Ambulance Provider Compliance Summary for
EMERGENCY RESPONSE
Compliance Criteria

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Source Information: Medicare Policy

Purpose
The United Mine Workers of America Health and Retirement Funds (the Funds) processes and pays Medicare claims as a Health Care Prepayment Plan contracted through the Centers for Medicare and Medicaid Services (CMS). The purpose of this summary is to provide education about Medicare documentation guidelines to improve the quality of records needed to support the payment of Medicare claims paid by the Funds on behalf of CMS.

Requirement & Retrospective Audits
Medicare requires documentation which is legible, complete, appropriately authenticated and supports medical necessity for services reported on the insurance claim form. You may be audited retrospectively by the Funds or CMS to ensure that you have complied with all Medicare payment policies.

Definitions & Terms

ALS1 (Advanced Life Support, Level 1): Advanced life support, level 1 (ALS1) is the transportation by ground ambulance vehicle and the provision of medically necessary supplies and services and the provision of an ALS assessment or at least one advanced life support (ALS) intervention.

ALS Assessment: An ALS assessment is an assessment performed by an ALS crew as part of an emergency response that was necessary because the beneficiary's reported condition at the time of dispatch was such that only an ALS crew was qualified to perform the assessment. An ALS assessment does not necessarily result in a determination that the patient requires an ALS level of service.

ALS Intervention: An ALS intervention is a procedure that is, in accordance with state and local laws, required to be done by an emergency medical technician-intermediate (EMT-Intermediate) or EMT-Paramedic. An ALS1 emergency is the provisions of ALS1 services in the context of an emergency response in which the ambulance provider or supplier begins as quickly as possible to take the steps necessary to respond to the call.

ALS2 (Advanced Life Support, Level 2): Advanced life support, level 2 (ALS2) includes ground ambulance transport, the provision of medically necessary supplies and services and:

- At least three separate administrations of one or more medications by intravenous push/bolus or by continuous infusion (excluding crystalloid fluids); or

- At least one of the following procedures:

- Manual defibrillation/cardioversion;
- Endotracheal intubation;
- Central venous line;
- Cardiac pacing;
- Chest decompression;
- Surgical airway; or
- Intraosseous line;

Basic Life Support (BLS) - Emergency: A BLS emergency is the provision of BLS services in the context of an emergency response in which the ambulance provider or supplier begins as quickly as possible to take the steps necessary to respond to the call.

Ambulance Vehicles Defined: A BLS ambulance vehicle must be staffed by at least two individuals, one of whom must be certified as an emergency medical technician (EMT) by the state or local authority where the services are being furnished and be legally authorized to operate all lifesaving and life-sustaining equipment on board the vehicle. An ALS ambulance vehicle must be staffed by at least two individuals, one of whom must be certified by the state or local authority as an EMT-Intermediate or an EMT-Paramedic.

Paramedic Intercept (PI): PI services are ALS services provided by an entity that does not provide the ambulance transport. PI may be required when the ambulance provider or supplier can provide only a BLS level of service and the beneficiary requires an ALS level of service (e.g., electrocardiogram monitoring, chest decompression, or intravenous therapy). Additional requirements may apply according to the law in your state.

"Provider" Definition: Medicare uses the term “provider” to reference a hospital-based ambulance provider which is owned and/or operated by a hospital, critical access hospital, skilled nursing facility, comprehensive outpatient rehabilitation facility, home health agency, or hospice program.

Specialty Care Transport (SCT): SCT is the interfacility transportation of a critically ill or injured beneficiary by a ground ambulance vehicle, including the provision of medically necessary supplies and services at a level beyond the scope of an EMT-Paramedic. SCT is necessary when the beneficiary’s condition requires ongoing care that must be furnished by one or more health professionals in an appropriate specialty area (e.g., emergency or critical care nursing, emergency medicine, respiratory or cardiovascular care, or a paramedic with additional training).

"Supplier" Definition: Medicare defines the term supplier as any ambulance service that is not institutionally based. A supplier can be an independently owned and operated ambulance service company, a volunteer fire and/or ambulance company, a local government run firehouse based ambulance, etc., that provides Part B Medicare covered ambulance services and is enrolled as an independent ambulance supplier.

NOTE: For ease of reference in this document, "provider" refers to either an ambulance provider or supplier as described above.

LEGIBILITY OF RECORDS

Clinical Records are expected to be legible, authenticated and complete.

Legibility: Upon request for records or for authorization purposes, if hand-written records are not legible, please also submit a typed or printed version of the record reflecting its contents word-for-word.

Authentication (Signatures)

- Medicare generally requires that services provided/ordered be appropriately authenticated by the author. The Funds follows applicable Medicare guidelines for authentication.
- Ambulance personnel should sign records to include credentials. Ambulance company signature logs should be made available with the start date, end date of employment, and credentials (EMT, EMT-I, EMT-P, etc) and should be provided when medical records are requested for review or audit.
- A signature log includes the typed or printed name of the author associated with initials or an illegible signature.
- An attestation statement may be submitted when a signature and/or credentials are missing from the documentation. The attestation statement must be signed and dated by the author of the medical record entry and must contain sufficient information to identify the beneficiary.
- Providers should not add late signatures to the documentation (beyond the short delay that occurs during the transcription process).

