

III. Specific Fraud and Abuse Risks Associated With Medicare Ambulance Coverage and Reimbursement Requirements

Ambulance suppliers should review and understand applicable ambulance coverage requirements. Ambulance suppliers that are not complying with applicable requirements should take appropriate, prompt corrective action to follow the relevant requirements. The new fee schedule covers seven levels of service, including Basic Life Support (BLS), Advanced Life Support, Level 1 (ALS1), Advanced Life Support, Level 2 (ALS2), Specialty Care Transport, Paramedic ALS Intercept, Fixed Wing Air Ambulance, and Rotary Wing Air Ambulance. Generally, Medicare Part B covers ambulance transports if applicable vehicle and staff requirements, medical necessity requirements, billing and reporting requirements, and origin and destination requirements are met. Medicare Part B will not pay for ambulance services if Part A has paid directly or indirectly for the same services.

A. Medical Necessity

Medically unnecessary transports have formed the basis for a number of Medicare and Medicaid fraud cases. Consequently, medical necessity is a risk area that should be addressed in an ambulance supplier's compliance program. Medicare Part B covers ambulance services only if the beneficiary's medical condition contraindicates another means of transportation. The medical necessity requirements vary depending on the status of the ambulance transport (*i.e.*, emergency transport vs. non-emergency transport). If the medical necessity requirement is met, Medicare Part B covers ambulance services when a beneficiary is transported:

- To a hospital, a critical access hospital (CAH), or a skilled nursing facility (SNF), from anywhere, including another acute care facility, or SNF;
- To his or her home from a hospital, CAH, or SNF;
- Round trip from a hospital, CAH, or SNF to an outside supplier to receive medically necessary therapeutic or diagnostic services; or
- To the nearest appropriate renal dialysis facility from his or her home.

1. Upcoding

Ambulance suppliers should be careful to bill at the appropriate level for services actually provided. The federal government has prosecuted a number of ambulance cases involving upcoding

from BLS to ALS related to both emergency and non-emergency transports. In 1999, for example, an OIG investigation determined that an ambulance supplier was not only billing for ALS services when BLS services were provided, but the ambulance supplier did not employ an ALS-certified individual to perform the necessary ALS services. This supplier paid civil penalties and signed a five-year corporate integrity agreement (CIA).

2. Non-Emergency Transports

There have also been a number of Medicare fraud cases involving non-emergency transports (i) to non-covered destinations and (ii) that were not medically necessary. An OIG OEI report, issued in December 1998, found that a high number of non-emergency transports for which Medicare claims were submitted were medically unnecessary as defined by Medicare's criteria. Medicare's ambulance fee schedule identifies non-emergency transport as appropriate if (i) the beneficiary is bed-confined and his or her medical condition is such that other methods of transportation are contraindicated, or (ii) the beneficiary's medical condition, regardless of bed-confinement, is such that transportation by ambulance is medically required. The beneficiary's medical condition and the necessity for ambulance transportation must be documented. In determining whether a beneficiary is bed-confined, the following criteria must be met: (i) The beneficiary must be unable to get up from bed without assistance; (ii) the beneficiary must be unable to ambulate; and (iii) the beneficiary must be unable to sit in a chair or wheelchair (42 CFR 410.40 (d)). The fact that other modes of transportation may not be as readily available or as convenient does not justify coverage for ambulance transport for a beneficiary who does not meet Medicare's medical necessity requirements.

Under no circumstances should ambulance suppliers mischaracterize the condition of the patient at the time of transport in an effort to claim that the transport was medically necessary under Medicare coverage requirements. If it is unclear whether the service will be covered by Medicare, the ambulance supplier should nonetheless appropriately document the condition of the patient and maintain records of the transport.

3. Scheduled and Unscheduled Transports

Because of the potential for abuse in the area of non-emergency transports, Medicare has criteria for the coverage of non-emergency scheduled and unscheduled ambulance transports. For example, physician certification statements (PCS) should be obtained by an ambulance supplier to verify that the transport was medically necessary. The PCSs should provide adequate information on the transport provided for each individual beneficiary, and each PCS must be signed by an appropriate physician or other appropriate health care professional. Except for pre-signed PCSs for scheduled, repetitive ambulance transports, which can be valid for up to 60 days of transport service, pre-signed and/or mass produced PCSs are not acceptable because they increase the opportunity for abuse.

Medicare does not cover transports for routine doctor and dialysis appointments when beneficiaries do not meet the Medicare medical necessity requirements. Similarly, ambulance services that are rendered for convenience or because other methods of more appropriate transportation are not available do not meet Medicare's medical necessity requirements and claims for such services should not be submitted to Medicare for payment. For example, an ambulance supplier was required to pay over \$1 million to the federal government and enter into a CIA with the OIG for billing for medically unnecessary ambulance trips and for non-covered ambulance trips to doctors' offices.

B. Documentation, Billing, and Reporting Risks

Currently, the HCFA 1491 or 1500 forms are the approved forms for requesting Medicare payment for ambulance services. Inadequate or faulty documentation is a key risk area for ambulance suppliers. The compilation of correct and accurate documentation (whether electronic or hard copy) is generally the responsibility of all the ambulance personnel, including the dispatcher who receives a request for transportation, the personnel transporting the patient, and the coders and billers submitting claims for reimbursement. When documenting a service, ambulance personnel should not make assumptions or inferences to compensate for a lack of information or contradictory information on a trip sheet, ACR, or other medical source documents.