Non-Emergency Ambulance Services: Regulations and Required Documentation

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

March 20, 2018

PALMETTO GBA
A CELERIAN GROUP COMPANY

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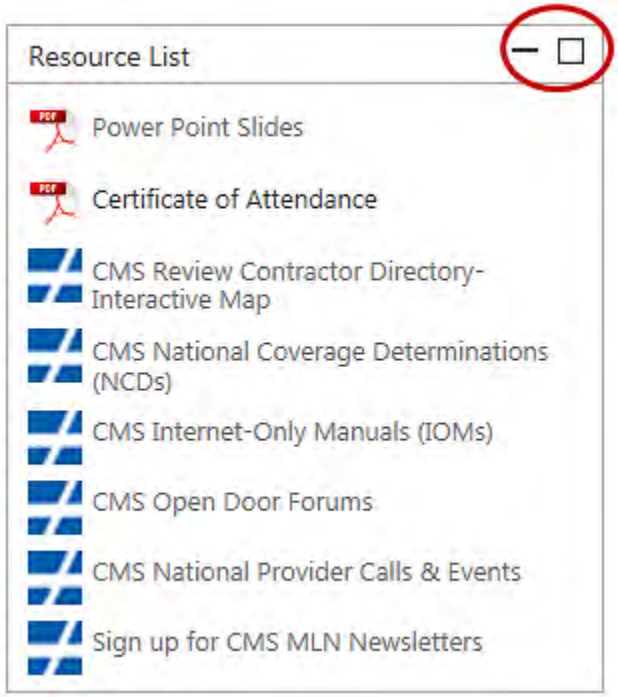


Disclaimer

- The information provided in this presentation was current as of March 20, 2018. Any changes or new information superseding the information in this presentation will be provided in articles and resources with publication dates after March 20, 2018, 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
- The Centers for Medicare & Medicaid Services (CMS) and the Railroad Retirement Board (RRB) employees, agents, and staff make no representation, warranty, or guarantee that this compilation of Medicare information is error-free and will bear no responsibility or liability for the results or consequences of the use of this guide .
- 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

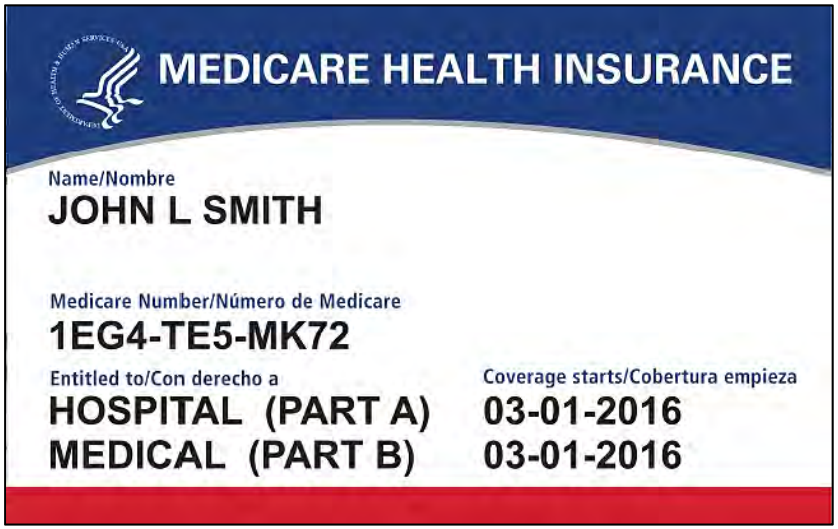
ADR	Additional Documentation Request
ALS	Advanced Life Support
BLS	Basic Life Support
CERT	Comprehensive Error Rate Testing
CFR	Code of Federal Regulations
CMS	Centers for Medicare & Medicaid Services
CR	Change Request
HCPCS	Healthcare Common Procedure Coding System
EMT	Emergency Medical Technician
IOM	Internet Only Manual
MLN	Medicare Learning Network
MR	Medical Review
RRB OIG	Railroad Board Office of Inspector General
PCS	Physician Certification Statement
POP	Point of Pick-up

CMS New Medicare Card Project

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

New Medicare Cards with MBIs

- Railroad Medicare MBIs will not be distinguishable from other MBIs
- Railroad Medicare cards will be distinct with Railroad Retirement Board name and seal



New Medicare Card Project
CMS Timeline

- **April 2018**
  - Begin mailing new Medicare cards to people with Medicare
  - All systems & processes able to accept MBI
  - Transition Period Starts: Can use either the HICN or MBI for data exchanges
  - Begin returning messages in HETS responses to show when new Medicare cards have been mailed to a specific patient and when a patient qualifies for Medicare through the RRB
- **June 2018**
  - Launch provider MBI look-up tool
- **October 2018**
  - Return MBI on Remittance Advice
- **January 2020**
  - Transition Period Ends: Must use the MBI on data exchanges (some exceptions)

Today's Objectives

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

- The basic Medicare benefit policy relating to BLS non-emergency ground ambulance transports (HCPCS Code A0428)
- Medicare documentation guidelines and the required elements to support each transport
- How to avoid documentation errors

Agenda

- Medicare Ambulance Benefit Policy
- Standards for All Transports
- Medical Review – Additional Documentation Requests
- Required Documentation and Documentation Examples
- 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 patient has occurred
- The patient 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.

Case Study 1: Resulting in a Technical Denial

Run Sheet Documentation:

- **Noted Required Quality Treatment-** Weakness
- **Patient's Current Condition-** Type II Diabetes, End-stage Renal Disease, Chronic Obstructive Pulmonary Disease, weakness, and hypertension
- **Level of Consciousness-** Alert and oriented, Cooperative
- **Service Provided-** EMT notates none
- **Mobility Status-** Able to ambulate without assistance

"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.

Case Study 2:
Is An Ambulance Transport Required?

Run Sheet Documentation:

- **Noted Required Quality Treatment-** Oxygen administration
- **Patient's Current Condition-** Patient denies shortness of breath, nausea and vomiting, dizziness, weakness, headache, numbness or tingling
- **Level of Consciousness-** Alert and oriented x4
- **Service Provided-** Oxygen administration
- **Mobility Status-** Able to stand and pivot unassisted

Standards for Non-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

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:

- BLS ambulances must be staffed by at least two people who meet the requirements of state and local laws where the services are being furnished
- At least one of the two crew members must be a certified at a minimum as an emergency medical technician-basic (EMT-basic)

Non-Emergency Transport Levels

- Ground ambulance transport
  - A0426 ALS1 Non-Emergency
  - **A0428 BLS Non-Emergency**
- "Ground" refers to both land and water transportation

BLS Non-Emergency (HCPCS A0428)

- Basic Life Support (BLS) – is transportation by a ground ambulance vehicle and the provision of medically necessary supplies and services.
- Non- emergency level transport is due to the patient's condition requiring non-emergency transport
- Per state laws, EMT- Basic medical technicians **may be** permitted to:
  - Operate limited equipment onboard vehicles
  - Assist more qualified personnel in performing assessments and interventions
  - Establish peripheral intravenous (IV) lines

Examples of Conditions Supporting BLS Non-Emergency Transport

Examples from CMS Ambulance Service Center Condition List
• Suctioning required in route, need for titrated O2 therapy or IV fluid management
• Airway control/positioning required in route
• Patient safety: Danger to self or others – restraints, monitoring, flight risk, or risk for falls
• Severe pain with other symptoms (abdominal, headache, etc.)

