

PROVIDER COMPLIANCE TIPS FOR AMBULANCE SERVICES



PROVIDER TYPES AFFECTED

Ambulance Suppliers

BACKGROUND

The Medicare Fee-For-Service improper payment rate for ambulance services for the 2017 reporting period is 15.5 percent, representing a projected improper payment amount of \$687.5 million.

Medicare covers ambulance services only for beneficiaries whose medical condition is such that use of any other means of transportation is contraindicated. The beneficiary's condition must require both the ambulance transportation itself and the level of service provided in order for the billed service to be considered medically necessary.

REASONS FOR DENIAL FOR AMBULANCE SERVICES

For the 2017 reporting period, insufficient documentation accounted for 57.3 percent of improper payments for ambulance services. Additional types of errors for ambulance services in the 2017 reporting period were medical necessity (36.9 percent), no documentation (2.7 percent), incorrect coding (2.3 percent), and other (1.0 percent).

TO PREVENT DENIALS OF EMERGENCY AMBULANCE SERVICES

The following conditions must be met to be considered eligible for Medicare emergent ambulance services:

- Patient was transported by an approved supplier of ambulance services
- The patient was suffering from an illness or injury, which contraindicated transportation by other means

The following scenarios constitute medical necessity:

- The patient was transported in an emergency situation, e.g., as a result of an accident, injury, or acute illness
- The patient needed to be restrained in order to prevent injury to themselves or others
- The patient required oxygen or other emergency treatment during transport to the nearest appropriate facility
- The patient was unconscious or in shock
- The patient exhibited signs and symptoms of acute respiratory distress or cardiac distress such as shortness of breath or chest pain

- The patient exhibited signs and symptoms that indicate the possibility of acute stroke
- The patient needed to remain immobile because of a fracture that had not been set or the possibility of a fracture
- The patient experienced severe hemorrhage
- The patient was confined to a bed before and after the ambulance trip

TO PREVENT DENIALS OF NON-EMERGENT AMBULANCE SERVICES:

Nonemergency transportation by ambulance is appropriate if either: the beneficiary is bed-confined, and it is documented that the beneficiary's condition is such that other methods of transportation are contraindicated; or, if his or her medical condition, regardless of bed confinement, is such that transportation by ambulance is medically required. Thus, bed confinement is not the sole criterion in determining the medical necessity of ambulance transportation. It is one factor that is considered in medical necessity determinations.

For a beneficiary to be considered bed-confined, the following criteria must be met:

- The beneficiary is unable to get up from bed without assistance
- The beneficiary is unable to ambulate
- The beneficiary is unable to sit in a chair or wheelchair

FOR AMBULANCE SERVICES:

Medicare requires the signature of the beneficiary, or that of a person authorized to sign the claim form on behalf of the beneficiary in order for an ambulance supplier or provider to submit a claim. If the beneficiary is unable to sign because of a mental or physical condition, the following individuals may sign the claim form on behalf of the beneficiary:

- Beneficiary's legal guardian
- A relative or other person who receives social security or other governmental benefits on behalf of the beneficiary
- A relative or other person who arranges for the beneficiary's treatment or exercises other responsibility for his or her affairs
- A representative of an agency or institution that did not furnish the services for which payment is claimed, but furnished other care, services or assistance to the beneficiary
- A representative of the provider or of the nonparticipation hospital claiming payment for services it has furnished, if the provider or nonparticipating hospital is unable to have the claim signed in accordance with 42 CFR 424.36(b) (1-4)

RESOURCES

| FOR MORE INFORMATION ABOUT... | RESOURCE |
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| 2017 Medicare Fee-for-Service Supplemental Improper Payment Data | https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/CERT/CERT-Reports-Items/2017-Medicare-FFS-Payment-Data.html?DLPage=1&DLEntries=10&DLSort=0&DLSortDir=descending |
| Code of Federal Regulations 42 CFR 410.40 | https://www.ecfr.gov/cgi-bin/text-idx?SID=1ecb0d5402f2047718d5da31f77f1125&mc=true&node=se42.2.410_140&rgn=div8 |
| Medicare Benefit Policy Manual, Chapter 10, Section 10.1.3 | https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c10.pdf |

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