FIRST COAST SERVICE OPTIONS, INC.

Ambulance Services: New Policy and Review Updates (A/B)

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CMS CENTERS FOR MEDICARE & MEDICAID SERVICES

Presented By

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Acronyms

FIRST COAST SERVICE OPTIONS, INC.

ALS	Advanced life support
BLS	Basic life support
CMS	Centers for Medicare & Medicaid Services
EMT	Emergency medical technician
ESRD	End-stage renal disease
GPS	Global Positioning System
HCPCS	Healthcare Common Procedure Coding System
HICN	Health insurance claim number
IOM	Internet-only manual
LCD	Local coverage determination
MAC	Medicare Administrative Contractor
MACRA	Medicare Access and Children's Health Insurance Program Reauthorization Act

Acronyms (Cont.)

FIRST COAST SERVICE OPTIONS, INC.

- MBI — Medicare beneficiary identifier
- PCS — Physician Certification Statement
- RA — Recovery auditor
- SCT — Specialty care transport
- SNF — Skilled nursing facility
- SPOT — Secure Provider Online Tool
- TPE — Targeted probe and educate
- UPIC — Unified Program Integrity Contractor
- ZPIC — Zone Program Integrity Coordinator

Agenda Items

- Knowledge assessment
- Ambulance services data
- Local Coverage Determination (LCD) L37697 – New Policy
  - Ambulance coding
  - Documentation
- Targeted probe and educate (TPE)
- Ambulance updates
- Ambulance resources

Learning Objectives

- At the conclusion of this webcast you'll be able to
  - Explain recent data relating to the billing of ambulance services
  - Review and apply First Coast's new LCD addressing ambulance services
  - Prepare for the new TPE review process
  - Locate resources that address the Centers for Medicare & Medicaid Services (CMS) guidelines for providing and billing ambulance services

Knowledge Assessment

Ambulance Services Data

2017 Improper Payment Data

Ambulance Overpayment Rates/$*

- A0425 (mileage) -- 16.3% $145,680,160
- A0427 (advance life support) -- 8.7% $144,776,487
- A0428 (basic life support) -- 24.9% $229,671,508

Ambulance among top 20 service types with highest overpayment rates

- Insufficient Documentation 57.3%
- Medical Necessity 36.9%

** Projected*

Source: 2017 Medicare Fee-for-Service Supplemental Improper Payment Data

Local Review Data

- Probe performed in response to aberrancies with Healthcare Common Procedure Coding System (HCPCS) code A0428 (non-emergency transport, basic life support), with modifier HN and code A0425 (mileage) and modifier HN
  - HN – Hospital to Skilled Nursing Facility
  - Dates of service February 1, 2016 to July 31, 2016
- Error rate for HCPCS Codes A0428-HN and A0425-HN: 33.61%

Common Findings

- A0425: documentation did not include information stating the patient's condition was such that other means of transport was contraindicated
- A0428: medical necessity was not established in submitted documentation
  - Condition of patient not documented
  - No signs of respiratory or other distress; no reference to self or other administration of oxygen
  - Documentation says patient alert, awake, oriented, vital signs stable and able to stand - then says unable to sit upright
  - Narrative on report sheet did not support that patient unable to ambulate, stand without assistance, bed confined or sit upright

Local Coverage Determination (LCD) L37697 – New Policy

LCD L37697

- Emergency and Non-Emergency Ground Ambulance Services
  - Draft posted for comments 2/1/18
  - Comment period ended 3/22/18
  - Notice period began 5/10/18
  - LCD effective date 6/28/2018
    - Prior LCD addressed Non-Emergency Ground Ambulance Services only (L33383) - retired

Medical Necessity

- Medical necessity is established when patient's condition is such that use of any other method of transportation is contraindicated
  - If any other means of transport could be use, whether available or not, no payment will be made
  - Payment made based on level of service furnished, not vehicle used
  - Medical necessity is met under certain circumstances, including bed-confinement, defined as
    - Unable to get up from bed without assistance AND
    - Unable to ambulate AND
    - Unable to sit in a chair or wheelchair

    (All three circumstances must be met to be defined as "bed confined")

Medical Necessity (Cont.)