Case Study 3: Concise Documentation Supports Transport

Run Sheet Documentation:

- **Noted Required Quality Treatment-** Monitoring use of restraints, Patient transferred via draw sheet with 3person assist
- **Patient's Current Condition-** Danger to self
- **Level of Consciousness-** Alert to self, GCS 9, fails to respond to questions, minimal movement observed
- **Service Provided-** Monitoring use of restraints
- **Mobility Status-** Minimal movement observed

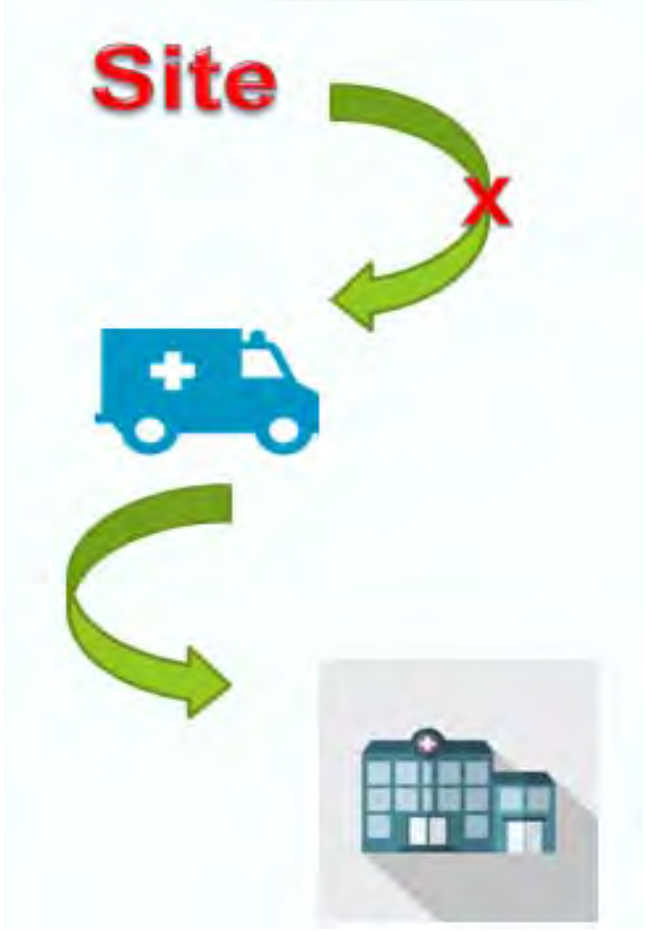
Non- Emergency Transport Destinations

Medicare coverage requires the patient's transport be medically reasonable and necessary and to a Medicare-approved destination

HCPCS Modifier	Descriptions
E	Residential, domiciliary, custodial facility
G	Hospital based ESRD facility
H	Hospital
J	Freestanding ESRD facility
N	Skilled Nursing facility (SNF)
R	Residence

Ground Transport Mileage

- Only local ambulance transportation is covered to the nearest appropriate facility
- Exceptions for additional mileage require supporting 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.)

Patient Refused Transport

- If a transport did not take place, due to the refusal of the patient, the patient , rather than Medicare, is billed directly for the services
  - When billing to Medicare, submit HCPCS A0998 along with the GY modifier
  - Document in the record "Patient refused transport"
- An Advance patient Notice (ABN) is not required

Patient's Death

Scenarios for when a patient is pronounced dead and its impact on payment for transport services:

Time of Death Pronouncement	Medicare Payment Determination
Before dispatch	None
After dispatch, before patient is loaded onboard ambulance (before or after arrival at the point-of-pickup)	The provider's/supplier's BLS base rate, no mileage or rural adjustment; use the QL modifier when submitting this type of claim
After pickup, prior to or upon arrival at the receiving facility	Medically necessary level of service furnished

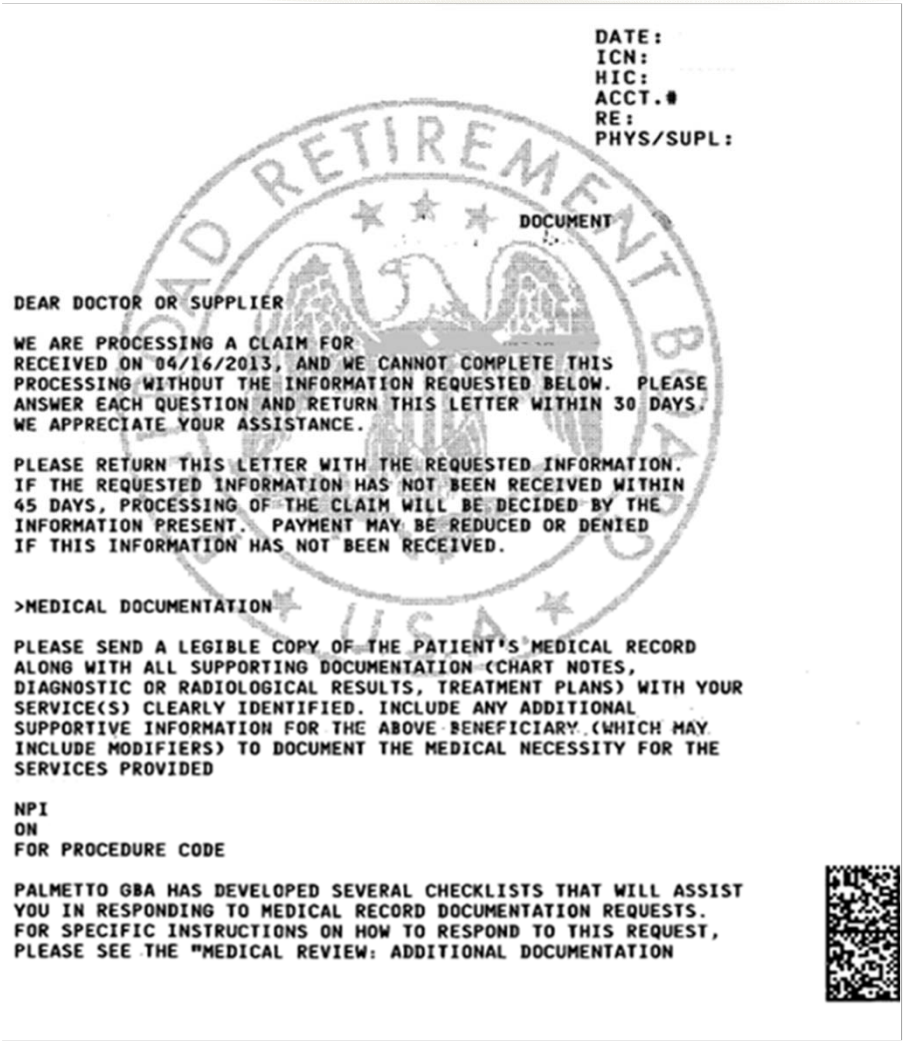
Medical Review – Additional Documentation Requests

Current Ambulance Service Reviews

Railroad Medicare is currently conducting reviews of non-emergency ambulance services submitted for Non-Emergency BLS Transport, HCPCS Code A0428

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



DATE:
ICN:
HIC:
ACCT.#
RE:
PHYS/SUPL:

DOCUMENT

DEAR DOCTOR OR SUPPLIER

WE ARE PROCESSING A CLAIM FOR
RECEIVED ON 04/16/2013, AND WE CANNOT COMPLETE THIS PROCESSING WITHOUT THE INFORMATION REQUESTED BELOW. PLEASE ANSWER EACH QUESTION AND RETURN THIS LETTER WITHIN 30 DAYS. WE APPRECIATE YOUR ASSISTANCE.

PLEASE RETURN THIS LETTER WITH THE REQUESTED INFORMATION. IF THE REQUESTED INFORMATION HAS NOT BEEN RECEIVED WITHIN 45 DAYS, PROCESSING OF THE CLAIM WILL BE DECIDED BY THE INFORMATION PRESENT. PAYMENT MAY BE REDUCED OR DENIED IF THIS INFORMATION HAS NOT BEEN RECEIVED.

