Determination of Closest Appropriate Destination Facility for Air and Critical Care Medical Transportation

Position Statement of the Air Medical Physician Association

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BACKGROUND

The determination of the closest appropriate destination for air or critical care medical transportation of both scene (primary missions) and interfacility transport (secondary missions) is a complex process. This life and death decision-making process is often done in adverse conditions, with limited information, and limited time. On-scene and hospital providers must act in a manner that protects the patient from further injury or medical deterioration and optimizes the patient's chances for survival. These providers are dispatched to perform these life saving services, usually without regard to their ability to get paid, and the patient's insurance status is usually not known.[1] Selection of the appropriate destination to meet the patient's acute needs is one of several critical decisions that must be made in this complex patient care situation.

Emergency air or critical care medical transport are requested by trained, authorized, individuals including physicians, EMS personnel, fire service personnel, law enforcement personnel, public service agencies, other transport agencies, and disaster management officials.[i] These officials are trained to request emergency medical transport according to federal, state, and local policies that are typically approved by physician medical directors responsible for medical oversight of the emergency medical system. In most cases, the requesting individuals determine medical necessity and destination facility at the time transport is requested and then the aircraft or vehicle is dispatched. Their decision may be based on factors such as a local destination policy (including considerations of availability of specific care capabilities, patient stability and the patient's destination request), regional referral networks, local or regional hospital divert status, local knowledge, weather, and a potential destination's ability to land an aircraft. In the event of multiple injured patients, the on-scene commander may also decide to split patients between several more distant facilities so as not to overload any one hospital. This decision may, in the long run, better utilize the available community resources and improve overall patient care.

For interfacility transport, the sending physician is responsible for making the appropriate destination decision. These decisions may or may not be made in consultation with the transport provider's medical director (or his/her designee), the transport team, and/or the receiving physician. The Emergency Medical Treatment and Active Labor Act (EMTALA) and professional liability principles make the sending physician ultimately responsible for assuring that the receiving hospital is capable of caring for the actual and potential needs of the patient, and that the type of vehicle (ground vs. air) as well as the level of care provided during the transport is appropriate.

The determination of the closest capable facility by the transferring physician is often a complex process that may include factors not obvious to the ambulance crew. These factors may include the real time availability of critical care beds in regional hospitals, the ability to locate a receiving physician specialist and, of course, the nature of the individual patient's medical condition and predicted likelihood of needing certain treatment modalities (e.g. if the sending physician determines that the patient requires a cardiac workup and has a high probability of requiring surgical intervention, they may opt not to send the patient to the closest hospital with a cardiologist and a catheterization lab, in favor of a full service cardiac center capable of surgical intervention). Rarely is the consideration of all factors in each case documented by the sending physician, much less discussed with the medical transport crew.

Patient requests occasionally do factor in and can usually be identified, but rarely do sending physicians inform transferred patients that they may be responsible for additional transport expenses.[ii] CMS (The Center for Medicare and Medicaid Services) recognizes that an advanced beneficiary notification (ABN)

[1] EMTALA 42 usc 1395dd

in emergency situations is neither appropriate nor necessary in order to bill for non-covered loaded miles for transport beyond the closer destination, because emergency patients are by definition under duress. In non-emergency situations, however, the ABN is needed when the transporting entity has a reason to believe that Medicare is likely to deny payment on the basis that the transport could be done safely and effectively by ground ambulance transportation.[2] Emergency situations are where managing patient requests for transport to a further facility is problematic.

For scene transports, once air medical transport has been requested, local EMS protocols and the standard of care generally require transport to a pre-designated destination (e.g. a trauma center) that may or may not necessarily be the closest facility with capability to care for the patient. It is also important to understand that these decisions are made prospectively by policy, and a retrospective judgment that a patient could have been cared for at a lesser capable facility is not relevant to the decision-making required at the time of the transport. In many areas of the country however, prehospital medical oversight is lacking and destination policies have not been created. In these and even in some better developed areas air medical crews are put in the position of having to select the closest appropriate facility based on their knowledge and experience of the health care system.

