1000 Second Avenue, Suite 3500, Seattle, WA 98104 • (206) 393-5400

Jim Fredman
(206) 393-5423
(206) 393-5401 Fax
jim.fredman@polsinelli.com

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Via Email: Nickolas.bohl@atg.wa.gov

Nickolas Bohl
Assistant Attorney General
Medicaid Fraud Control Unit

SUBJECT TO RULE 408

Re: San Juan Island EMS Investigation

Dear Nickolas:

I am writing in response to your September 26, 2019 letter that summarizes the Medicaid Fraud Control Unit's ("MFCU") initial investigation and proposed settlement. It's been over four years since your office opened this investigation and we've had no substantive discussions during that time. We look forward to finally starting a dialogue to resolve this matter.

An open and cooperative dialogue will also help me better understand your assertions. It's very difficult for me to fully respond to your assertions as you provided no detail to support your findings. In any case, it would appear that you have concluded that every flight from 2010 through 2016 was fraudulently billed.

We simply do not agree with your conclusions. We believe: (1) you have overestimated the number of claims that SJI EMS billed to the Medicaid program; (2) you have misjudged the medical necessity of the air ambulance flights; (3) the mental health patient flights were appropriate; and (4) intra-island flights were also appropriate.

SJI EMS Background. SJI EMS is owned and operated by San Juan Island Public Hospital District No. 1. SJI EMS provides necessary ground and marine emergency transport services to people located on San Juan Island and multiple remote surrounding islands. SJI EMS provided fixed-wing air ambulance services until April, 2016 when Island Air Ambulance ("IAA") took over the fixed-wing air ambulance service. Prior to 2016, SJI EMS provided medical services for air ambulance trips and IAA provided aviation.

The District also supports Peace Island Medical Center (the "Hospital"). The Hospital is a small 10 bed critical access hospital that provides limited services to patients. The Hospital does not have obstetrical, gynecologic, nor neonatal capabilities. It does not perform emergency surgery, provide definitive emergent cardiac care, provide involuntary inpatient mental health

treatment, and does not set complex fractures. The Hospital maintained the lowest level trauma designation during the time that SJI EMS provided air ambulance services. As a result, you should expect that most, if not all, emergency medical conditions with any complexity and labor and delivery will require a transfer to a larger hospital.

Transportation of emergency patients by air ambulance service was directed by medical control which consisted of the Washington Department of Health designated county medical program director and Hospital board certified emergency department specialists. These providers decided if air ambulance transportation was required after considering the patient's medical condition, the capabilities of the Hospital and risk related to delay in necessary treatment caused by ground transportation. No Medicaid patient was flown off the island unless a board certified emergency physician or medical control determined that the patient had an emergency medical condition that required transport via air ambulance.

The physicians, like all residents of the San Juan Islands, are aware that travel to the mainland for medical care must occur in almost all instances by ferry or air. The ferry, even if timing was perfect, requires at least an hour and a half trip to Anacortes. The ferries are often delayed or even cancelled due to weather. Ferry wait times, which can be significant and in some instances overnight, were also considered when choosing the appropriate mode of transportation. In most instances, the patient would be at the receiving hospital via air ambulance before the ferry would leave Friday Harbor. After disembarking the ferry, the subsequent ambulance ride to the nearest appropriate hospital with the capacity to accept the patient would add time to the trip. These factors favored air ambulance transportation in nearly all emergent situations.

Air Ambulance Reimbursement. Washington Medicaid pays for air ambulance services when: (a) the necessary medical treatment is not available locally, or the client's point of pick up is not accessible by ground ambulance; (b) the client's destination is an acute care hospital; and (c) the client's physical/medical condition requires immediate and rapid ambulance transportation that cannot be provided by ground ambulance. WAC 182-546-0700. Medicaid does not provide any further guidance on the conditions or time frames that would justify air ambulance transport.

Medicare provides the necessary guidance. Medicare will consider air transportation to be appropriate when it would take a ground ambulance 30-60 minutes or more to transport a beneficiary whose medical condition at the time of pick-up required immediate and rapid

transport due to the nature and/or severity of the beneficiary's illness/injury. Medicare BPM Chapter 10, 10.4.3 - Time Needed for Ground Transport (Rev. 1, 10-01-03). Medicare also identifies situations where air ambulance is deemed appropriate including, accident, acute illness, trauma, or a broken bone that has not been set. Providers often supplement Medicaid's guidance with guidance from other payors including Medicare when not contradicted. This helps ensure uniform treatment of patients with emergency needs.

Applying these guidelines means that air ambulance transport of nearly every patient on one of the islands served by SJI EMS with an emergency medical condition that requires rapid ambulance transport due to trauma, acute illness, broken bone, or accident, is justified. Given the location, the only true issue when deciding if air ambulance is appropriate should be whether the patient's emergency condition was such that it required immediate and rapid transport. This is a medical decision.

MFCU would need to provide expert testimony to support its conclusion that the transport was not medically appropriate. Even if it prevailed in a number of these cases, a bonafide medical disagreement is the basis for an overpayment and refund, not fraud and the resulting penalties. This is especially true given that the SJI EMS transported patients only after at least one, and often two, physician(s) board certified in emergency medicine deemed the transport by air ambulance medically necessary.