Completeness of Clinical Records

Providers should maintain documentation to support their claims that includes the following information:

- Reason for the transport: A concise explanation of the symptoms reported by the patient and/or other observers and details of the patient's physical assessments that clearly demonstrate that the patient requires ambulance transportation and cannot be safely transported by an alternate mode of transportation.
- An objective description of the patient's physical condition in sufficient detail to demonstrate that the patient's condition or functional status at the time of transport meets the Medicare limitation of coverage for ambulance services.
- The relevant history (when available), observations, the patient's condition at the time of transfer and a detailed description of existing safety issues.
- A description of the traumatic event when trauma is the basis for the patient's suspected injuries.
- A detailed description of special precautions taken (if any) and an explanation of the need for such precautions.
- A description of all supplies used for the patient.

Documentation to Support Billing

Please submit the following to the Funds with your claims for payment:

- Point of pickup/destination (identify place and complete address).

- For hospital-to-hospital transports, a trip record that clearly indicates the precise treatment or procedure (or medical specialist) that is available only at the receiving hospital. Non-specific or vague statements such as "needs cardiac care" or "needs higher level of care" are insufficient.
- Any additional documentation available that supports the medical necessity of ambulance transport (e.g., emergency room report, Skilled Nursing Facility (SNF) record, End Stage Renal Disease (ESRD) facility record, hospital record).
- A dispatch record.
- A run sheet that includes information to support the HCPCS codes and ICD-9-CM codes reported on the health insurance claim.

Documenting Mileage

Documentation supporting the number of loaded miles billed should be submitted to the Funds. Odometer readings or proof of mileage should be submitted to the Funds.

- Roundtrip mileage less than 100 covered miles? If yes, report mileage units rounded up to the nearest tenth of a mile (except hard copy billers that use the UB-04). Providers and suppliers must submit fractional mileage using a decimal in the appropriate place (e.g., 99.9). Medicare contractors will truncate mileage units with fractional amounts reported to greater than one decimal place (e.g., 99.99 will become 99.9 after truncating the hundredths place).

- Roundtrip mileage 100 miles or greater? If yes, continue to report mileage rounded up to the nearest whole number mile (e.g., 999). Medicare contractors will truncate mileage units totaling 100 and greater that are reported with fractional mileage; (e.g., 100.99 will become 100 after truncating the decimal places).

- Roundtrip mileage less than 1 mile? If yes, providers and suppliers must include a "0" prior to the decimal point (e.g., 0.9). For ambulance mileage HCPCS only, Medicare contractors will automatically default "0.1" unit when the total mileage units are missing in Item 24G of the CMS-1500 claim form.

Air Ambulance Transport

There are two categories of air ambulance services: 1) fixed wing (airplane); and 2) rotary wing (helicopter) aircraft. The air ambulance mileage rate is calculated per actual loaded (patient onboard) miles flown and is expressed in statute miles (not nautical miles). Therefore, the following should be submitted to the Funds with your claims for air ambulance transport:

- Documentation showing whether a fixed wing or rotary wing aircraft was used for transport.
- Documentation showing the mileage recorded per actual load with patient onboard expressed in statute miles.
- Documentation of the patient's medical condition and need for immediate, rapid ambulance transportation that could not have been provided by ground ambulance. Such documentation should also show that the point of pickup is inaccessible by ground vehicle or that there are great distances or other obstacles involved in getting the patient to the nearest hospital with appropriate facilities.

- If the patient does not survive the air transport, a pronouncement of death made by an individual authorized under state law to make such pronouncements.
- Documentation showing that the signature requirements, above, are met and indicating that applicable ALS air transport team qualifications, if any, are met.

Medical necessity must be evident according to Medicare policy. The patient's condition must justify air transportation for payment to be considered. The list below is not all inclusive of all situations that justify air transportation, nor is it intended to justify air transportation in all locales in the circumstances listed, but represents the types of situations which may support medical necessity for air transport:

- Intracranial bleeding requiring neurosurgical intervention;
- Cardiogenic shock;
- Burns requiring treatment in a burn center;
- Conditions requiring treatment in a Hyperbaric Oxygen Unit;
- Multiple severe injuries; or
- Life-threatening trauma.

Air ambulance transports are ***not covered to a facility that is not an acute care hospital***. Air ambulance transports to the following destinations are ***not covered****:*

- Nursing facilities;
- Physicians' offices; and
- Beneficiaries' homes.

Recommended Medicare Resources & References (not all inclusive)

Medicare Benefit Policy Manual Chapter 10, Ambulance Services
Medicare Claims Processing Manual Chapter 15, Ambulance
Medicare Program Integrity Manual Chapter 6
Medlearn Matters - MM7065 Fractional Mileage