Emergency Ambulance Services: Regulations and Required Documentation

Railroad Retirement Board
Specialty Medicare Administrative Contractor (RRB SMAC)
Provider Outreach and Education

December 12, 2017
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Disclaimer

• The information provided in this presentation was current as of 12/12/2017. Any changes or new information superseding the information in this presentation will be provided in articles and resources with publication dates after 12/12/2017 posted on our website at www.PalmettoGBA.com/RR. Medicare policy changes frequently so links to the source documents have been provided within the document for your reference.

• This presentation was prepared as a tool to assist providers and is not intended to grant rights or impose obligations. Although every reasonable effort has been made to assure the accuracy of the information within these pages, the ultimate responsibility for the correct submission of claims and response to any remittance advice lies with the provider of services.

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• This publication is a general summary that explains certain aspects of the Medicare Program, but is not a legal document. The official Medicare Program provisions are contained in the relevant laws, regulations, and rulings.
# Frequently Used Acronyms

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
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<tbody>
<tr>
<td>ADR</td>
<td>Additional Documentation Request</td>
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<tr>
<td>ALS</td>
<td>Advanced Life Support</td>
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<tr>
<td>BLS</td>
<td>Basic Life Support</td>
</tr>
<tr>
<td>CERT</td>
<td>Comprehensive Error Rate Testing</td>
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<tr>
<td>CFR</td>
<td>Code of Federal Regulations</td>
</tr>
<tr>
<td>CMS</td>
<td>Centers for Medicare &amp; Medicaid Services</td>
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<tr>
<td>CR</td>
<td>Change Request</td>
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<tr>
<td>HCPCS</td>
<td>Healthcare Common Procedure Coding System</td>
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<tr>
<td>IOM</td>
<td>Internet Only Manual</td>
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<tr>
<td>MLN</td>
<td>Medicare Learning Network</td>
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<tr>
<td>MR</td>
<td>Medical Review</td>
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<tr>
<td>RRB OIG</td>
<td>Railroad Board Office of Inspector General</td>
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<tr>
<td>PCS</td>
<td>Physician Certification Statement</td>
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<tr>
<td>POP</td>
<td>Point of Pick-up</td>
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Objectives

At the end of this presentation you will be familiar with:

• The basic Medicare benefit policy relating to ALS emergency ground ambulance transports (HCPCS Code A0427)
• Medicare documentation guidelines and the required elements to support each transport
• Frequent ambulance claim denial reasons
• How to avoid documentation errors
Agenda

• Medicare Ambulance Benefit Policy
• Standards for All Transports
• Medical Review – Additional Documentation Requests
• Documentation
• Medical Review Results
• Resources
• Questions and Answers
Medicare Ambulance Benefit Policy
A Transport Benefit

Medicare’s benefit for ambulance services is a “transport” benefit – without a transport to a Medicare-covered destination, there is no Medicare billable service.
Medicare Ambulance Benefit

Medicare Part B ambulance coverage is met only in the following conditions:

• The transportation is not covered under Part A
• The ambulance supplier meets all applicable vehicle, staffing, billing, and reporting requirements
• The services are medically necessary based on the patient’s condition at the time of transport
• A definite transport of the beneficiary has occurred
• The beneficiary is transported to a Medicare-approved destination
Technical Denials Explained

The patient’s transport must be contraindicated by other means:

When means of transportation other than ambulance can be used without endangering the individual's health, whether or not such other transportation is actually available, no payment may be made for ambulance services.
“Not for Fred Today”: Selecting the Correct Level of Service

• The ambulance service meets the criteria of covered Medicare service

• Once the benefit is established, the level of service billed must be supported by the documentation

CMS expresses this as “Not for Fred today” – Meaning the patient needed ambulance service, but not at the level billed.
Standards for Emergency Transports
Vehicle Equipment

Ambulance equipment includes:

• Oxygen and accessories
• Stretcher
• Lifesaving emergency medical equipment
• Linens and medical supplies
• Emergency warning lights, sirens, and telecommunication equipment required by state or local law:
  - Wireless telephone
  - Two-way voice radio
Staffing Requirements

The level of service supplied is supported by the credentials of the crew members.

