner. These companies have nowhere to turn and while none of them want to send a veteran to collections or cause them anxiety for a debt they should not be responsible for paying, the time it currently takes for the VA to process their ambulance claim simply cannot sustain them. Whenever possible, these small companies have begun to question whether they want to contract with VA facilities in their area to provide ambulance services to their patients. Small ambulance providers are hesitant to enter into any service agreements to provide service to these VA facilities when they know they won't receive timely reimbursement. This is beginning to cause access issues for veterans in many areas of the county.

## **Conclusion**

We appreciate the Subcommittee's examination of the issue. While we were all hopeful that the Veterans Access, Choice and Accountability Act, which was signed into law last year, would help resolve these critical payment issues, unfortunately it has not. In fact, since the bill was signed into law, the problem has only gotten worse. The VA is already subject to prompt payment laws—laws the agency is not following. Respectfully, we submit that Congress needs to take more aggressive action to fix the VA's health care system and ensure that our nation's veterans receive the care they deserve.