- Transport must be to obtain Medicare covered service or return from such a service
- Physician's order for ambulance transport neither proves or disproves whether transport was medically necessary
- Appropriate documentation must be kept on file and, upon request, presented to the A/B Medicare Administrative Contractor (MAC)

Signature

- Medicare requires signature of beneficiary or that of his or her representative for assignment and payment of claims
  - If beneficiary unable to sign, other representatives may sign on their behalf (see LCD for options)
- Signature not required at time of transport for accepting assignment – must be obtained within timely filing guidelines (12 months)
  - Must be obtained prior to filing claim
- If signature is refused, ambulance provider may not bill Medicare
  - May bill beneficiary or their estate for ambulance services

Mileage

- Mileage charges based on loaded mileage only (i.e., from point of pickup to arrival at destination)
  - Less than 100 total miles (round trip) – round to nearest tenth of a mile (i.e., 99.9)
  - If 100 miles or greater, round to next whole number mile without decimal (i.e., 998.5 would be reported as 999)
  - If trip is less than one mile, enter “0” before the decimal (i.e., 0.9)
- Documented miles and units should match
- Conflicting information may result in denial

Mileage (Cont.)

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- Providers are responsible for ensuring they have necessary equipment to measure fractional mileage to the tenth of a mile
  - Ensure onboard gauges are in working order
  - Tools that may be used:
    - Digital or analog odometers
    - Trip odometers
    - Global positioning system (GPS)
    - Onboard trip computers or navigation systems

Source: Fractional Mileage Amounts Submitted on Ambulance Claims

SCT Payment

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- Specialty Care Transport (SCT)
  - Inter-facility transport of critically injured/ill beneficiary by ground ambulance at level beyond scope of emergency medical technician (EMT)-Paramedic
    - Includes provision of medically necessary supplies and services
    - Patient requires ongoing care from one or more providers with additional training in appropriate specialty area
      - EMT-Paramedic level of care set by each state
    - For SCT payment, origin and destination facility must meet Medicare requirements

Source: Medicare Benefit Policy Manual, Chapter 10 - Ambulance Services

PCS

- Physician Certification Statement (PCS)
  - For **scheduled, repetitive** ambulance services
  - Before service, ambulance provider must obtain written order from beneficiary's attending provider certifying medical necessity
    - Dated no earlier than 60 days before date of service

    or
  - For ambulance services that are **unscheduled or scheduled on a non-repetitive basis** for a resident of a facility who is under the care of a physician
    - Within 48 hours of transport, ambulance provider must obtain written order from physician certifying medical necessity

PCS (Cont.)

- 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 required certification within 21 calendar days after date of service, may submit claim
  - Must document attempts to obtain the certification

Level of Support

- BLS (basic life support) or ALS (advanced life support) first level (ALS1) ambulance response must be in accordance with local 911 dispatch protocol ALS second level (ALS2) has additional requirements)
  - If no local protocol exists, state or jurisdictional protocol applies
  - When not consistent with protocol, patient's condition at the scene determines appropriate level of payment
  - Conditions warranting emergency services may manifest with acute symptoms of sufficient severity such that absence of medical attention would result in
    - Placing patient's health in serious jeopardy
    - Causing serious impairment to bodily functions
    - Causing serious dysfunction of any body organ or part

Destination

- An ambulance transport (that meets all other requirements for coverage) is covered to nearest appropriate facility to obtain necessary diagnostic and/or therapeutic services (such as a computerized tomography scan or cobalt therapy) as well as the return transport.
  - Only to the following destinations
    - Hospital
    - Critical Access Hospital
    - Skilled nursing facility (SNF)
    - Beneficiary's home
    - Dialysis facility for end stage renal disease (ESRD) patient who requires dialysis

Destination (Cont.)

