

Testimony of Barry J. Wojtcuk, Vice President  
American Ambulance Service, Inc.

[Proposed S.B. No. 253](#) AN ACT CONCERNING PAYMENT TO AN AMBULANCE SERVICE

Public Health Committee, Wednesday, March 11, 2015

Senator Gerratana, Representative Ritter and Distinguished Members of the Committee.

My name is Barry J. Wojtcuk. I am a Vice President of American Ambulance Service, Inc. I would like to offer testimony in **opposition** to S.B. No. 253.

I have managed the billing for American Ambulance Service, Inc. for more than 10 years and have an understanding of the intricacies of this portion of the provision of emergency medical services, an already complex and involved service.

Let me start by saying we would much prefer to bill any insurance directly.

Typically, an ambulance request for service is received, screened, resources are committed to handling the request, and available information, if any, is received and the processing has started. Once the call is completed, the information is reviewed, and again the available information is processed and verified, or the investigation period begins. **IF** insurance information is available and able to be verified, the insurance is then billed. If no information is available, and attempts to obtain it from the facility that had patient involvement are unsuccessful, attempts to contact the patient are made, and if successful, insurance is billed. If not, as a last resort, a patient is billed in an attempt to either get information or payment.

There are situations where it is generally known that the insurance will not pay (perhaps to a location that is not the closest accepting facility, or patient convenience, or in the case of Medicare even to Doctor's offices), and the patient is responsible for those services. We often do bill for a denial in those cases, but that can negatively impact cash flow, and possibly incorrect reasons for denial or even misleading instructions regarding patient responsibility.

There are instances where it is clear an ambulance is not required and the patient or family wants that level of services (piece of mind, or for patient comfort). This bill would put an unnecessary delay in payment for the service provided. While payment responsibility would not be disputed, this bill would mandate billing a payor, waiting for a denial, and then billing the party that had agreed to the responsibility prior to the service being received. This could add a substantial delay billing the willing responsible party.

We encounter many patients that are not from the local area and after an incident and initial treatment and stabilization, wish to be transported closer to their residence for additional treatment. If that patient is transported out of the local area, the chance of collecting payment decreases once the transportation is provided, as not all insurers will cover transportations to more distant locales. This proposed bill could have the affect of not allowing even partial billing (the portion that would not be covered for any of a

number of reasons – such as “excess mileage”) until the transportation (and costs associated with it) were provided, and then collections often become difficult with “out of area” residents.

We encounter some instances where non-contracted insurers are billed, and the services are covered, and payments are made, but to the patient, not the provider of services. If the patient has received a bill, called with insurance information, they are made aware a payment may come to them to pay the service, expediting payment processing. Connecticut needs a strong “direct payment” law (where the provider of services is paid directly).

Many times, information regarding insurance coverage is not available or incomplete or inaccurate at the time of emergency service. Insurance cards are often not available. A patient may assume the information has been provided and is complete and accurate; billing a patient to get them to call in their information is the only tool available to provide this information.

We do experience instances in auto related accidents that claims are NOT filed by the parties involved. Seeking information from the insurance companies even when known, is often an exercise in futility, as if no claim has been filed, they are unwilling to discuss medical coverage on those policies.

Timely filing of claims also can surface as a result of a delay in obtaining insurance information, which is obtained only after the patient has received a bill and calls in that information. It is not uncommon to have information requests get ignored for periods of time by the patient as they do not want to file a claim, until they receive a bill.

Existing Connecticut Statute, C.G.S. 19a-193a “Liability for emergency medical treatment services or transportation services provided by an ambulance service or paramedic intercept service”, assigns liability for payment to the person receiving treatment/transport.

Billing insurance providers for claims of their customers is our preferred practice. People buy insurance to provide for these services. Unfortunately, where ambulance services are often conducted without an ability to prescreen, the risks of non payment are high, and that adversely affects everyone. In this time of budgetary constraint and reductions, further impeding the cash flow of ambulance services may have the undesired side affect of restricting resources and the provision of some services. A time delay in having to wait to receive a denial before be able to bill a patient could impose a cash flow to a point that would leave no option other than service reductions. I am opposed to this proposed bill, SB253 and urge you to **defeat this proposal.**

Thank You for your consideration.