<u>Volume of Claims</u>. We believe that MFCU has over estimated the number of flights and claims submitted for Medicaid air ambulance services provided by SJI EMS. MFCU alleges that SJI EMS submitted over 414 improper Washington Medicaid claims for fixed-wing air ambulance flights. Our records show that SJI EMS flew approximately 226 Medicaid patients via air ambulance from January 1, 2010 through April 2016, not the 414 that you claim. Washington Medicaid reimbursed SJI EMS approximately $168,000 for these 226 flights. This averages out to approximately 32 flights and $24,000 in reimbursement from the Medicaid program per year. The average reimbursement per flight was $750 during this period. The average cost to SJI EMS was over $3500 per flight.

SJI EMS lost nearly $3000 per flight. SJI EMS simply had no financial incentive to fly Medicaid patients via air ambulance. SJI EMS was solely driven by the need to ensure that the patients received necessary treatment in a timely manner and that no patient's condition was put at risk due to a delay in transportation to the appropriate hospital.

ALS Ambulance. We reviewed the record of each Washington Medicaid air ambulance transport provided by SJI EMS from January 1, 2010 through 2015 and determined that ALS coding was appropriate. You allege that you identified over 200 instances where SJI EMS coded the services as ALS but the patient file supported only BLS. You justify your conclusion by claiming that other EMS agencies coded the service as BLS when they transferred the patient from the landing site to the receiving hospital. We are not surprised that other EMS agencies would bill the service as BLS. SJI EMS has a long-standing understanding with other agencies that they need only provide BLS level transportation as one of the SJI EMS flight nurses or paramedics would accompany the patient from the airport to the receiving hospital. In that instance, the other EMS agency would not need to take one of their higher level ambulances out of circulation for the transport and would bill the transport as BLS. This is standard practice in the industry.

Inter-Hospital Transports. You claim to have identified over 100 claims involving inter-hospital transports that were not appropriate. You seem to have concluded that these transports from the Hospital to another higher level hospital were simply for convenience and not an appropriate emergency medical transfer.

All the Medicaid patients that were transferred from the Hospital and flown to another hospital came to the Hospital's emergency room for treatment of an emergency medical condition. They were not patients admitted to the Hospital, stabilized and then transferred for convenience. The medical condition of these patients generally involved: 1. Active labor; 2. Cardiac condition; 3. Internal bleeding; 4. Trauma/fracture; 5. Overdose; 6. Psychiatric event with harm to self or others; 7. Gastric or Respiratory distress; or 8. Severe pain. Each of these conditions requires immediate treatment or stabilization to minimize further harm.

You must also consider the limited capabilities of the Hospital. The Hospital under EMTALA must treat and stabilize an emergency medical condition. If, however, the Hospital does not have the capability to treat the patient's emergency medical condition, the Hospital is required to transfer the patient to a hospital that has the capacity and capability to treat the patient. Given the Hospital's small size and limited capabilities, almost all cases that involve trauma or complexity of any nature, require a transfer. Once the provider makes the decision that a higher level of care is needed, the emergency department staff contacts other hospitals for potential transfer. The patient is then transported to the closest Hospital with the capacity to treat the patient. The location of the receiving hospital and patient's condition were considered when determining whether land or air ambulance was appropriate. Again, considering that even

in the best circumstances a transfer by land and ferry takes over an hour and a half, the physicians more often than not decided that air transport was appropriate for the patient. When travel is by air, the mileage between the closest hospitals in Anacortes, Mt. Vernon and Bellingham is relatively equivalent. As a result the difference in Medicaid reimbursement is minimal.

Authorization of Mental Health Patient Transports. You allege that SJI EMS transported 34 Medicaid patients without authorization from the County Designated Mental Health Professional ("CDMHP"), now referred to as Designated Crisis Responders. In some instances, patients may have been transported without CDMHP authorization for purposes of stabilizing their emergent medical rather than mental health condition. These transports are medical transports and are appropriate without CDMHP authorization.

In all other instances, SJI EMS believes that CDMHP approval was obtained. The receiving facility would not have accepted the patient without CDMHP approval and the patient would not have been transferred without the receiving hospital agreeing to accept the patient. We have reviewed our records, worked with other transporting ambulance providers and the CDMHPs to identify records authorizing transfers. We have been informed that the only copy of the CDMHP authorization, including the transfer to the receiving hospital, will be in the patient's record at the receiving hospital. We do not have access to those records, but your office can obtain the records.

Intra-Island Flights. You state that MFCU has identified 80 intra-island flights that were not verified by the Department. These flights are from other islands in the San Juans to Friday Harbor. Our records identified only a handful of these flights. Furthermore, we are not aware of the basis for your conclusion that these flights were not verified or appropriate.

Medicaid Program Integrity Audit. Washington Medicaid's Program Integrity Section ("Program Integrity") audited claims paid to SJI EMS from February 1, 2012 through January 31, 2015 including fixed-wing air ambulance claims. Program Integrity reviewed 376 unique client records. SJI EMS finds it interesting that Program Integrity identified only 38 claims as potentially problematic with an estimated overpayment of $7,558.34, which has been refunded. SJI EMS does not understand how your office and Program Integrity, who are the experts on Medicaid claims, can reach such different conclusions.

Finally, your office, based on conclusions reached before any significant investigation, directed the Medicaid program to withhold payments for air ambulance services. SJI EMS

continued to provide the medically necessary air ambulance services to Medicaid patients as directed by Medical Control and Emergency Department providers without payment. It is my understanding that approximately $40,000 in claims have been withheld by Medicaid.

As discussed above, SJI EMS disagrees with nearly all of your assertions. SJI EMS believes that the air ambulance flights it billed to the Washington Medicaid program were appropriate. We look forward to beginning a dialogue so that your office and SJI EMS can put this time consuming and unnecessary process behind us.

Sincerely,

Jim J. Fredman