• BLS - two crew members, at least one:
  - EMT - Basic (EMT-B)
• ALS – two crew members, at least one:
  - EMT - Intermediate (EMT-I), or
  - EMT - Paramedic (EMT-P)
Ambulance Staff/Vehicle Regulation Changes

As a result of CR 9761, ‘Ambulance Staffing Requirements’, effective January 1, 2017, revisions were made to ambulance vehicle/staffing requirements. The changes are:

• Advanced Life Support vehicles must be staffed by at least two people who meet the requirements of state and local laws where the services are furnished

• At least one of the two crew members must be a certified EMT-Intermediate or an EMT-Paramedic
Emergency Transport Levels

• Ground ambulance transport:
  – A0429 BLS Emergency
  – A0427 ALS1- Emergency
  – A0433 ALS2 (3 separate medications by IV)
• “Ground” refers to both land and water transportation
ALS 1 Emergency (HCPCS A0427)

- Advanced Life Support, Level 1 (ALS1) – Includes an ALS assessment or at least one ALS intervention and provision of medically necessary supplies and services
- ALS Intervention(s) must be performed by an emergency medical technician who is an:
  - EMT-Intermediate
  - EMT-Paramedic
- Emergency-level transport is due to the patient condition requiring emergency transport
## Conditions Supporting an ALS Emergency Transport

### Examples of Conditions Supporting ALS Emergency Transport

- Transport as a result of an accident/injury with threat to life or body system (major burns, electrocution, near drowning, multiple fractures, suspected internal injuries, etc.)
- Severe hemorrhaging
- Unconscious/shock
- Acute respiratory distress/ dyspnea
- Abnormal cardiac rhythm/ chest pain/ cardiac arrest
- Stroke/ altered mental status/ seizures
- Severe pain with other symptoms (abdominal, headache, etc.)
- Anaphylaxis
ALS Response Resulting in BLS Transport

• Medicare will not pay all claims billed as an ALS level in areas that have “ALS Mandates”

• Medicare may allow a claim for an ALS-level response to a BLS-level patient when the dispatch protocols initially indicates an ALS emergency service

Example: ALS ambulance was sent due to reported patient condition. After arrival, an ALS assessment is performed and the patient condition supports a BLS transport
Emergency Transport Destinations

Medicare coverage requires the beneficiary’s transport be medically reasonable and necessary and to a Medicare-approved destination.

<table>
<thead>
<tr>
<th>HCPCS Modifier</th>
<th>Descriptions</th>
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<tbody>
<tr>
<td>H</td>
<td>Hospital</td>
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<tr>
<td></td>
<td>Note: This modifier must be submitted for a psychiatric facility located at a hospital</td>
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<tr>
<td>I</td>
<td>Site of transfer (e.g., airport or helicopter pad) between types of ambulance vehicles</td>
</tr>
<tr>
<td>X</td>
<td>(Destination code only) Intermediate stop at a physician’s office on the way to a hospital (includes HMO non-hospital facility, clinic, etc.)</td>
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Ground Transport Mileage

- Only local ambulance transportation is covered to the nearest appropriate facility.
- Exceptions for additional mileage require documentation.
- Only loaded mileage, when the patient is on board, may be billed.
Transport Beyond The Nearest Facility

Conditions that may prohibit transport to the nearest facility:

• Extreme weather (blizzard conditions, heavy fog, etc.)

• Extensive road construction

• Specialist/equipment not available at closest hospital (orthopedic surgeon; neurologist, etc.)

• Hospital on diversion (no beds, inclement weather, not accepting new patients, etc.)
No Transportation/Patient Refused Transport

• If a transport did not take place, the patient, rather than Medicare, is billed directly for services
  – If billing to Medicare, submit HCPCS A0998 along with the GY modifier
  – Document in the record “No Transport” or “Patient refused transport”

• An Advance Beneficiary Notice (ABN) is not required
**Beneficiary Death**

Medicare’s payment for services, in the circumstance of the beneficiary’s death, are outlined on this chart.

<table>
<thead>
<tr>
<th>Time of Death Pronouncement</th>
<th>Medicare Payment Determination</th>
</tr>
</thead>
<tbody>
<tr>
<td>Before dispatch.</td>
<td>None.</td>
</tr>
<tr>
<td>After dispatch, before beneficiary is loaded onboard ambulance (before or after arrival at the point-of-pickup).</td>
<td>The provider’s/supplier’s BLS base rate, no mileage or rural adjustment; use the QL modifier when submitting this type of claim.</td>
</tr>
<tr>
<td>After pickup, prior to or upon arrival at the receiving facility.</td>
<td>Medically necessary level of service furnished.</td>
</tr>
</tbody>
</table>
Multiple Patient Transport

**2 Patients to Same Destination Simultaneously**

- **Base Rate = 75%** of the payment allowance per Medicare beneficiary
- **Mileage = 50%** of total mileage per Medicare beneficiary

**3 or More Patients to Same Destination Simultaneously**

- **Base Rate = 60%** of payment allowance per Medicare beneficiary
- **Mileage = Single payment allowance prorated by number of patients aboard**

Modifier GM should be used to indicate transport of multiple patients
Remote Rescues

• Vehicle staff may need to assist in rescuing a patient from a remote scene if an injury occurs such as, rock climbing, snowmobiling, hiking, etc.