>MEDICAL DOCUMENTATION

PLEASE SEND A LEGIBLE COPY OF THE PATIENT'S MEDICAL RECORD ALONG WITH ALL SUPPORTING DOCUMENTATION (CHART NOTES, DIAGNOSTIC OR RADIOLOGICAL RESULTS, TREATMENT PLANS) WITH YOUR SERVICE(S) CLEARLY IDENTIFIED. INCLUDE ANY ADDITIONAL SUPPORTIVE INFORMATION FOR THE ABOVE BENEFICIARY (WHICH MAY INCLUDE MODIFIERS) TO DOCUMENT THE MEDICAL NECESSITY FOR THE SERVICES PROVIDED

NPI
ON
FOR PROCEDURE CODE

PALMETTO GBA HAS DEVELOPED SEVERAL CHECKLISTS THAT WILL ASSIST YOU IN RESPONDING TO MEDICAL RECORD DOCUMENTATION REQUESTS. FOR SPECIFIC INSTRUCTIONS ON HOW TO RESPOND TO THIS REQUEST, PLEASE SEE THE "MEDICAL REVIEW: ADDITIONAL DOCUMENTATION

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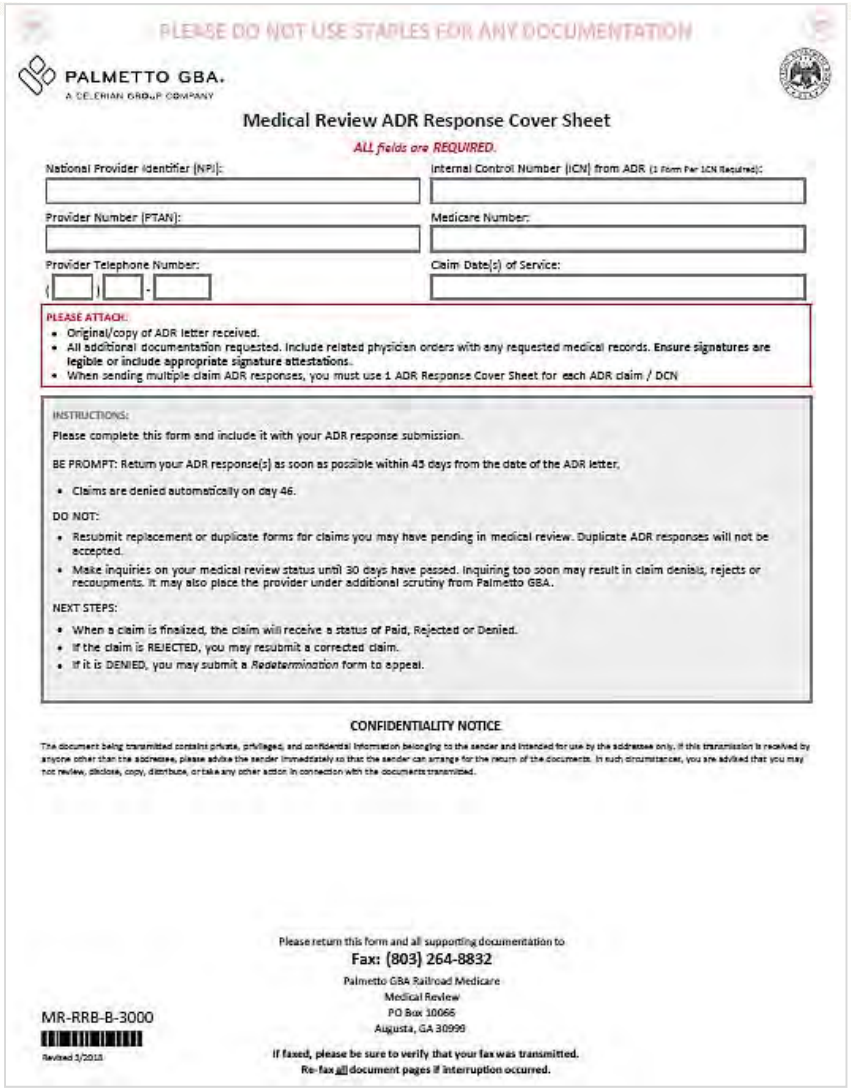
How to Respond to an ADR

- 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



PLEASE DO NOT USE STAPLES FOR ANY DOCUMENTATION

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Medical Review ADR Response Cover Sheet

ALL fields are REQUIRED.

National Provider Identifier (NPI):

Internal Control Number (ICN) from ADR (1 Form Per ICN Required):

Provider Number (PTAN):

Medicare Number:

Provider Telephone Number:

Claim Date(s) of Service:

PLEASE ATTACH:
- Original/copy of ADR letter received.
- All additional documentation requested. Include related physician orders with any requested medical records. Ensure signatures are legible or include appropriate signature attestations.
- When sending multiple claim ADR responses, you must use 1 ADR Response Cover Sheet for each ADR claim / DCN

INSTRUCTIONS:

Please complete this form and include it with your ADR response submission.

BE PROMPT: Return your ADR response(s) as soon as possible within 45 days from the date of the ADR letter.
- Claims are denied automatically on day 46.

DO NOT:
- Resubmit replacement or duplicate forms for claims you may have pending in medical review. Duplicate ADR responses will not be accepted.
- Make inquiries on your medical review status until 30 days have passed. Inquiring too soon may result in claim denials, rejects or recoupments. It may also place the provider under additional scrutiny from Palmetto GBA.

NEXT STEPS:
- When a claim is finalized, the claim will receive a status of Paid, Rejected or Denied.
- If the claim is REJECTED, you may resubmit a corrected claim.
- If it is DENIED, you may submit a *Redetermination* form to appeal.

CONFIDENTIALITY NOTICE

The document being transmitted contains private, privileged, and confidential information belonging to the sender and intended for use by the addressee only. If this transmission is received by anyone other than the addressee, please advise the sender immediately so that the sender can arrange for the return of the documents. In such circumstances, you are advised that you may not review, disclose, copy, distribute, or take any other action in connection with the documents transmitted.

Please return this form and all supporting documentation to
Fax: (803) 264-8832
Palmetto GBA Railroad Medicare
Medical Review
PO Box 10066
Augusta, GA 30999

If faxed, please be sure to verify that your fax was transmitted.
Re-fax all document pages if interruption occurred.

MR-RRB-B-3000
Revised 1/2018

Required Documentation

Supporting Documentation

- Documentation should support medical necessity for each transport. Elements to include are:
- Run sheet/ trip report
- Physician Certification Statement (PCS), if necessary
- Crew signatures and credentials
- Patient /Representative signature

