FIRST COAST SERVICE OPTIONS, INC.

First Coast Ambulance Update

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Presented By

FIRST COAST SERVICE OPTIONS, INC.

First Coast Service Options, Inc.
Provider Outreach & Education

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Acronyms

- ABN — Advance beneficiary notice
- ALS — Advanced life support
- BLS — Basic life support
- CERT — Comprehensive error rate testing
- CMS — Centers for Medicare & Medicaid Services
- IOM — Internet-only manual

Agenda Items

- Data and coding
- Medical necessity
- Documentation
- Compliance
- Ambulance resources
- Questions and answers

Learning Objectives

- At the conclusion of this session, you'll be able to
  - Understand that data is showing widespread errors in billing for ambulance services
  - Explain Medicare requirements relating to necessity and documentation of ambulance services
  - Verify guidelines in development of compliance programs for proper review and billing of ambulance services
  - Locate resources that explain Medicare's requirements for proper ambulance billing and coding

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Data and Coding

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WHEN EXPERIENCE COUNTS & QUALITY MATTERS

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CERT

- Comprehensive Error Rate Testing
  - Random, post-pay sampling of contractor claim payment
  - Includes request (to provider) for documentation supporting services billed
  - Error rate determined based on how/if documentation supports services billed
    - Five categories of error
      - No documentation
      - Insufficient documentation
      - Medical necessity
      - Improper coding
      - Other

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WHEN EXPERIENCE COUNTS & QUALITY MATTERS

2016 CERT Data

- Medicare Fee-for-Service 2016 Improper Payments Report
  - Projected ambulance service error types, rates and dollars
    - Insufficient documentation – 8.6% ($412 million)
    - Medical necessity – 1.8% ($87 million)
    - No documentation – .3% ($13 million)
    - Upcoding – .3% ($13 million)
  - Among top 20 service types with highest improper payments: 11.7% – ($556 million)

The Supplementary Appendices for the Medicare Fee-for-Service 2016 Improper Payments Report

Review of Ambulance Codes

- Widespread probe to validate proper documentation/medical necessity
  - A0427 – ambulance service, advanced life support, emergency transport, level 1 (ALS 1)
  - A0428 – ambulance service, basic life support, non-emergency transport

Advanced Life Support (ALS1)

- A0427
  - Emergency transport, Level 1
  - ALS assessment or ALS intervention
      - Required to be done by emergency medical technician (EMT)-Intermediate or EMT-Paramedic
      - Applies only to ground transports
    - Must be in accord with 911 dispatch protocol
      - Immediate response at time of call
    - Beneficiaries' condition on scene may determine level of payment

Basic Life Support (BLS)

- A0428
  - Non-emergency transport
  - Reasons
    - Beneficiary is bed confined (at least one of the following)
      - Unable to get up from bed without assistance
      - Unable to ambulate
      - Unable to sit in chair or wheelchair
      - By itself not sufficient to determine Medicare coverage
    - Risk of physical injury to patient – observation required
    - Ongoing IV medicine/fluids required during transport
    - Medical treatment/observation needed during transport to prevent endangering patient's health

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Medical Necessity

Code of Federal Regulations

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- https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AmbulanceFeeSchedule/downloads/cfr410_40.pdf
  - "Medicare covers ambulance services…only if they are furnished to a beneficiary whose medical condition is such that other means of transportation are contraindicated"
  - Beneficiary's condition must require both ambulance transportation and level of service provided

WHEN EXPERIENCE COUNTS & QUALITY MATTERS

CMS Ambulance Guidelines

- If other transportation options available without endangering patient's health, no payment will be made for ambulance services
- Transport must be to obtain medically necessary Medicare covered service or return from such service
- Payment made according to level of medically necessary service provided
  - Not based on vehicle used
- No payment for transport of staff when beneficiary is not onboard

Documentation

Documentation Specifics

- Must support that beneficiary's condition required level of care
  - Procedure/diagnosis codes alone not basis for coverage
- Appropriate documentation
  - Dispatch instructions
  - Patient's condition
  - Other on-scene information
  - Details of transport (medications administered, changes in patient's condition, miles traveled)
  - Proper and eligible signatures
- Paint the picture!

Signature

- Documentation requires signature of beneficiary or their representative
  - Legal guardian
  - Relative or other person who
    - Receives governmental benefits on behalf of beneficiary
    - Arranges for beneficiary's treatment or has responsibility for their affairs
  - Representative of entity that did not provide ambulance service but furnished other care to beneficiary
  - Representative of provider or nonparticipating hospital if unable to have provider/hospital sign
    - Must make efforts to obtain from above selections

Signature (Cont.)

