Patient Transportation, Facilities & Reimbursement:

A Building Relationships Seminar

An Educational Tool from Cornerstone Adminisystems, Inc.

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Ambulance Billing Experts

Patient Transportation, Facilities & Reimbursement:
A Building Relationships Seminar

Agenda

- Modes of Transportation
- Medical Necessity & Reasonableness
- Call Intake
- Physician Certification Statement (PCS)
- Covered Destinations & Closest Appropriate Facility
- CMS Prior Authorization Program
- Consolidated Billing
- Contracting & Compliance
- A Relationship that Works

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Modes of Transportation

- Basic or Advanced Life Support Ambulance (BLS/ALS)
  - Staffed by 2 medically trained crew members
  - Must meet medical necessity guidelines
  - May require additional paperwork
- Invalid Coach, Stretcher Van & Wheelchair Van
  - Staffed by 1 non-medically trained provider, unless state guidelines stipulate otherwise
    - Invalid/Stretcher – Patient flat on a stretcher in a van or van-type vehicle
    - Wheelchair – Patient must be able to sit in a wheelchair for transport

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Modes of Transportation

- Important to understand any state provisions that may determine proper mode of transport
  - For instance, invalid coach/stretcher van transports *performed in a van* typically fall under a state's Public Utilities Commission, not the governing body over EMS, which is generally the state's Department of Health. It is for this reason only 1 non-medically trained provider is acceptable.
  - However, if an ambulance company provides these services *in an ambulance*, they would fall under the governing body over EMS. In such cases, the crew requirements would then be for a BLS transport. Billing for an invalid/stretcher transport in this manner would be inappropriate.

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Modes of Transportation

BLS

- Emergency
  - 911 or equivalent
  - Meets definition of emergency
  - Meets definition of immediate response
  - Meet crew requirements

ALS

- Emergency
  - 911 or equivalent
  - Meets definition of emergency
  - Meets definition of immediate response
  - Meet crew requirements (EMT-I, EMT-P, or PHRN)
  - Provision of interventions or assessment

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Modes of Transportation

- Medicare defines an emergency as a BLS or ALS level of service that has been provided in immediate response to a 911 call or the equivalent.
- An immediate response is one in which the ambulance provider/supplier begins as quickly as possible to take the steps necessary to respond to the call.

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Modes of Transportation

- The phrase "911 call or equivalent" is intended to establish the standard that the nature of the call at the time of dispatch is the determining factor.
- Regardless of the medium by which the call is made the call is of an emergent nature when, based on the information available to the dispatcher at the time of the call, it is reasonable for the dispatcher to issue an emergency dispatch in light of accepted, standard dispatch protocol.

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Modes of Transportation

- A non-emergency transport, according to Medicare guidelines, is any transport that does not meet the definition of an emergency.
  - Can be scheduled or unscheduled
  - Provisions for repetitive transports
  - Emphasis on *medical necessity* & *reasonableness*
  - Emphasis on *properly executed* supporting paperwork

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Modes of Transportation

- ALS Level II is based on criteria (patient condition and interventions), *not* if it's an emergency or non-emergency
  - At least three separate administrations of one or more medications by intravenous push/bolus or by continuous infusion, **or**
  - Ground ambulance transport and the provision of at least one of the procedures listed below
    - Manual defibrillation/cardioversion
    - Endotracheal intubation
    - Central venous line
    - Cardiac pacing
    - Chest decompression
    - Surgical airway
    - Intraosseous line

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Modes of Transportation

- A transfer out of an emergency department does not necessarily make the transport an emergency according to CMS guidelines.

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Medical Necessity & Reasonableness

- Medicare defines medical necessity as "the patient's condition is such that going by any other method of transportation is contraindicated." Medical necessity must exist for both the ambulance transport and the level of service.
  - In other words, if taking the patient by a stretcher van would endanger the patient's health, then an ambulance must be used.

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Medical Necessity & Reasonableness

- Medicare has provided a list of conditions which help to establish medical necessity
  - Emergency
  - Patient needs restrained
  - Patient is unconscious or in shock
  - Patient requires oxygen or other emergency treatment
  - Patient exhibits signs of acute respiratory distress
  - Patient exhibits signs of acute stroke
  - Patient needs to be immobilized due to possible fracture
  - Patient experiencing severe hemorrhage
  - Patient can only be moved by stretcher (with valid reason)
  - Patient was bed confined before/after transport (with valid reason)

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Medical Necessity & Reasonableness

- Bed Confined
  - All 3 criteria must be met
    - Unable to get up from bed without assistance; **and**
    - Unable to ambulate; **and**
    - Unable to sit in a chair/wheelchair

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Medical Necessity & Reasonableness

- Provided the patient is bed confined before and after transport, with a valid reason explicitly documented and supported by all associated paperwork, bed confinement *may* be permitted to be used in and of itself to demonstrate medical necessity (though nothing is guaranteed).
  - What we are seeing is that, even if a patient is bed confined, if he/she does not require an attendant (meaning patient is conscious, alert & oriented), Medicare will deny

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Medical Necessity & Reasonableness

- In some cases, a patient may not be bed confined at all, but may still have a medical condition that does in fact warrant the use of an ambulance. For this reason, the establishment of medical necessity is not restricted solely to whether or not the patient is bed confined.