Documentation: Trip Report

General Information

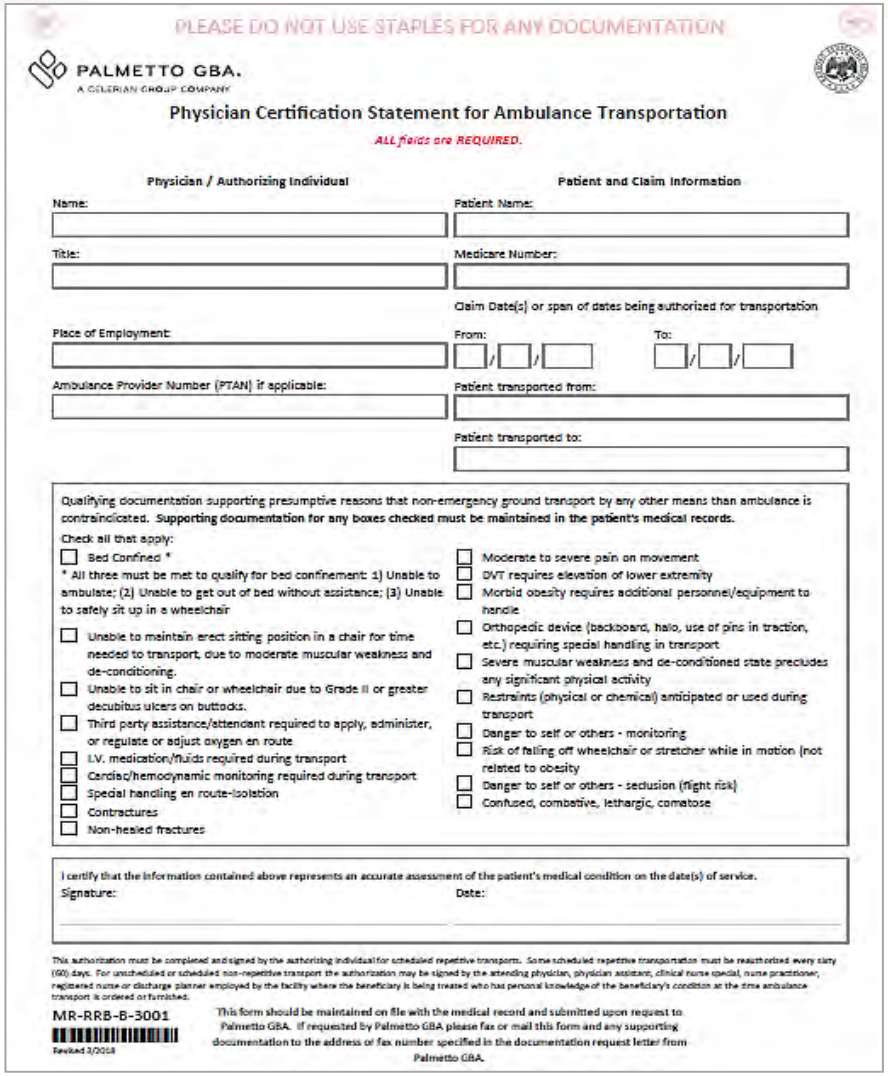
- Patient name
- Date and Time
- Point of Pick-up and Destination
- Reason for ambulance transport
- Loaded mileage

Medical Information

- Signs/symptoms
- Assessment/Exam
- Treatments
- Patient response
- Mode of transfer
- Mobility status
- Special Circumstances

Physician Certification Statement (PCS)

- A Physician Certification Statement (PCS) is a written order certifying the medical necessity of non-emergency ambulance transports
- A PCS is required for non-emergency repetitive scheduled and non-repetitive unscheduled transports for patients under the direct care of a physician



PLEASE DO NOT USE STAPLES FOR ANY DOCUMENTATION

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Physician Certification Statement for Ambulance Transportation

ALL fields are REQUIRED.

Physician / Authorizing Individual

Name:

Title:

Place of Employment:

Ambulance Provider Number (PTAN) if applicable:

Patient and Claim Information

Patient Name:

Medicare Number:

Claim Date(s) or span of dates being authorized for transportation

From: / / To: / /

Patient transported from:

Patient transported to:

Qualifying documentation supporting presumptive reasons that non-emergency ground transport by any other means than ambulance is contraindicated. **Supporting documentation for any boxes checked must be maintained in the patient's medical records.**

Check all that apply:

- ☐ Bed Confined *
  * All three must be met to qualify for bed confinement: 1) Unable to ambulate; (2) Unable to get out of bed without assistance; (3) Unable to safely sit up in a wheelchair
- ☐ Unable to maintain erect sitting position in a chair for time needed to transport, due to moderate muscular weakness and de-conditioning.
- ☐ Unable to sit in chair or wheelchair due to Grade II or greater decubitus ulcers on buttocks.
- ☐ Third party assistance/attendant required to apply, administer, or regulate or adjust oxygen en route
- ☐ I.V. medication/fluids required during transport
- ☐ Cardiac/hemodynamic monitoring required during transport
- ☐ Special handling en route-isolation
- ☐ Contractures
- ☐ Non-healed fractures
- ☐ Moderate to severe pain on movement
- ☐ DVT requires elevation of lower extremity
- ☐ Morbid obesity requires additional personnel/equipment to handle
- ☐ Orthopedic device (backboard, halo, use of pins in traction, etc.) requiring special handling in transport
- ☐ Severe muscular weakness and de-conditioned state precludes any significant physical activity
- ☐ Restraints (physical or chemical) anticipated or used during transport
- ☐ Danger to self or others - monitoring
- ☐ Risk of falling off wheelchair or stretcher while in motion (not related to obesity
- ☐ Danger to self or others - seclusion (flight risk)
- ☐ Confused, combative, lethargic, comatose

I certify that the information contained above represents an accurate assessment of the patient's medical condition on the date(s) of service.

Signature: Date:

This authorization must be completed and signed by the authorizing individual for scheduled repetitive transports. Some scheduled repetitive transportation must be reauthorized every sixty (60) days. For unscheduled or scheduled non-repetitive transport the authorization may be signed by the attending physician, physician assistant, clinical nurse special, nurse practitioner, registered nurse or discharge planner employed by the facility where the beneficiary is being treated who has personal knowledge of the beneficiary's condition at the time ambulance transport is ordered or furnished.

MR-RRB-B-3001
Revised 3/2018

This form should be maintained on file with the medical record and submitted upon request to Palmetto GBA. If requested by Palmetto GBA please fax or mail this form and any supporting documentation to the address or fax number specified in the documentation request letter from Palmetto GBA.

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PCS to Support the Transport

- Reasons for transport included in PCS must be supported by the trip report and other submitted documentation
- A PCS should be individualized for each patient and reflect the patient's condition at time of transport

It is important to note that the presence (or absence) of a physician's order for a transport by ambulance does not necessarily prove (or disprove) whether the transport was medically necessary. The ambulance service must meet all program coverage criteria in order for payment to be made.

PCS Documentation

General Information

- Patient's Name and additional identifiers
- Date being authorized
- Origin/Destination of transport

Medical Necessity

- Medical Condition
- Bed Confinement
- Mobility
- Complicating Conditions

Authorized Signature

- Legible name and credentials of provider or provider representative
- MD or DO for non-emergency scheduled repetitive; or other authorized provider representative for non-emergency unscheduled transport

When a PCS is Required

Type of Transport	PCS Required?	Specific Requirements
Non-Emergency **Scheduled** **Repetitive** "Repetitive is defined as medically necessary ambulance transportation that is furnished three or more times within a 10-day period or once a week for at least three weeks ."	Yes	• Obtain the PCS from the physician before submitting claims and before services are furnished. • The PCS must be dated **no earlier than 60 days before the date the service is furnished**. • Dialysis services and respiratory therapy are examples of treatments that are considered repetitive.

When a PCS is Required

Type of Transport	PCS Required?	Specific Requirements
Non-emergency **Unscheduled** The patient is a resident of a facility and is under the direct care of a physician.	Yes	• Obtain the PCS before submitting claims. • The PCS may be obtained within 48 hours of the transport. • If unable to obtain PCS within 21 calendar days following the date of transport, document attempts to obtain the PCS, then submit claim. • Example of documentation to substantiate PCS request attempts include: a USPS return receipt signed by the vendor; or another delivery service that can substantiate delivery of the document. • If the attending physician is not available to sign, a signed certification statement may be obtained from a Physician Assistant (PA), Nurse Practitioner (NP), Clinical Nurse Specialist (CNS), Registered Nurse (RN), or a discharge planner who has personal knowledge of the patient's medical history. In this case, the PA, NNP, CNS, RN, or discharge planner must be employed by the attending physician or by the hospital or facility where the patient being treated and from which the patient is being transported.