- Representative of ambulance provider who is present during transport
  - Must retain documentation for at least four years from date of service
  - Documentation must indicate that neither beneficiary nor any other person can sign
- Signature not required at time of transport – may be obtained any time prior to claim submission

Physician Certification Statement

- PCS
  - Addresses medically necessary, nonemergency, scheduled, repetitive ambulance services
    - Obtained by ambulance provider prior to furnishing service
    - Must be obtained no earlier than 60 days before date of service
    - No existing specific Medicare-approved form
    - Written order from beneficiary’s attending physician, certifying medical necessity
      - Physician Certification Statement form alone does not demonstrate medical necessity

PCS

- If unable to obtain from beneficiary's attending physician, can be obtained from
  - Physician assistant
  - Nurse practitioner
  - Clinical nurse specialist
  - Registered nurse
  - Discharge planner

  (Must have personal knowledge of beneficiary's condition at time of order and be employed by physician or facility)
- If unable to obtain within 21 calendar days following date of service, ambulance provider must document requests made and may submit claim

Mileage

- Billed separately from services
- Only mileage to nearest appropriate facility equipped to treat patient is covered
  - Covered exceptions relate to level/type of care needed or space limitations
  - For elected transports to facility that is not the nearest appropriate facility, beneficiary is only responsible for additional mileage to preferred facility

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Documentation Examples

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Documentation Example 1

- Code billed: A0427 (ambulance service, advance life support, emergency transport, level 1)
  - Documentation
    - “911 with immediate response for sick person. Patient with don’t feel well”; “still present”; “general malaise”
    - “Sick person (specific diagnosis listed) not alert”
    - “General feeling of weakness”
    - “No trauma”

  DENIED

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WHEN EXPERIENCE COUNTS & QUALITY MATTERS

Documentation Example 2

- Code billed: A0427
  - Documentation
    - “Patient complaining of pain all over”; “altered mental status”; “chronic pain from cancer”; “confused”; “malaise”; “lying on back”; “pain (unspecified)”; “pain level 7”; “all over/non-radiating”
    - Care events – patient assessment
      - “Inappropriate words”; “inconsistently consolable”; “moaning”
      - “Aphasia”
      - Multiple aberrant readings
    - “Stretcher”

  APPROVED

Documentation Example 3

- Code: A0428 (ambulance service, basic life support, non-emergency transport)
  - Documentation
    - “Medical necessity – Pt had bed confining generalized weakness. Pt is bed confined. Pt is unable to ambulate without assistance. Pt is unable to support self in wheelchair. Pt requires oxygen (unable to self administer”
    - “REASON FOR TRANSPORT BY AMBULANCE: pt is bed confined due to generalized weakness AAOX2 [Awake, alert and oriented to person and place], unable to care for self all other means of transport could endanger pt.; required O2 admin…could not self administer”; “altered mental status”

APPROVED

Documentation Example 4

- Code: A0427
  - Documentation
    - "911 with immediate response for unconscious/fainting. patient with weak"; "pt co feeling weak today. pt released from AMC yesterday for same. pt had BP increased. Pt denies cp [chest pain], caox3 [conscious, alert and oriented to person, place and time], maex4 [moves all extremities]. warm and dry. pt had positive ortho change. Attempted iv unsuccessful. Transport to amc"

DENIED

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WHEN EXPERIENCE COUNTS & QUALITY MATTERS

Documentation Answers Needed

- Why did the patient need an ambulance?
  - Why not another means of transportation?
- Why did the patient need the level of service provided?
- Why were they transported if they were AAO2 or CAOX3?
- Upon arrival, did patient's condition support transport?
  - Is medical necessity evident/documented?
- Has signature been captured?

Are these questions answered within the documentation?

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WHEN EXPERIENCE COUNTS & QUALITY MATTERS

Compliance

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WHEN EXPERIENCE COUNTS & QUALITY MATTERS

Compliance Program

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- Office of the Inspector General
  - https://oig.hhs.gov/fraud/docs/complianceguidance/032403ambulancecpgfr.pdf
    - Voluntary compliance program guidance for ambulance suppliers

WHEN EXPERIENCE COUNTS & QUALITY MATTERS

Compliance Program

1. Development of compliance policies and procedures
   - Develop written standards and procedures
   - Address specific areas of potential fraud or abuse
   - Review and revise periodically (e.g., annually)
2. Designation of a compliance officer
   - Officer and other bodies responsible for operating/monitoring compliance program
   - High-level individual reporting to upper management

Compliance Program (Cont.)

3. Education and training programs
   - Regular training and education of employees and other appropriate individuals
   - Tailored for delivery to maximize understanding of target audience
4. Internal monitoring and reviews
   - Identify problems
   - Review bills and medical records for compliance with coding and billing requirements
     - Random sampling of claims

Compliance Program (Cont.)

