

Provider Compliance Tips for Ambulance Services



What's Changed?

Updated the improper payment rate for ambulance services for the 2020 reporting period.

You'll find substantive content updates in dark red font.

Provider Types Affected

Ambulance Suppliers

Introduction

This publication is meant to educate providers on how to successfully submit Ambulance Services claims.

Background

The Medicare Fee-for-Service (FFS) improper payment rate for ambulance services for the 2020 reporting period is 7.2%, a projected improper payment amount of \$349 million.

Medicare covers ambulance services via ground transportation, as well as air ambulance services, including fixed wing and rotary wing ambulance services, only if they're provided to a patient whose medical condition is such that other means of transportation are contraindicated. The patient's condition requires both the ambulance transportation and the level of service provided for the billed service to be considered medically necessary.

Reasons for Denial for Ambulance Services

For the 2020 reporting period, insufficient documentation accounted for 62.5% of improper payments for ambulance services. Additional types of errors for ambulance services in the 2020 reporting period were medical necessity (23.5%) and incorrect coding (10.8%).

How to Prevent Denials of Emergency Ambulance Services

We, CMS, require the following conditions for the patient to be eligible for Medicare ambulance services:

- An approved supplier of ambulance services transported the patient to and or from a proper location
- The patient suffered from an illness or injury, which contraindicated transportation by other means, and medically required ambulance services.

- We note that bed confinement isn't the sole criterion in determining the medical necessity of ambulance transportation. We consider it one factor in medical necessity determinations.

We give the following scenarios as instances in which Medicare Administrative Contractors (MACs) would presume medical necessity for both emergent and non-emergent ambulance services:

- You, the health care professional transported the patient in an emergency, for example, as a result of an accident, injury, or acute illness
- You needed to restrain the patient to prevent injury to the patient or others
- The patient required oxygen or other emergency treatment during transport to the nearest proper facility
- The patient was unconscious or in shock
- The patient showed signs and symptoms of acute respiratory distress or cardiac distress, such as shortness of breath or chest pain
- The patient showed signs and symptoms that show the possibility of acute stroke
- The patient needed to stay immobile because of a fracture that hadn't been set or the possibility of a fracture
- The patient experienced severe hemorrhage
- The patient could be moved only by stretcher
- The patient was bed-confined before and after the ambulance trip

How to Prevent Denials of Non-Emergent Ambulance Services

Nonemergency transportation by ambulance is proper if **either**:

- The patient is bed-confined, and it's documented that the patient's condition is such that other methods of transportation are contraindicated; **or**,
- If their medical condition, regardless of bed confinement, is such that transportation by ambulance is medically required.

As a result, bed confinement **isn't** the sole criterion in determining the medical necessity of ambulance transportation. We consider bed confinement as 1 factor in medical necessity determinations. For a patient to be considered bed-confined, the following criteria must be met:

- The patient can't get up from bed without help
- The patient can't ambulate
- The patient can't sit in a chair or wheelchair

Special rules discuss nonemergency ambulance services that are either unscheduled or that are scheduled on a nonrepetitive basis. Medicare covers medically necessary nonemergency ambulance services that are either unscheduled or that are scheduled on a nonrepetitive basis under 1 of the following circumstances:

- For a resident of a facility who's under the care of a physician, if the ambulance provider or supplier obtains a physician certification statement within 48 hours after the transport.
- For a patient residing at home or in a facility who isn't under the direct care of a physician. We don't require a physician certification.
- If you the ambulance provider or supplier can't obtain a signed physician certification statement from the patient's attending physician, they must obtain a non-physician certification statement.
- If you can't obtain the required physician or non-physician certification statement within 21 calendar days

following the date of the service, you must document its attempts to obtain the requested certification and may then send the claim.

- In all cases, the provider or supplier must keep documentation on file and, when asked, present it to the contractor. The presence of the physician or non-physician certification statement or signed return receipt doesn't alone show that the ambulance transport was medically necessary. We require all other program criteria be met for Medicare to make payment.

Signature Requirements for All Ambulance Services

Medicare requires the signature of the patient, or that of a person authorized to sign the claim form on behalf of the patient for you to send a claim. If the patient can't sign because of a mental or physical condition, the following individuals may sign the claim form on behalf of the patient:

- Patient's legal guardian
- A relative or other person who receives social security or other governmental benefits on behalf of the patient
- A relative or other person who arranges for the patient's treatment or exercises other responsibility for their affairs
- A representative of an agency or institution that didn't provide the services for which claims payment, but provided other care, services or help to the patient
- A representative of the provider or of the nonparticipation hospital claiming payment for services it has provided, if the provider or nonparticipating hospital can't have the claim signed under [42 CFR 424.36\(b\) \(1-4\)](#)
- Your representative who's present during an emergency and or nonemergency transport, if you keep certain documentation in its records for at least 4 years from the date of service. You (or your employee) can't request payment for services provided except under circumstances fully documented to show that the patient can't sign and that there's no other person who could sign.

Resources

- [2020 Medicare Fee-for-Service Supplemental Improper Payment Data](#)
- [Code of Federal Regulations 42 CFR 410.40](#)
- [Medicare Benefit Policy Manual, Chapter 10](#)

This fact sheet is based on Non-Public Health Emergency rules. [Contact your MAC](#) if this service or supply is impacted by The Coronavirus Aid, Relief, and Economic Security (CARES) Act, published March 2020, which deals with Medicare flexibilities related to the COVID-19 crisis.

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