

To ensure that adequate and appropriate information is documented, an ambulance supplier should gather and record, at a minimum, the following:

- Dispatch instructions, if any;
- Reasons why transportation by other means was contraindicated;
- Reasons for selecting the level of service;
- Information on the status of the individual;
- Who ordered the trip;
- Time spent on the trip;
- Dispatch, arrival at scene, and destination times;
- Mileage traveled;
- Pickup and destination codes;
- Appropriate zip codes; and
- Services provided, including drugs or supplies.

1. Healthcare Common Procedure Coding System (HCPCS)

The appropriate HCPCS codes should be used when submitting claims for reimbursement. The HCPCS codes reported on the ambulance trip sheets or claim forms should be selected to describe most accurately the type of transport provided based on the patient's illness, injury, signs, or symptoms at the time of the ambulance transport. HCPCS codes should not be selected based on information relating to the patient's past medical history or prior conditions, unless such information also specifically relates to the patient's condition at the time of transport. Ambulance suppliers should use caution not to submit incorrect HCPCS codes on trip sheets or claims to justify reimbursement.

2. Origin/Destination Requirements—Loaded Miles

Medicare only covers transports for the time that the patient is physically in the ambulance. Effective January 1, 2001, ambulance suppliers must furnish the "point of pickup" zip code on each ambulance claim form. Under the new Medicare ambulance fee schedule, the point of pickup will determine the mileage payment rate. The ambulance supplier should document the address of the point of pickup to verify that the zip code is accurate.

The ambulance crew should accurately report the mileage traveled from the point of pickup to the destination. Medicare covers ambulance transports to the nearest available treatment facility. If the nearest facility is not appropriate (e.g., because of traffic patterns or an inability to address the patient's condition), the beneficiary should be taken to the next closest appropriate facility. If a beneficiary

requests a transport to a facility other than the nearest appropriate facility, the ambulance supplier should inform the patient that he or she may be responsible for payment of the additional mileage incurred.

3. Multiple Payors—Coordination of Benefits

Ambulance suppliers should make every attempt to determine whether Medicare, Medicaid, or other federal health care programs should be billed as the primary or as the secondary insurer. Claims for payment should not be submitted to more than one payor, except for purposes of coordinating benefits (e.g., Medicare as secondary payor). Section 1862(b)(6) of the Act (42 U.S.C. 1395y(b)(6)) states that an entity that knowingly, willfully, and repeatedly fails to provide accurate information relating to the availability of other health benefit plans shall be subject to a civil money penalty (CMP).

The OIG recognizes that there are instances when the secondary payor is not known or cannot be determined before the ambulance transportation claim is submitted. This may be particularly true for ambulance suppliers that have incomplete insurance information from a transported patient. In such situations, if an ambulance supplier receives an inappropriate or duplicate payment, the payment should be refunded to the appropriate payor in a timely manner. Accordingly, ambulance suppliers should develop a system to track and quantify credit balances to return overpayments when they occur.

C. Medicare Part A Payment for "Under Arrangements" Services

In certain instances, SNFs, hospitals, or CAHs, may provide ambulance services "under arrangements" with an ambulance supplier. In such cases, the SNF, hospital, or CAH is the entity furnishing the transport. Accordingly, Medicare pays the SNF, hospital, or CAH for the service. The SNF, hospital, or CAH pays the ambulance supplier a contractually agreed amount. Ambulance suppliers that provide such transports "under arrangements" with a SNF, hospital, or CAH should not bill Medicare for these transports. All such arrangements should be carefully reviewed to ensure that there is no violation of the anti-kickback statute, as more fully described in section V.

IV. Medicaid Ambulance Coverage

The Medicaid program, a joint federal and state health insurance program, provides funds for health care providers and suppliers that perform or deliver

medically necessary services for eligible Medicaid recipients. Each state establishes its own Medicaid regulations, which vary depending on the state plan. However, two federal regulations form the basis for all Medicaid reimbursement for transportation services and ensure a minimum level of coverage for transportation services. First, all states that receive federal Medicaid funds are required to assure transportation for Medicaid recipients to and from medical appointments (42 CFR 431.53). Second, federal regulations further define medical transportation and describe costs that can be reimbursed with Medicaid funds (42 CFR 440.170(a)).

In short, Medicaid often covers transports that are not typically covered by Medicare, such as transports in wheelchair vans, cabs, and ambulettes. However, the transports are subject to strict coverage and payment rules. The state Medicaid Fraud Control Units and federal law enforcement have pursued many fraud cases related to transportation services billed to Medicaid programs. Ambulance suppliers should review the Medicaid regulations governing their state or service territories to ensure that any billed services meet applicable Medicaid requirements.

V. Kickbacks and Inducements

A. What Is the Anti-Kickback Statute?

The anti-kickback statute prohibits the purposeful payment of anything of value (i.e., remuneration) in order to induce or reward referrals of federal health care program business, including Medicare and Medicaid business.¹² (See section 1128B(b) of the Act (42 U.S.C. 1320a-7b).) It is a criminal prohibition that subjects violators to possible imprisonment and criminal fines. In addition, violations of the anti-kickback statute may give rise to CMPs and exclusion from the federal health care programs. Both parties to an impermissible kickback transaction may be liable: the party offering or paying the kickback, as well as the party soliciting or receiving it. The key inquiry under the statute is whether the parties intend to pay, or be paid, for referrals. Paying for referrals need not be the only or primary purpose of a payment; as courts have found, if any one purpose of the payment is to induce or reward referrals, the statute is violated. (See, e.g., *United States v. Kats*, 871 F.2d 105 (9th Cir. 1989); *United States v. Greber*, 760 F.2d 68 (3d Cir.), cert. denied, 474 U.S. 988 (1985).) In short, an ambulance supplier should