5. Responding appropriately to detected misconduct
   - Develop policies and procedures to detect offenses
   - Initiate corrective actions
     - Vary based on facts and circumstances
     - Resolve and correct in a timely manner
6. Developing open lines of communication
   - Maintain process to resolve and process complaints
   - Ensure effective lines of communication between compliance officer and all employees
   - Protect anonymity of complainants
   - Protect whistleblowers from retaliation

Compliance Program (Cont.)

7. Enforcing disciplinary standards through well-publicized guidelines
   - Develop policies and procedures to ensure appropriate disciplinary mechanisms and standards applied consistently and appropriately
   - Address situations where employees or contractors violate internal compliance policies, statutes, regulations or federal health care program requirements

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Ambulance Resources

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Payment Data

- Office of the Inspector General: Inappropriate Payments and Questionable Billing for Medicare Part B Ambulance Transports
  https://oig.hhs.gov/oei/reports/oei-09-12-00351.pdf
- US Department of Health and Human Services – The Supplementary Appendices for the Medicare Fee-for-Service 2016 Improper Payments Report
  https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/CERT/Downloads/AppendicesMedicareFee-for-Service2016ImproperPaymentsReport.pdf

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WHEN EXPERIENCE COUNTS & QUALITY MATTERS

CMS Internet-only Manuals

- Medicare guidelines regarding policy, coverage and billing
  - Publication 100-02, Medicare Benefit Policy Manual, Chapter 10 - Ambulance Services
  - Publication 100-04, Medicare Claims Processing Manual, Chapter 15 – Ambulance
  - Publication 100-08, Medicare Program Integrity Manual, Chapter 6 - Medicare Contractor Medical Review Guidelines for Specific Services

  https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs.html

CMS Ambulance Booklet

- Medicare Ambulance Transports

  https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Medicare-Ambulance-Transports-Booklet-ICN903194.pdf

CERT Document Request Listing

- Miles
- Trip record
- ER records
- ABN
- Physician's signed certification
- For Electronic Health Records, copy of electronic signature policy and procedures
  - Validation depends on obtaining this information
- Signature
- Proof of delivery

  https://certprovider.admedcorp.com/Content/DocRequestListings/Part%20B/Ambulance%20(provider%20specialty%2059).pdf

First Coast Resources

- Ambulance specialty webpage
  - https://medicare.fcso.com/Landing/138180.asp
- Local Coverage Determination (LCD)
  - Non- Emergency Ground Ambulance Services https://medicare.fcso.com/Fee_lookup/LCDDisplay.asp?id=L33383

Summary of Today's Topics

- Today we have reviewed
  - Data that is showing widespread errors in billing for ambulance services
  - Medicare requirements relating to necessity and documentation of ambulance services
  - Office of the Inspector General (OIG) Guidelines for development of compliance programs for proper review and billing of ambulance services
  - Resources that explain Medicare data and requirements for proper ambulance billing and coding

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WHEN EXPERIENCE COUNTS & QUALITY MATTERS

Question and Answer Session

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WHEN EXPERIENCE COUNTS & QUALITY MATTERS

Do ABNs Apply to Ambulance?

- Advance Beneficiary Notice (ABN): Medicare waiver of liability providers are required to give to Medicare patients for services provided that may not be covered or considered medically necessary
  - May not be used emergency care situations
  - Only applies when denial of claim is expected based on “not reasonable and necessary” exclusion
    - For nonemergency transports
    - Two criteria
      - It would have to be a Medicare covered service
      - The particular services would have to be determined to be not reasonable and necessary

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WHEN EXPERIENCE COUNTS & QUALITY MATTERS

Are Medicare Claims Crossed Over to Medicaid?

- If information for patient is within the Common Working File (CWF) at the time of claim processing, this is crossed over to Medicaid
  - Submitted electronically (not sent to postal address)
- Medicaid provides carrier with file of Medicaid enrollees – Medicare claims will automatically cross over to Medicaid
- Process is coordinated via the Benefits Coordination and Recovery Center (BCRC)
  - 855-798-2627; M-F, 8AM-8PM
- Medicaid never pays first when services covered by Medicare
  - Services should be billed to Medicare first

  https://medicare.fcso.com/COB/

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WHEN EXPERIENCE COUNTS & QUALITY MATTERS

Timely Filing?

- Does timely filing apply when secondary payer recoups payment saying Medicare was primary after timely filing deadline has passed?
  - Exceptions exist for timely filing (each case reviewed separately)
    - Retroactive Medicare entitlement: dually enrolled beneficiary receives notice of Medicare enrollment retroactive to or after date of service
      - Medicaid recoups payment, and timely filing limit has expired
    - Retroactive disenrollment from Medicare Advantage to date of service on or after disenrollment
  - Appeal of timely filing should include provision of disenrollment notification letter received by beneficiary

Thank You for Participating

- First Coast values your feedback
  - Please complete your evaluation form and return it before leaving