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Medicare Payments for Ambulance Transports

Key Words

SE0724, Ambulance, transports

Provider Types Affected

Providers, physicians, and suppliers who bill Medicare Fiscal Intermediaries (FIs), carriers, and A/B Medicare Administrative Contractors (MACs) for ambulance services or who initiate ambulance transports for their Medicare patients

Key Points

- According to a recent study conducted by the Office of the Inspector General (OIG) ("*Medicare Payments for Ambulance Transports"*), during calendar year 2002, twenty-five percent of ambulance transports did not meet Medicare's program requirements.
- This resulted in an estimated $402 million of improper payments. In two out of three cases, third-party providers (most likely not the patient) who requested transports may not have been aware of Medicare's requirements for ambulance transports.
- Some key provisions of the OIG Report are as follows:

  Medicare Coverage of Ambulance Transports

  - When evaluating coverage of ambulance transport services, two separate questions are considered:
    - At the time of the service, would the patient's health be jeopardized if an ambulance service was not used?
      - If so, Medicare will cover the ambulance service whether it is emergency or non-emergency use of the transport.
      - If not, the Centers for Medicare & Medicaid Services (CMS) will deny the transport claim. Additionally, Medicare does not cover non-ambulance transports.

- Once coverage requirements are met, Medicare asks the following question: What level of service (determined by medical necessity) is appropriate with regard to the diagnosis and treatment of the patient's illness or injury?
  - If the incorrect level of service is billed and subsequently denied, Medicare will usually reimburse at a lower rate, reflecting the lower level of services judged appropriate.
  - Levels of ambulance service are differentiated by the equipment and supplies carried in the transport and by the qualifications and training of the crew. They include:
    - Basic life support
    - Advanced life support
    - Specialty care transport
    - Air transport – fixed wing and rotary wing.

Emergency Ambulance Transport

- An emergency transport is one that is provided after the sudden onset of a medical condition that manifests itself with acute symptoms of such severity that the absence of immediate medical attention could reasonably be expected to:
  - Place the patient's health in serious jeopardy;
  - Result in serious impairment of bodily functions; or
  - Result in serious dysfunction of any bodily organ.
- Symptoms or conditions that may warrant an emergency ambulance transport include, but are not limited to:
  - Severe pain or hemorrhage;
  - Unconsciousness or shock;
  - Injuries requiring immobilization of the patient;
  - Patient needs to be restrained to keep from hurting himself or others;
  - Patient requires oxygen or other skilled medical treatment during transportation; and
  - Suspicion that the patient is experiencing a stroke or myocardial infarction. See Chapter 15 of the *Medicare Claims Processing Manual* (Pub. 100-4) and Chapter 10 of the *Medicare Benefit Policy Manual (*Pub. 100-2) at *http://www.cms.hhs.gov/Manuals/IOM/list.asp* on the CMS website.

Non-Emergency Ambulance Transports

- Non-emergency ambulance transportation is appropriate when:
  - A patient who is bed-confined, and his/her condition is such that other methods of transportation are contraindicated; or

  - The patient's condition, regardless of bed-confinement, is such that transportation by ambulance is medically required (patient poses a danger to himself/herself or to others).

- Bed-confinement alone is neither sufficient nor necessary to determine the coverage for Medicare benefits. To be considered bed-confined, the patient must be unable to do all three of the following:
  - Get up from bed without assistance;
  - Ambulate; and
  - Sit in a chair or wheelchair.

Documentation Requirements

- Ambulance suppliers are not required to submit documentation in addition to the uniform Medicare billing form CMS-1500 that is submitted by independent ambulance suppliers to Medicare carriers or A/B MACs, or the UB-04 (form CMS-1450) billed to FIs or A/B MACs by ambulance suppliers that are owned by or affiliated with a Medicare Part A provider such as a hospital.
- Ambulance suppliers are required to retain documentation that contains information about the personnel involved in the transport and the patient's condition. They must make it available to Medicare FIs, carriers, and A/B MACs upon request.
- Ambulance suppliers are also required to obtain a Physician Certification Statement (PCS) for non-emergency transports in some circumstances (see 42 CFR 410.40 link in the Important Links section). The PCS states the reason(s) a patient requires non-emergency transportation by ambulance. It is effective for 60 days from the date it is signed.
- The PCS, or proof of the supplier's attempt to obtain it, is required within 48 hours after provision of the ambulance service. The "trip ticket" is documentation used in emergency transports and contains the date, mileage, crew, origin, destination, type and level of ambulance service provided, patient condition, the type of service, and supplies provided to the patient while in transport.

How to Avoid Improper Billing

- Suppliers should:
  - Be sure that coverage criteria and level of service criteria for ambulance transport are met and that it is backed up with the appropriate documentation.
  - Refer to Change Request (CR) 5442 (*"Ambulance Fee Schedule – Medical Conditions List – Manualization"*), which contains an educational guideline that was developed to assist ambulance providers and suppliers communicate the patient's condition to Medicare FIs, carriers, and A/B MACs as reported by the dispatch center and as observed by the ambulance crew. The link to this CR is provided in the Important Links section below.

- Maintain documentation that will help to determine whether ambulance transports meet program requirements, when Medicare FIs, carriers, and A/B MACs conduct medical reviews.
- Be sure to send complete documentation when requested by the FI, carrier, or A/B MAC. Generally, coverage errors for emergency transports were due to documentation discrepancies between the ambulance supplier and the third-party provider (e.g., emergency room records).
- Note whether their FI, carrier, or A/B MAC has implemented origin or destination modifiers, such as for a dialysis facility and for non-emergency transports to and from a hospital, nursing home, or physician's office. Be sure to include these modifiers (if available) when billing for ambulance services. They will help the FI, carrier, or A/B MAC to determine, through a prepayment edit process, whether the coverage and/or level of service for ambulance use is correct.

Note: Liability for overpayment resulting from a denied ambulance transport claim depends on the type of denial. A denial due to coverage reasons (such as when other forms of transportation are not contraindicated) may result in a liability to the Medicare beneficiary. Claims denied due to level of service requirements are often down-coded to a lower level of ambulance service. In this case, the ambulance supplier is generally liable in the event of an overpayment.

Important Links

The related MLN Matters article can be found at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0724.pdf* on the CMS website

SE0724 is based on the January 2006 U.S. Department of Health and Human Services' OIG report, *Medicare Payments for Ambulance Transports*, which is located at *http://oig.hhs.gov/oei/reports/oei-05-02-00590.pdf* on the OIG website.

CR5442, dated February 23, 2007 ("*Ambulance Fee Schedule – Medical Conditions List – Manualization Revisions"),* is located at *http://www.cms.hhs.gov/transmittals/downloads/R1185CP.pdf* on the CMS website.

The regulations at 42 CFR 410.40(d)(2) and (3) state the circumstances when a PCS is required and may be found at *http://www.cms.hhs.gov/AmbulanceFeeSchedule/downloads/cfr410_40.pdf* on the CMS website.

If providers have any questions, they may contact their Medicare contractor at their toll-free number, which may be found at *http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip* on the CMS website.