When a PCS is Required

Type of Transport	PCS Required?	Specific Requirements
Non-emergency **Scheduled** **Non-Repetitive** The patient is a resident of a facility and is under the direct care of a physician.	Yes	• Obtain the PCS before submitting claims. • The PCS may be obtained within 48 hours of the transport. • If unable to obtain PCS within 21 calendar days following the date of transport, document attempts to obtain the PCS, then submit claim. • Example of documentation to substantiate PCS request attempts include: a USPS return receipt signed by the vendor; or another delivery service that can substantiate delivery of the document. • If the attending physician is not available to sign, a signed certification statement may be obtained from a Physician Assistant (PA), Nurse Practitioner (NP), Clinical Nurse Specialist (CNS), Registered Nurse (RN), or a discharge planner who has personal knowledge of the patient's medical history. In this case, the PA, NNP, CNS, RN, or discharge planner must be employed by the attending physician or by the hospital or facility where the patient being treated and from which the patient is being transported.

Corrected slide 3/20/2018 post–presentation.

When a PCS is Not Required

Type of Transport	PCS Required?	Specific Requirements
Non-Emergency **Non-repetitive** **Unscheduled or scheduled** The patient resides at home or is a resident of a facility and is not under the direct care of a physician.	No	• No PCS is required before submitting claims. • Non-emergency, non-repetitive ambulance transport is covered only if they are furnished to a beneficiary whose medical condition is such that other means of transportation are contraindicated. • For a beneficiary residing at home or in a facility who is not under the direct care of a physician, a physician certification is not required.

Case Study 4: Conflicting Documentation

- **Run sheet Documentation**
  - Primary Compliant- Chest pain/Discomfort
  - Mental Status- Confused
  - Skin- Warm, Dry, and Intact
  - Lung Sounds- Lower and Upper Lungs Clear Bilaterally
  - All other Systems- Not Assessed
- **PCS Documentation**
  - Non-healed fractures
  - Moderate to severe pain during movement

Case Study 5: Non-Covered Transport

- **Run sheet Documentation**
  - Primary Compliant- Transport to dialysis
  - Mental Status- A&O X 4
  - Skin- Warm, Dry, and Intact
  - All other Systems- Not Assessed
  - Mobility Status- Ambulatory with assistance
- **PCS Documentation**
  - Dialysis transport
  - Weakness

Medical necessity is established when the patient's condition is such that use of any other method of transportation is contraindicated, regardless of whether or not such other transportation is actually available.

Case Study 6: Supporting Documentation

Run Sheet Documentation:

- **Requiring Quality Treatment-** Cardiac/Hemodynamic monitoring, Transfer via draw sheet with two person assist
- **Patient's Current Condition-** General weakness post dialysis
- **Level of Consciousness-** Alert
- **Mobility Status-** Trunk weakness, weakness with spontaneous movement to all extremities
- **Vital Signs:**
  - **1538** Blood Pressure 148/70,Pulse 63,Respirations 20, **Oxygen Saturation** 96% **Temperature** 97.2
  - **1544 Blood pressure** 128/80, **Pulse** 60, **Respirations** 20, **Oxygen Saturation** 94%, **Temperature** 97.2

PCS Documentation:

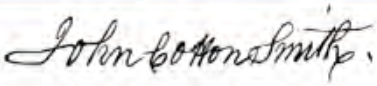
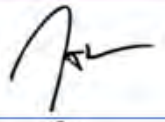
- **Medical Conditions-** History of respiratory distress, Bradycardia, Congestive heart failure, End-stage renal disease, Life sustaining Hemodialysis Severe Trunk weakness, Muscle deconditioning
- **Special Requirements:** Cardiac/Hemodynamic monitoring during transport, Assistance maintaining an upright position during transport

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 Crew 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:

Name and Credentials	Signatures	Initials	License #
John Smith, EMT- B			B-12345 - NY
Jane Goode, EMT- I			I-67890 – WV
Grey T. Scott, Paramedic			P-13579 - CA

Patient Signature Requirements

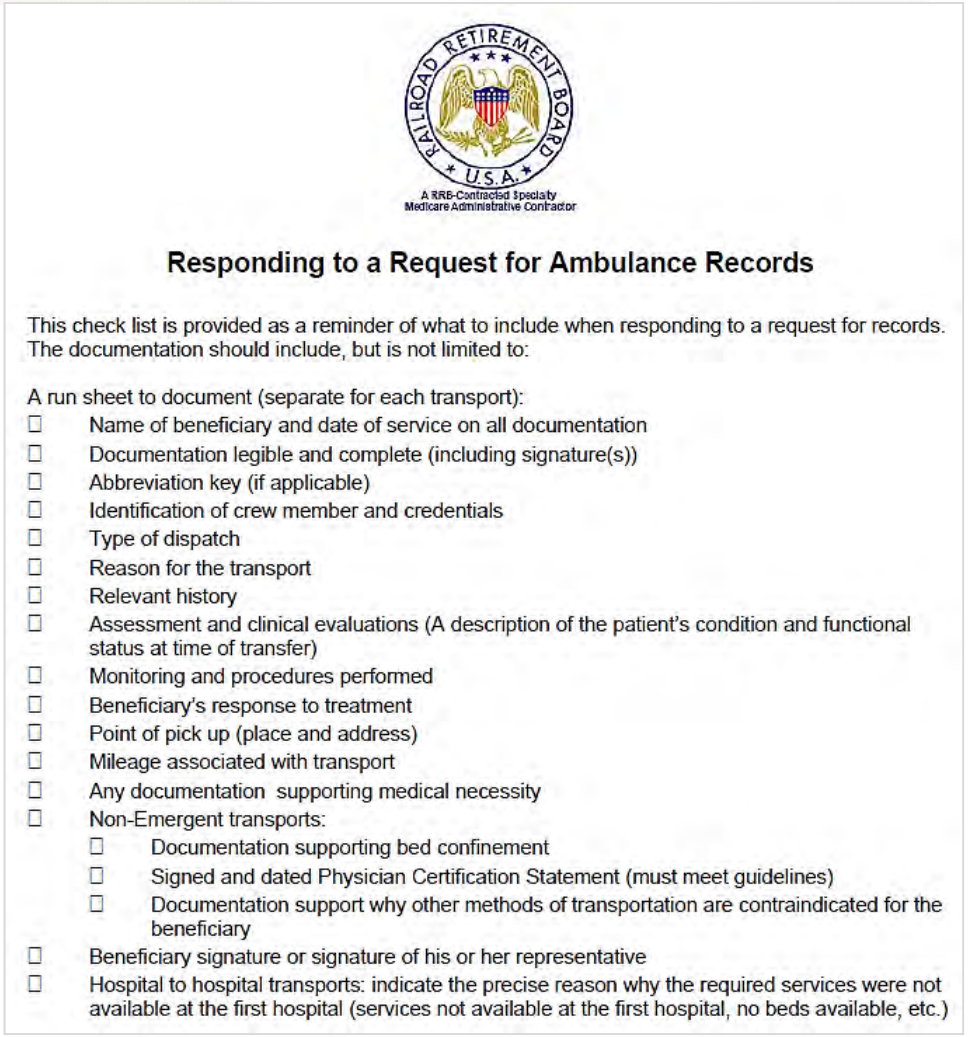
- Medicare requires the signature of the patient, or that of his or her representative, for each date of transport, for both the purpose of accepting assignment and submitting a claim to Medicare
- The patient signature requirement must be met prior to submitting a claim to Medicare
- If the patient or their representative refuses to authorize the submission of a claim, including a refusal to furnish an authorizing signature, the claim cannot be submitted to Medicare, but the provider may bill the patient