- Covered destinations for **emergency** ambulance services are limited to
  - Hospitals
  - Physician's office only if, during emergency transport to hospital, ambulance stops at physician's office because of patient's dire need for professional attention, and immediately thereafter, continues to hospital
    - Patient deemed to have been transported directly to covered destination and payment may be made for single transport and entire mileage of transport, including any additional mileage traveled because of stop at physician's office

Locality

- “Locality” - service area surrounding the institution to which the individuals normally travel or are expected to travel to receive hospital or SNF services
  - EXAMPLE: *Mr. A becomes ill at home and requires ambulance service to hospital. Small community in which he lives has a 35-bed hospital. Two large metropolitan hospitals are located some distance from Mr. A's community and both regularly provide hospital services to community's residents. Community is within the "locality" of both metropolitan hospitals and direct ambulance service to either of these (as well as to the local community hospital) is covered.*

Vehicle Qualifications

- Vehicle must be specifically designed/equipped to respond to medical emergencies and, in nonemergency situations, capable of transporting beneficiaries with acute medical conditions
  - BLS ambulance must be staffed by at least two people – one with specific qualifications (state or local EMT-basic certification) and authorized to operate all lifesaving/sustaining equipment on- board
  - ALS vehicles must be staffed by at least two people and at least one must meet BLS vehicle staff requirements above and meet state or local qualifications as EMT-Intermediate or EMT-Paramedic

Source: Medicare Benefit Policy Manual, Chapter 10 - Ambulance Services

Transportation Limitations

- The following are not reasonable and necessary
  - To a funeral home
  - Between residences
  - From hospital with appropriate facilities/staff to another hospital
  - Multiple types of vehicles not qualified for emergency transport
  - Ambulance transportation services covered under Part A
    - (e.g., transport covered under hospital inpatient stay or SNF consolidated billing)
  - Ambulance response and treatment without transportation
  - Patient refusal for transport
  - Transportation to receive excluded service
  - Transportation if for the purpose of receiving service that could have been provided safely/effectively at point of origin

Covered Indications

- Payment may be made if following conditions met
  - Patient transported by approved supplier of ambulance services
  - Patient suffering from illness or injury which contraindicated transportation by other means
    - Multiple conditions/scenarios specified in LCD
  - Transported from and to specific points listed within LCD

Ambulance Coding

Ambulance Procedure Codes

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- A0425 Ground mileage, per statute mile
- A0426 Ambulance service, non-emergency transport, Level 1 (ALS1)
- **A0427** Ambulance service, emergency transport, Level 1, (ALS1-Emergency)
- A0428 Ambulance, basic life support, non-emergency transport, (BLS)
- **A0429** Ambulance service, basic life support, emergency transport (BLS-Emergency)
- **A0433** Advanced life support, Level 2 (ALS2)
- A0434 Specialty care transport
- A0999 Unlisted ambulance service

Ambulance Coding Rules

- Emergency ambulance services will be denied if not billed with destination modifier H (Hospital).
- Providers should report most appropriate ICD-10-CM code that adequately describes patient's medical condition as primary diagnosis and must report a secondary diagnosis listed in the LCD

Ambulance Service Modifiers

- D Diagnostic or therapeutic site other than P or H when used as origin codes
- E Residential, domiciliary, custodial facility (other than 18/19)
- G Hospital based ESRD facility
- H Hospital
- I Site of transfer (e.g. airport or helicopter pad) between modes of ambulance transport
- J Freestanding ESRD facility
- N Skilled nursing facility
- P Physician's office
- R Residence
- S Scene of accident or acute event
- X Intermediate stop at physician's office on way to hospital (destination code only)

Ambulance Diagnosis Codes

- Secondary ICD-10 codes
  - Z74.01 Bed confinement status
  - Z74.3 Need for continuous supervision
  - Z78.1 Physical restraint status
  - Z78.9 Other specified health status
  - Z99.11 Dependence on respirator (ventilator) status
  - Z99.81 Dependence on supplemental oxygen
  - Z99.89 Dependence on other enabling machines and devices

Documentation

Documentation Requirements

- Maintained in patient's medical record and available upon request
- Legible and include complete patient information and appropriate signatures
- Applicable procedure and diagnosis codes
- Dispatch instructions, patient's condition, other on-scene information, details of transport (e.g., medications administered, changes in patient's condition and mileage)
  - PCS when required
- Trip record: detailed description of patient's condition at time of transport to determine that other means of transportation are contraindicated
- Description of specific monitoring and/or treatments ordered and performed/administered during transport