• No additional charge is allowed for extricating a patient or for any mileage traveled from “site of incident” to ambulance
Medical Review – Additional Documentation Requests
Current Ambulance Service Reviews

Railroad Medicare is currently conducting reviews of emergency ambulance services submitted for Emergency ALS1 Transport, HCPCS Code A0427
Additional Documentation Requests (ADR)

- Request for documents to support service
- Respond to ADR promptly within 45 days
- Medical Review will review responses within 30 days of receipt
- Do not send replacement/duplicate ADR responses
How to Respond to an ADR

• Provide documents listed on the ADR and any related supportive information

• Include a copy of the ADR letter

• If you don’t have the ADR letter, include a ‘Medical Review ADR Response Cover Sheet’ for each ADR letter/claim

• Ambulance checklist may help you ensure each required element is submitted
Required Documentation
Supporting Documentation

Documentation should support medical necessity for each transport. Elements to include are:

• Run sheet/ trip report
• Crew signatures and credentials
• Beneficiary or representative signature
# Documentation: Trip Report

## General Information
- Patient name
- Date and Time
- Point of Pick-up and Destination
- Reason for ambulance transport
- Loaded mileage

## Medical Information
- Signs/symptoms
- Assessment/ Exam
- Treatments
- Patient response
- Mode of transfer
- Mobility status
- Special Circumstances
Crew Credentials

• Crew credentials must be documented
  – Crew credentials can be simply stated (i.e. EMT-P, EMT-I, EMT-B)
  – Crew member license number

• Documented credentials confirm:
  – The crew is licensed to provide the level of service billed
  – The staffing levels match vehicle requirements
Valid Signatures

- Documentation must contain valid crew signatures
- Must include a legible form of the name and credentials
- Printed or typed names must be accompanied by initials or signatures
- Electronic signatures must indicate it is an electronic signature (i.e. “electronically signed by” date/time stamps, etc.)
- Signature examples

<table>
<thead>
<tr>
<th>Name and Credentials</th>
<th>Signature</th>
<th>Initials</th>
<th>License #</th>
</tr>
</thead>
<tbody>
<tr>
<td>John Smith, EMT – B</td>
<td></td>
<td></td>
<td>B-12345 - NY</td>
</tr>
<tr>
<td>Jane Goode, EMT – I</td>
<td></td>
<td></td>
<td>I-67890 - WV</td>
</tr>
<tr>
<td>Grey T. Scott, Paramedic</td>
<td></td>
<td></td>
<td>P-13579 - CA</td>
</tr>
</tbody>
</table>
Beneficiary Signature Requirements

• Medicare requires the signature of the beneficiary, or that of his or her representative, for each date of transport, for both the purpose of accepting assignment and submitting a claim to Medicare

• The beneficiary signature requirement must be met prior to submitting a claim to Medicare

• If the beneficiary or their representative refuses to sign, the provider may bill the beneficiary
Beneficiary Signature - Representatives

• If the beneficiary is unable to sign due to a physical or mental condition, a representative’s signature is acceptable

• Examples of representatives are:
  – Beneficiary’s legal guardian
  – An individual who receives governmental benefits on behalf of the beneficiary
  – An individual who arranges the beneficiary’s treatment or manages the beneficiary’s affairs
  – Receiving facility representative
  – Representative of the ambulance supplier who is present during transport, with additional collaborative documentation as noted in 42 CFR 424.36 - Signature Requirements
Advance Beneficiary Notice (ABN) and Emergency Transports

Ambulance suppliers cannot issue an ABN for any emergency transport and cannot shift liability to the beneficiary under the Limitation On Liability (LOL) Provision.
Documentation Tips

- Make sure the documentation contains the actual trip report for the billed service requested in the ADR.
- Consider what adjunctive notes could support medical necessity (examples: hospital admission face-sheet, physician progress notes, etc.).
- Review and use our checklist when compiling documentation.
Medical Review Results
Top Denial for All Services

#1 Non-response
No response to Additional Documentation Request

To avoid this denial:

• Respond promptly within 45 days. Claims automatically deny on the 46th day if no response is received

• Choose to electronically upload your response through our provider portal for quick receipt, or submit through esMD, or respond by fax or by mail