Patient Signature - Representatives

- If the patient is unable to sign due to a physical or mental condition, a representative's signature is acceptable
- Examples of representatives are:
  - Patient's legal guardian
  - An individual who receives governmental benefits on behalf of the patient
  - An individual who arranges the patient's treatment or manages the patient'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

Documentation Tips

- Make sure the documentation contains the actual trip report for the transport identified 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



A RRB-Contracted Specialty Medicare Administrative Contractor

Responding to a Request for Ambulance Records

This check list is provided as a reminder of what to include when responding to a request for records. The documentation should include, but is not limited to:

A run sheet to document (separate for each transport):

- ☐ Name of beneficiary and date of service on all documentation
- ☐ Documentation legible and complete (including signature(s))
- ☐ Abbreviation key (if applicable)
- ☐ Identification of crew member and credentials
- ☐ Type of dispatch
- ☐ Reason for the transport
- ☐ Relevant history
- ☐ Assessment and clinical evaluations (A description of the patient's condition and functional status at time of transfer)
- ☐ Monitoring and procedures performed
- ☐ Beneficiary's response to treatment
- ☐ Point of pick up (place and address)
- ☐ Mileage associated with transport
- ☐ Any documentation supporting medical necessity
- ☐ Non-Emergent transports:
  - ☐ Documentation supporting bed confinement
  - ☐ Signed and dated Physician Certification Statement (must meet guidelines)
  - ☐ Documentation support why other methods of transportation are contraindicated for the beneficiary
- ☐ Beneficiary signature or signature of his or her representative
- ☐ Hospital to hospital transports: indicate the precise reason why the required services were not available at the first hospital (services not available at the first hospital, no beds available, etc.)

Resources

CMS Ambulance Resources

- CMS Ambulances Services Center
  https://tinyurl.com/CMSAmbulancesCenter
- CMS IOM Publication 100-02 Medicare Benefit Policy Manual, Chapter 10, "Ambulance Services"
  https://tinyurl.com/IOMBPCH10
- CMS IOM Publication 100-04, Medicare Claims Processing Manual, Chapter 15, "Ambulance"
  https://tinyurl.com/IOMCPCH15
- Guidance on Patient Signature Requirements for Ambulance Transportation
  https://tinyurl.com/PatSigAmbTransport

Medicare Learning Network® Resources

- The Medicare Learning Network® Page
  https://tinyurl.com/MLNPage
- MLN National Provider Calls
  - National Provider Calls & Events page www.cms.gov/npc/
- MLN Provider Compliance Resources
  https://tinyurl.com/MLNProvCompliance
  - Complying with Medicare Signature Requirements
  - Complying with Medical Record Documentation Requirements
  - Provider Compliance Tips for Ambulance Services (Emergent and Non-Emergent)

MLN® Ambulance Resources

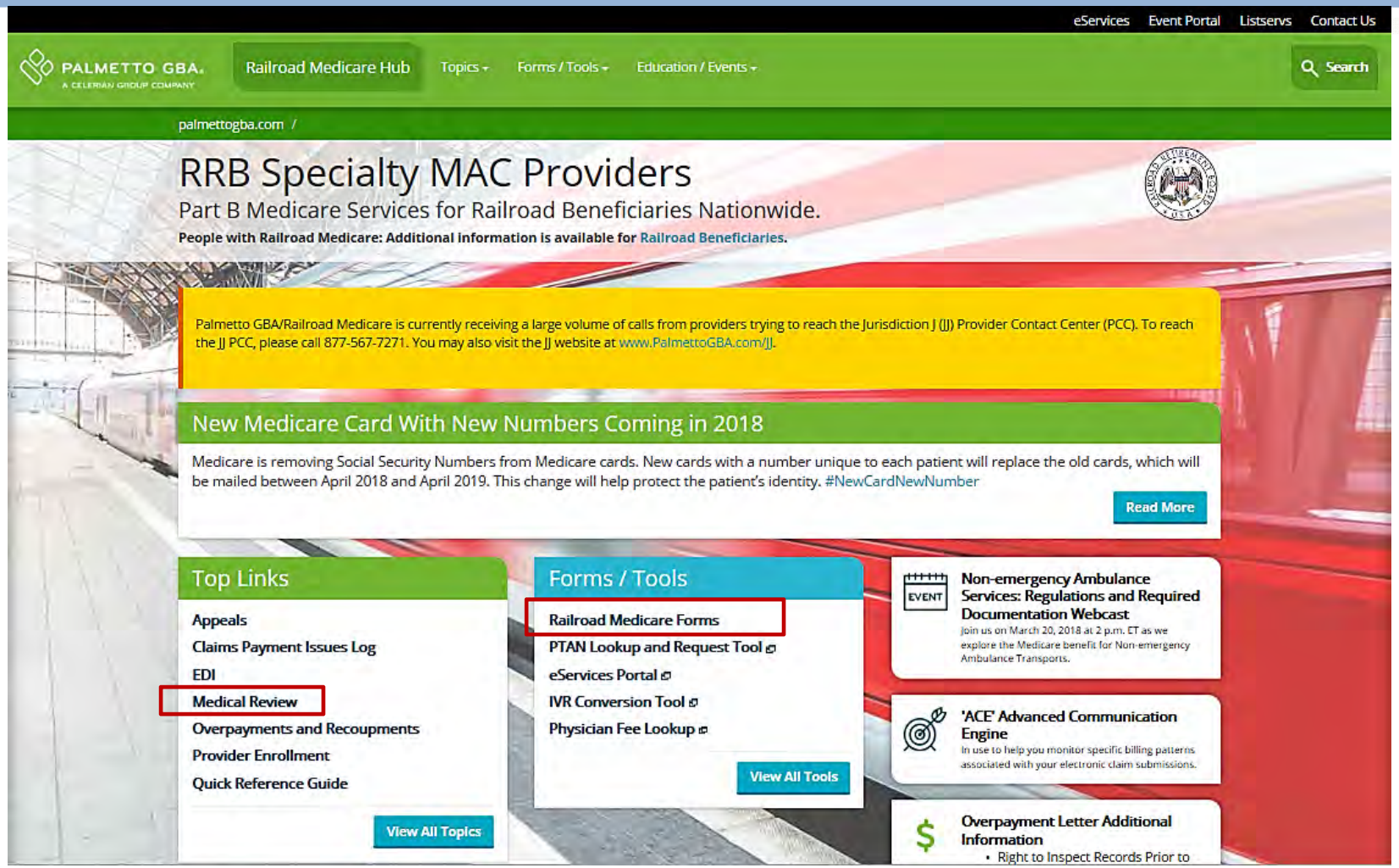
- Medicare Ambulance Transports Booklet
  https://tinyurl.com/MLN903194
- Ambulance Fee Schedule Fact Sheet
  https://tinyurl.com/MLN006835

