

# Ambulance Provider Compliance Summary for AMBULANCE TRANSPORT SERVICES Compliance Criteria

---

Date: April 23, 2012  
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**

**Ambulance Vehicles Defined:** A BLS (Basic Life Support) 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 (Advanced Life Support) 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.

**"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.

**"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

**Legibility:** Upon a 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**

#### ***Documentation to Support Billing***

Ground Ambulance Transports:

The following coverage requirements apply to ground ambulance transports:

- 1) The service must be medically necessary and reasonable;
- 2) A beneficiary must be transported; and
- 3) The facility must be the nearest appropriate facility.

A medically reasonable and necessary ground ambulance service must meet the following requirements:

- Due to the beneficiary's condition, the use of any other method of transportation is contraindicated; and
- The purpose of the transport is to obtain a Medicare-covered service or to return from obtaining such service.
- The ambulance transport will **not be covered** if some means of transportation other than an ambulance could be used without endangering the beneficiary's health, regardless of whether or not the other means of transportation is actually available.

For ambulance transportation services, the presence (or absence) of a physician's order for a transport by ambulance does not necessarily prove (or disprove) whether the transport was medically necessary. The ambulance service must meet all program coverage criteria in order for payment to be made. Please keep the physician's order on file and forward it when a request for information is made.

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 separate run sheet for each transport (e.g., two run sheets for roundtrips) that includes information to support the HCPCS codes and ICD-9-CM codes reported on your health insurance claim.
- A dispatch record.

### **Documenting Mileage**

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

### **Recommended Medicare Resources & References (not all inclusive):**

Medicare Benefit Policy Manual Chapter 10, Ambulance Services

Medicare Claims Processing Manual Chapter 15, Ambulance

---

The Funds - Provider Communications: Summary for Ambulance Emergency Transport Page 3 of 3

**Disclaimer: This information is provided by the UMWA Funds as an educational summary and may not include all requirements for Medicare coverage and payment. This summary does not supersede the official policies of the Centers for Medicare & Medicaid Services, and compliance with the guidance in this summary will not necessarily ensure payment. It is each health care provider's responsibility to understand and to stay current with all coding & billing guidelines, Local and National Coverage Determinations, and any other legal requirements of the Medicare program.**