Targeted Probe and Educate

TPE Initiation

- MACs identify topics and providers for review
  - Letter sent to providers/suppliers identified for review
    - Outlines TPE process
    - Notification that MACs have option for referring providers/suppliers to recovery auditor (RA) or Zone Program Integrity Contractor/Unified Program Integrity Contractor (ZPIC/UPIC) for non-response
    - For prepayment TPE
      - Notification letter sent prior to documentation request
    - For post payment TPE
      - Notification letter sent with documentation request

TPE Activities

TPE activities performed for three rounds

Notification letter sent outlining TPE process

Documentation requested for a minimum of 20 and maximum of 40 claims

Letter sent to provider at the conclusion of each round detailing review results and offering one-on-one education

Gap of 45-56 days between each educational intervention and next round, allowing provider time to make improvements

Review discontinued if/when the provider becomes compliant

Providers remaining non-compliant referred to CMS for additional action

TPE - Ambulance

- TPE Process
- Notice of medical review topics
  - A0425
  - A0428

Learning Assessment

Ambulance Updates

MM10550

- Ambulance Transportation for a SNF Resident in a Stay not Covered by Part A – Medicare Benefit Policy Manual, Chapter 10, and Medicare Claims Processing Manual, Chapter 15
  - **Effective**: 07/16/18 **Implementation**: 07/16/18
  - Medically necessary ambulance transport from SNF to nearest supplier of medically necessary services not available at SNF where beneficiary resides (including round trip) may be covered under Part B
    - Applies to beneficiaries in SNF stay not covered by Part A but who have Part B
      - Example: transport from SNF (modifier N) to nearest diagnostic site, other than office or hospital (modifier D)

MM10549

- Increased Ambulance Payment Reduction for Non-Emergency BLS Transports to and from Renal Dialysis Facilities
  - **Effective**: 10/01/18 **Implementation**: 10/01/18
  - Reduces ambulance payment by 23 percent for non-emergency BLS transports of individuals with ESRD, to and from renal dialysis treatment
    - For both hospital-based and freestanding renal dialysis treatment facilities
    - Payment reduction applies to base rate and mileage
      - HCPCS codes A0428 (non-emergency BLS) and A0425 (mileage)
    - Accurate origin and destination modifiers must be reported for each ambulance trip provided

MM10549 (Cont.)

- Reduction to be applied to all claim lines with modifier codes “G” (hospital based ESRD facility) and “J” (freestanding ESRD facility)
- MACs may override or reverse reduction on appeal based on supporting documentation

New Medicare Cards

New Medicare Cards

- Medicare Access and Children's Health Insurance Program Reauthorization Act (MACRA) requires removal of Social Security Numbers from all Medicare cards
  - New cards mailed between April 2018 and April 2019
  - Health insurance claim number (HICN) replaced with Medicare beneficiary identifier (MBI)
- For more information and resources
  - CMS' New Medicare cards web page
  - New Medicare cards Open Door Forums
  - First Coast home page icon
  - Learning On Demand
    - 11/14 -- New Medicare cards are coming: Will you be ready?

Ambulance Resources

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medicare.fcso.com

medicareespanol.fcso.com

First Coast Resources

- Ambulance Specialty page
- Secure Provider Online Tool (SPOT)
  - July
    - Timeout session warning message at 10 minutes
  - August
    - Appeals outcome tool
  - October
    - Reopenings expansion to multiple actions per line

Medicare Speaks 2018

- ***Panama City***
  - November 7-8

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CMS Resources

- CMS Internet-only manuals (IOMs)
  - Publication 100-02, Medicare Benefit Policy Manual, Chapter 10 - Ambulance Services
  - Publication 100-04, Medicare Claims Processing Manual, Chapter 15 – Ambulance
- Medicare Ambulance Transports
- CMS Ambulances Services Center

Summary of Today's Topics

- Today we have reviewed
  - Recent data relating to the billing of ambulance services
  - First Coast's new LCD addressing ambulance services
  - The new Targeted Probe and Educate review process
  - Resources that address CMS guidelines for providing and billing ambulance services

Questions and Answers

- Participant instructions
  - Click on "raise hand" button to indicate you have a question
  - When called upon to ask your question, we'll un-mute your phone line
  - Please speak clearly when asking your question

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