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

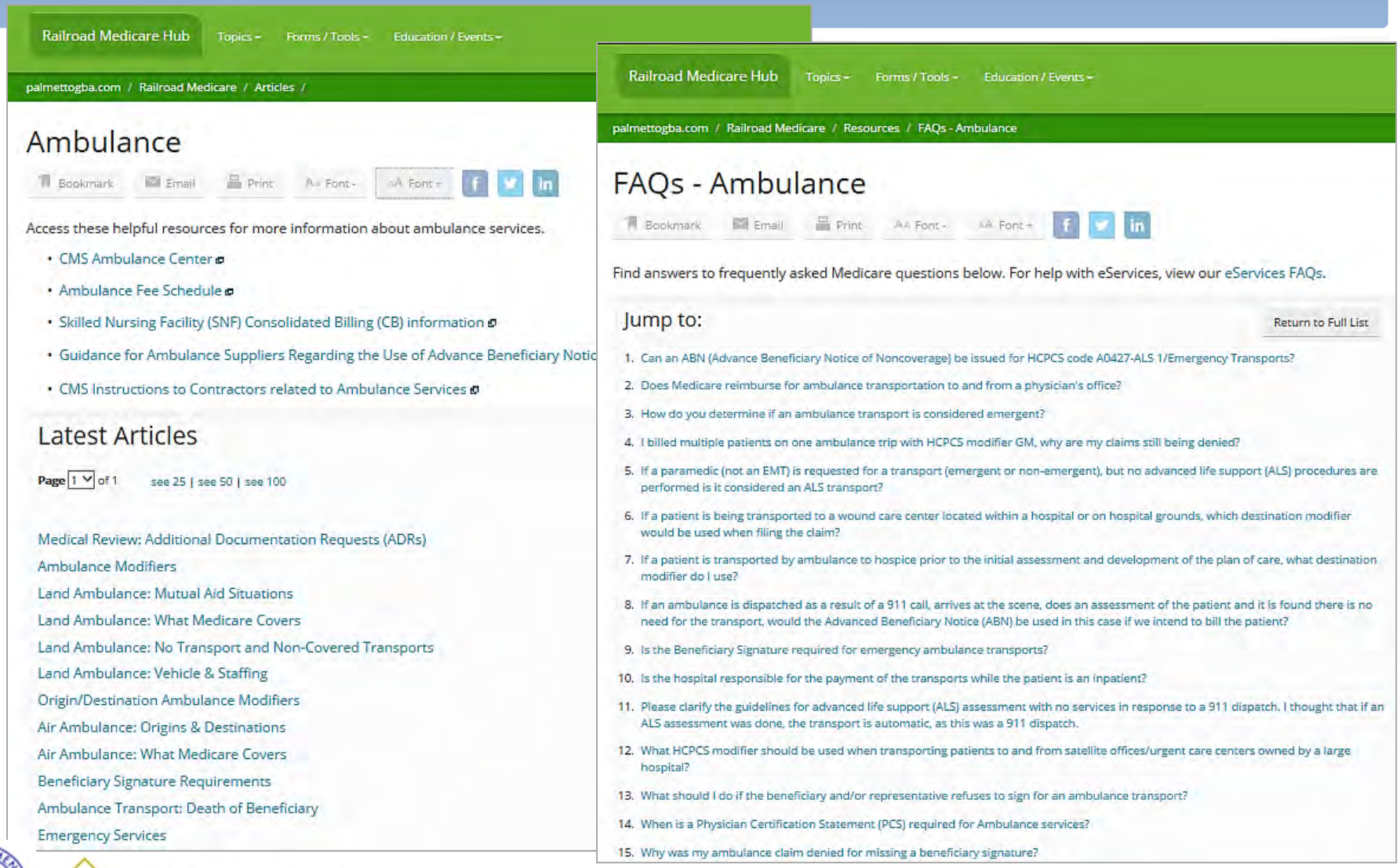
  https://tinyurl.com/AmbulanceODF

RRB SMAC Resources



www.PalmettoGBA.com/RR

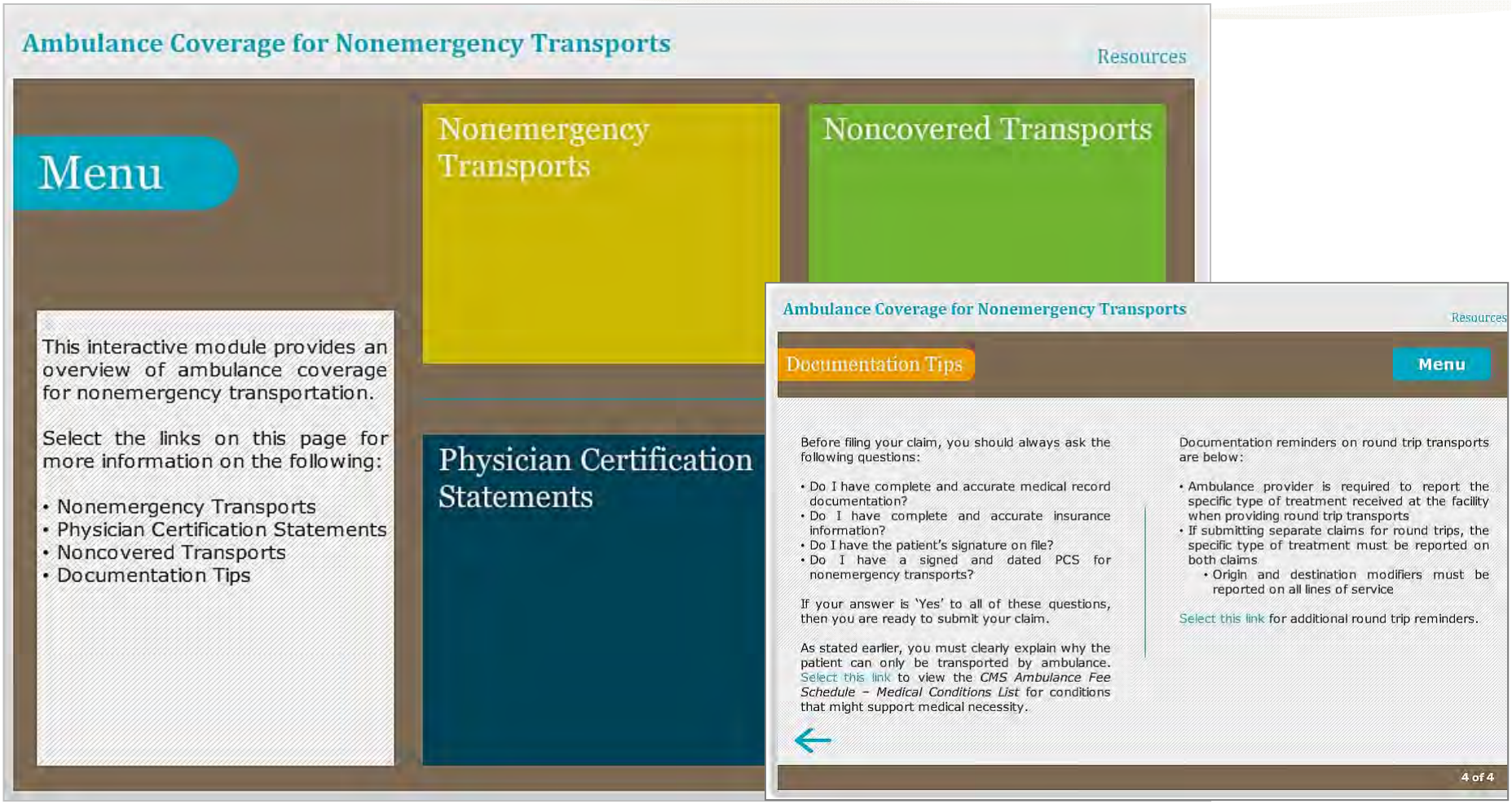
RRB SMAC Ambulance Resources



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

Ambulance Coverage for Non-Emergency Transports Module



https://www.palmgba.com/elearn/Ambulance_Coverage_RR/story.html

Top 10 Medical Review Denials Module

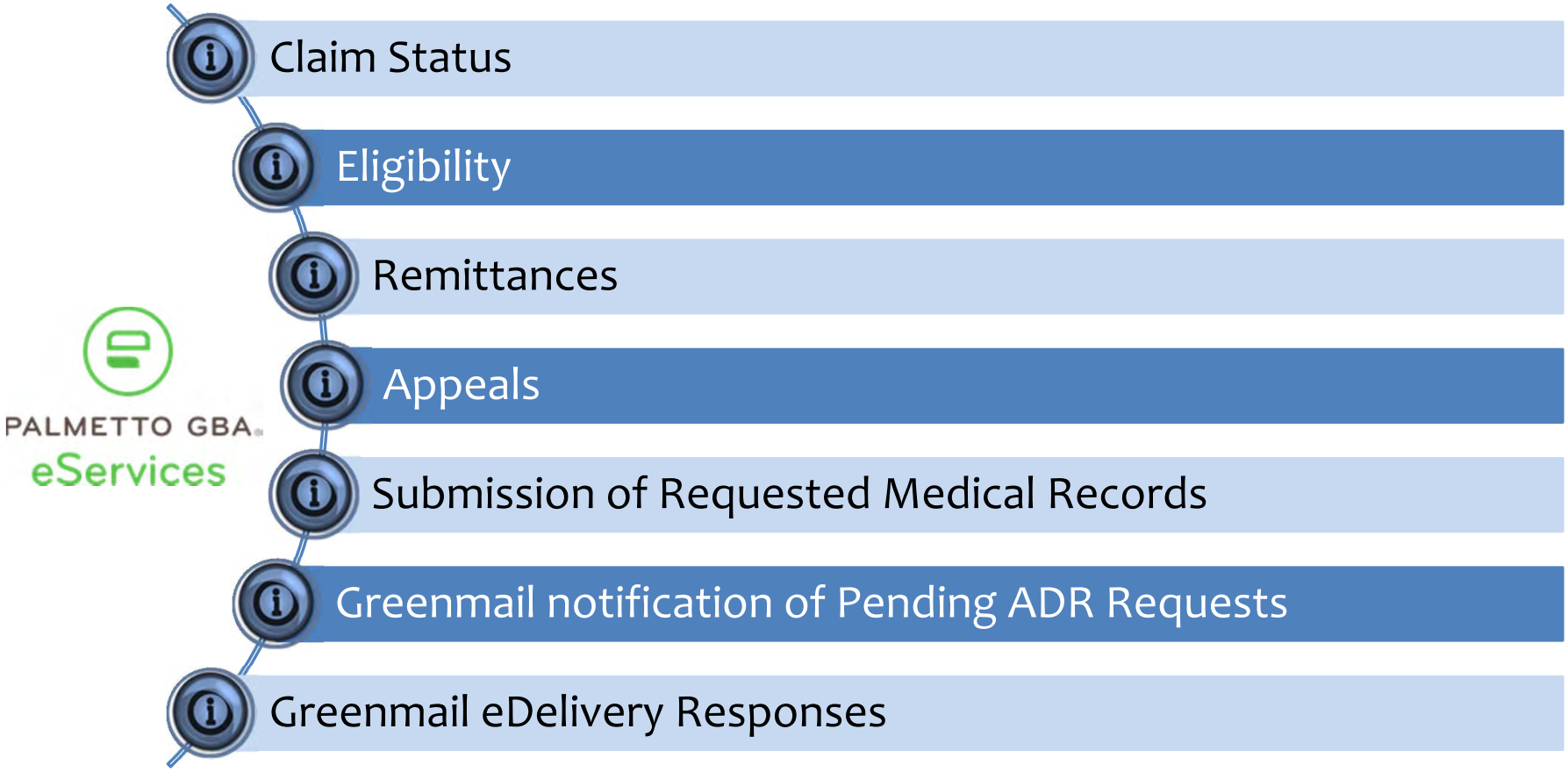
Railroad Medicare Medical Review Denials by Service Type
Ranked by Category

Reporting Period: October 1, 2017 - December 31, 2017

Service Type	Rank	Medical Review Comment	Medical Review Comment Description
Ambulance	1	Non-response	No Response to Additional Documentation Request
Ambulance	2	NODOC	Documentation requested for this date of service was not received or was incomplete