• Keep your mailing address current with Railroad Medicare
“Granular” Error Denial Reasons

A response was received but documentation may have been:

- Missing the notes that support medical necessity
- Missing the date of service
- For an incorrect date of service or wrong beneficiary
- Missing valid crew or beneficiary/representative signatures
- Illegible
NOTMN - Payer deems the information submitted does not support medical necessity of services billed

This denial is given when the review finds:

- Transport destinations not covered (ER, EP)
- No medical need for care by EMT/paramedic
- Hospital to Hospital transports where services were available at the original hospital

Avoid this denial:

- Be familiar with the Medicare service guidelines for the transport billed
- Educate facilities and patients/families on coverage guidelines
- Complete documentation to support medical necessity
NODOC - Documentation requested for this specific date of service was not received or was incomplete

Included in response:

• Hospital registration face-sheet
• Runsheet for:
  - Same date-of-service but different transport
  - Different date-of-service
  - Different patient

Avoid this denial by:

• Submitting the documentation for the transport that matches the service requested
• If you performed more than one emergency transport for a patient on the same day, send information on both to support the medical necessity of the multiple trips

Missing from response:
• Runsheet for transport submitted on claim
This may occur when submission contains:

- Blank beneficiary signature form
- Crew signature without receiving facility representative signature
- Crew signature/representative signature without documentation that patient is unable to sign for self

Avoid this denial by:

- Obtaining the beneficiary signature before submitting claim to Medicare
- Ensure staff documents the reason patient cannot sign (ex: dementia, injury)
- Obtain signature from receiving facility to support transport occurred
ISIGN

ISIGN – Invalid or Illegible provider signature

• Illegible signature
  - Signature is unreadable without printed or typed version of the name below it

• Signature Requirements
  - Medicare requires that services provided/ordered be authenticated by the inclusion of the practitioner’s first and last name
  - For clarification purposes, include your applicable credentials (e.g., PM, EMT-I, or EMT-B, etc.)
ILDOC - Information submitted deemed illegible

- Illegibility is usually due to:
  - Poor copy quality
  - Unreadable handwriting
- To avoid this denial:
  - Consider uploading documentation through our eServices portal
  - Utilize EHR when possible
  - Include a translation or transcribed notes in addition to copies of original document.
Resources
The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) requires CMS to remove Social Security Numbers (SSNs) from all Medicare cards by April 2019.

A new randomly generated Medicare Beneficiary Identifier (MBI) will replace the SSN-based Health Insurance Claim Number (HICN) on new Medicare cards for transactions like billing, eligibility status, and claim status.

- CMS New Medicare Card Overview Page

- CMS New Medicare Card Provider Page
  https://www.cms.gov/Medicare/New-Medicare-Card/Providers/Providers.html
CMS New Medicare Card Project

• Railroad Medicare MBIs will not be distinguishable from other MBIs

• Railroad Medicare cards will be distinct with Railroad Retirement Board name and seal
CMS Ambulance Resources

• CMS Ambulances Services Center
  https://www.cms.gov/Center/Provider-Type/Ambulances-Services-Center.html

• CMS IOM Publication 100-02 Medicare Benefit Policy Manual, Chapter 10, “Ambulance Services”

• CMS IOM Publication 100-04, Medicare Claims Processing Manual, Chapter 15, “Ambulance”

• Guidance on Beneficiary Signature Requirements for Ambulance Transportation
Medicare Learning Network® Resources

• The Medicare Learning Network® Page
  - MLN National Provider Calls
  - National Provider Calls & Events page www.cms.govnpc/

• MLN Provider Compliance Resources
  https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/ProviderCompliance.html
  - Complying with Medicare Signature Requirements
  - Complying with Medical Record Documentation Requirements
  - Provider Compliance Tips for Ambulance Services (Emergent and Non-Emergent)
MLN® Ambulance Resources

• Medicare Ambulance Transports Booklet

• Ambulance Fee Schedule Fact Sheet
CMS Ambulance Open Door Forums

• CMS sponsors regularly scheduled “Ambulance Open Door Forums“ providing opportunities for live dialogue between CMS and the ambulance stakeholder community at large

• Subscribe to the Ambulance Open Door Forum Mailing List to be notified when forums are scheduled or when new information is posted to the website

• CMS Ambulance Open Door Forums page

https://www.cms.gov/Outreach-and-Education/Outreach/OpenDoorForums/ODF_Ambulance.html
RRB SMAC Resources

www.PalmettoGBA.com/RR
RRB SMAC Ambulance Resources

Ambulance

Access these helpful resources for more information about ambulance services.