Given that physicians, transport providers, and prehospital EMS personnel use their best medical judgment in selecting the appropriate destination facility, and given that patients are usually not in a position to evaluate or second guess that decision, it is unfair and inappropriate to deny reimbursement based on a retrospective determination on what was the closest appropriate facility in these circumstances. Transport providers provide their services in good faith reliance on the assumption that the requester's destination choice is appropriate. Transport service utilization and appropriate destination selection can and should be retrospectively evaluated as part of a continuous quality improvement process. The process can identify patterns of inappropriate utilization and/or destination selection so that authorized requesters can be appropriately educated and thus improve prospective decision making. Transport providers do have an obligation to identify non-emergency transports done for the convenience of the patient, physician, or hospital. Standardized procedures for addressing these patients' obligation to pay for the non-covered benefit portion of the transport should be in place.

The all too common practice of Medicare Contractors reliance on references such as "The Hospital Blue Book" to retrospectively determine the capability of a specific hospital is not appropriate. This practice has lead to a significant number of denials that are subsequently allowed only after great expense and significant delays in payment to the provider. The Hospital Blue Book lists contact information on all hospitals in the United States and includes a list of abbreviated hospital capabilities that is not specific enough to determine the capability within a given service. Critical information is often missing or inaccurate. For example, a rural hospital may claim that they have a cardiac service, when in actuality it is a sole cardiologist who runs an office out of the hospital 1 day every 2 weeks.[iii] Additionally, the national epidemic of bed delays and lack of specialist coverage makes "hospital capability" a moving target that changes from moment to moment rather than from year to year. Local authorities are in the best position to track these fluctuations and make decisions based on the needs and resource availabilities of the moment. Resources such as the Hospital Blue Book do not include information such as distance to the closest appropriate helipad or airport (possibly necessitating another prolonged ground transport leg). In the fixed wing transport arena, where closer facility denials are common, it is often the availability of airports, ground transport availability to the hospital, and complications of local weather that dictate when a patient may not be taken to the closest facility. CMS inappropriately levies the entire burden of closer facility determination on the medical transport provider. The burden of documentation of justification for transport to a further facility is onerous in the circumstances surrounding an emergency medical transport, especially considering that the medical transport provider is not usually the destination selection decision maker.

POSITION STATEMENT

For emergency interfacility medical transport, the closest appropriate destination facility capable of caring for the potential needs of a given patient is determined by the sending physician, based on his or her best medical judgment as well as the condition of the patient and a myriad of other factors operative at the time of the request for transport.

[2] CMS FAQ #1828

Although useful for the medical transport team to understand, these contributing factors may not be evident to the team. Even if they are known, the team can seldom significantly impact the destination selection once it has been made by the legally responsible transferring physician.

Determination of closest appropriate destination for emergency scene medical transport is made by the requesting authorized prehospital provider based on applicable policy, the best medical judgment of the requester at the time of the request for transport (often early in the patient encounter), the condition of the patient, and other information available at, and particular to, the time of the request for emergency transport.

AMPA and AAMS believe that encouraging a medical transport provider to attempt to influence transport destination at the time of either emergency scene or interfacility transport is burdensome, at times inappropriate, but may be required in time-critical situations when they are the highest level of expertise available. The position of AMPA and AAMS is that the ultimate determination of the closest appropriate facility is derived from well thought out destination policies or by an experienced sending physician and only when necessary by the air medical crew.

AMPA and AAMS oppose the use of these reference books, and encourage the development and use of references that are specifically designed to capture hospital capability as it applies to medical transportation for the purpose of generating denials for closer appropriate facility.

AMPA and AAMS support educating and encouraging referring physicians to document the reasons behind their decisions regarding the destination facility on a Certification of Medical Necessity (CMN) form.

AMPA and AAMS support the use of retrospective reviews of medical transports as a method for identifying patterns of inappropriate selection of more distant facilities. AMPA and AAMS support that the information obtained in these reviews must be appropriately transmitted to the authorized requesting entities with the goal of improving selection of more appropriate closer facilities.

References:

[i] CMS Manual System. Pub 100-08 Medicare Program Transmittal 93 January 14th, 2005./ Change request 3571. Department of Health and Human Services, Centers for Medicare and Medicaid Services.

[ii] Personal Experience of authors (two board certified Emergency Physicians and a Medicare denial management expert) on sending MD behaviors

[iii] Personal experience of authors Kevin Hutton, MD and William Bryant

Acknowledgements:

This position paper was authored by the Position Paper Task Force of the Air Medical Physician Association (AMPA) and was authored by Kevin Hutton, MD (Chairman and AMPA Board Member) Laurie Romig, MD (AMPA Board Member and Medical Director of Pinellas County EMS, and LifeNet Medical Transport, Bartow Florida), and William Bryant MPH (President, Sierra Health Consulting, Dallas, Texas).