Ambulance	3	BNSIG	Documentation received lacks the necessary beneficiary or authorized representative signature
Ambulance	4	ILDOC	Information submitted deemed illegible
Ambulance	5	ASAVA	Alternative services were available and should have been utilized
Ambulance	6	ISIGN	Information submitted contains an invalid/illegible provider signature

https://www.palmgba.com/elearn/Top10MRDenialsRRB/story.html

eServices Portal



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…

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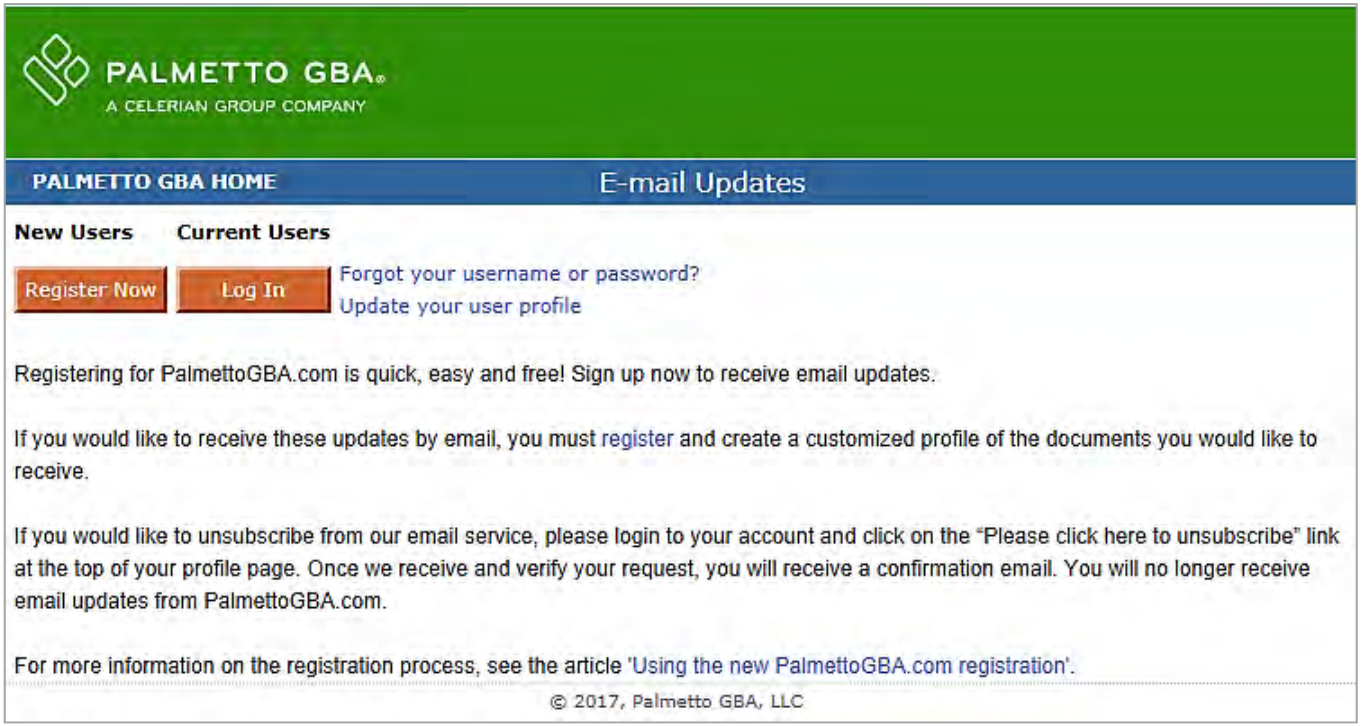

Railroad Medicare Contacts

RAILROAD MEDICARE RESOURCES	
Railroad Medicare Homepage	www.PalmettoGBA.com/RR
Palmetto GBA Listserv	www.PalmettoGBA.com/RR Select 'Listservs' from top tool bar
Contact Us By Email	Medicare.Railroad@PalmettoGBA.com
eServices	www.PalmettoGBA.com/eServices www.PalmettoGBA.com/RR Under Forms/Tools
CMS Listserv	https://tinyurl.com/CMSEmailUpdates

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