- CMS Ambulance Center
- Ambulance Fee Schedule
- Skilled Nursing Facility (SNF) Consolidated Billing (CB) Information
- Guidance for Ambulance Suppliers Regarding the Use of Advance Beneficiary Notice
- CMS Instructions to Contractors related to Ambulance Services

FAQs - Ambulance

Find answers to frequently asked Medicare questions below. For help with eServices, view our eServices FAQs.

Jump to:

1. Can an ABN (Advance Beneficiary Notice of Noncoverage) be issued for HCPCS code AD427 (ALS/EMS /Emergency Transports)?
2. Does Medicare reimburse for ambulance transportation to and from a physician's office?
3. How do you determine if an ambulance transport is considered emergent?
4. I billed multiple patients on one ambulance trip with HCPCS modifier CM, why are my claims still being denied?
5. If a paramedic (not an EMT) is requested for a transport (emergent or non-emergent), but no advanced life support (ALS) procedures are performed is it considered an ALS transport?
6. If a patient is being transported to a skilled care center located within a hospital or on hospital grounds, which destination modifier would be used when filing the claim?
7. If a patient is transported by ambulance to hospital prior to the initial assessment and development of the plan of care, what destination modifier do I use?
8. If an ambulance is dispatched as a result of a 911 call, arrives at the scene, does an assessment of the patient and it is found there is no need for the transport, would the Advanced Beneficiary Notice (ABN) be used in this case if I intend to bill the patient?
9. Is the Beneficiary Signature required for emergency ambulance transports?
10. Is the hospital responsible for the payment of the transports unless the patient is an inpatient?
11. Please clarify the guidelines for advanced life support (ALS) assessment with no services in response to a 911 dispatch. I thought that if an ALS assessment was done, the transport is automatic, so this was a 911 dispatch.
12. What HCPCS modifier should be used when transporting patients to and from satellite offices/urgent care centers owned by a large hospital?
13. What should I do if the beneficiary and/or representative refuses to sign for an ambulance transport?
14. What is a Physician Certification Statement (PCS) required for Ambulance Services?
15. Why was my ambulance claim denied for missing a beneficiary signature?
Visit www.PalmettoGBA.com/RR

- MLN articles from the Centers for Medicare & Medicaid Services (CMS)
- Articles and FAQs by topic
- Self-Services Tools
- eServices Online Portal
- Redetermination Status Tool
- Quick Reference Guide
- Modifier Lookup
- MSP Lookup
- Reason/Remark Code Lookup
Claim Status
Eligibility
Remittances
Appeals
Submission of Requested Medical Records
Greenmail notification of Pending ADR Requests
Greenmail eDelivery Responses

www.PalmettoGBA.com/eServices
Respond to ADRs in eServices

- Respond to Medical Review ADRs through eServices using the MR ADR Response secure eForm
- Attach an unlimited number of PDF files to each form. Each attachment can be up to 40 MB. The total size of all attachments on each ADR eForm can be no more than 150 MB
- Track submission of your ADRs
- Must have an Electronic Data Interchange (EDI) Enrollment Agreement on file with Palmetto GBA Railroad Medicare and a finalized claim in history
- Enroll for eServices at www.palmettogba.com/eServices
Stay Connected With Us…

- Join our listserv at www.PalmettoGBA.com/RR
- Choose ‘Register Now’ and select the topics you want to receive updates on
- Facebook
- Twitter
- YouTube
- eChat
# Railroad Medicare Contacts

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<th>RAILROAD MEDICARE RESOURCES</th>
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<td>Railroad Medicare Homepage</td>
<td><a href="http://www.PalmettoGBA.com/RR">www.PalmettoGBA.com/RR</a></td>
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<td>Palmetto GBA Listserv</td>
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<td>Select ‘Listservs’ from top tool bar</td>
</tr>
<tr>
<td>Contact Us By Email</td>
<td><a href="mailto:Medicare.Railroad@PalmettoGBA.com">Medicare.Railroad@PalmettoGBA.com</a></td>
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<td>eServices</td>
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**Provider Contact Center**  
EDI / eServices  
Telephone Reopenings  
Provider Enrollment  

888-355-9165

**Interactive Voice Response (IVR) System**  

877-288-7600

**Palmetto GBA**  
Railroad Medicare  
PO Box 10066  
Augusta, GA 30999
Questions?

Q&A Widget

Survey Widget - Please take our short survey. We appreciate your feedback.

Resource Widget
Thank you!

Questions about this webcast?

Provider Contact Center
1-888-355-9165

Medicare.Railroad@PalmettoGBA.com