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Medical Necessity & Reasonableness

- Medicare requires a transport be "reasonable" which refers to the purpose of the trip. This pertains to whether or not the service in question could be more economically provided where the patient is found.
  - In other words, while the patient's condition may warrant the use of an ambulance, why is this particular transport even necessary? Can the service in question be brought to the patient?

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Medical Necessity & Reasonableness

- Common examples of transports that could be questionable
  - Certain types of wound care
  - Routine exam
  - Blood draw
- Conversely, a common example of a transport that would generally be covered (assuming all other coverage criteria are met)
  - Patient needs a cardiac catheterization procedure, something not provided by the hospital in which the patient is found

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Medical Necessity & Reasonableness

- From a billing perspective, if the documentation of the transport does not clearly show the need for an ambulance crew, the claim will be submitted to Medicare for a denial. Once denied, the next payer will be billed. This is often the facility or the patient.

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Call Intake

- Critical to the proper allocation of resources and ensuring efficient and accurate billing
- EMS/Facility can share responsibilities
  - Obtain insurance/payment information
  - Obtain supporting paperwork (PCS, etc.)
  - Obtain pre-authorization
  - Determine medical necessity
  - Transport specifics can reveal Part A/B responsibility

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Call Intake

- Pre-authorization
  - Most carriers require pre-authorization for non-emergencies
  - If insurance rep says one is *not* required, obtain rep's identifying info
  - Critical to ensure appropriate mode of transportation is scheduled
    - May have changed since pre-auth was obtained

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Call Intake

- HCPCS Codes
  - BLS Non-Emergency A0428
  - ALS Non-Emergency A0426
  - BLS/ALS Mileage A0425
  - Wheelchair A0130
  - Wheelchair Mileage S0209
  - Stretcher Van T2005
  - Stretcher Van Mileage T2049

- *Consider using our sample Call Intake Quick Reference on the next slide*

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Call Intake Quick Reference:

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Patient Info

Name | Phone | Address
SSN | DOB

Transport Info

Person Requesting Transport
Phone for Person Requesting
Date of Service (anticipated)
Time of Service (anticipated)
Time Requested
Reason for Transport
Physician NPI
Equipment Needed

Pickup Location:
Select one:
☐ ER ☐ Acute
☐ SNF ☐ Office
☐ Swing Bed ☐ Nursing Home

Destination:
Select one:
☐ ER ☐ Acute
☐ SNF ☐ Office
☐ Swing Bed ☐ Nursing Home

Is transport any one of the following?

Scenario	**Y/N**
Initial admission to SNF	
Final discharge from SNF (to home, no return same day)	
SNF to hospital for admission	
Hospital to SNF after discharge	
SNF to dialysis, if at free-standing or hospital-based facility	

Any of the following, if closest appropriate facility is in a hospital setting

Cardiac Cath
CT Scan
MRI
Ambulatory surgery utilizing operating room
Emergency room services
Radiation therapy
Angiography
Lymphatic & venous procedures

Qualifying Questions

☐ Can patient ambulate?
☐ Can patient sit in chair?
☐ Can patient sit in wheelchair?
☐ Does patient have own wheelchair?
☐ Can patient get up from bed without assistance?
☐ Does patient use walker/cane?
☐ Does patient use restroom unassisted?
☐ Does patient receive physical therapy?
☐ Does patient require oxygen?
☐ Does patient have own oxygen?
☐ Does patient require restraints?
☐ Does patient require airway monitoring/protection?
☐ Is patient on ventilator?
☐ Does patient require infectious disease precautions?
☐ Does patient require IV during transport?

Insurance/Authorization

☐ Copy of insurance card (front/back), facility face sheet, and/or remit record
☐ Prior authorization obtained

☐ Yes:
Prior Auth #
HCPCS Code
Rep Name
Employee ID
Reference #
Date/Time

☐ No, insurance rep states no prior auth needed:
Rep Name
Employee ID
Reference #
Date/Time

HCPCS Codes Reference:

BLSN Base Rate	AO428	Wheelchair Van Base Rate	AO130	Stretcher Van Base Rate	T2005
ALSN Base Rate	AO426	Wheelchair Van Mileage	SO209	Stretcher Van Mileage	T2049
Mileage	AO425				

Supporting Paperwork

☐ PCS *(*Ensure mode authorized is mode that is medically necessary and mode that is used)*
☐ Assignment of Benefits
☐ Advanced Notice of Non-Covered Service *(*For some state Medicaid programs, e.g. PA)*
☐ ABN
☐ Statement of Financial Responsibility
☐ Notice of Privacy Practices

This form should be included as an attachment to the PCR for billing. It is designed to help our clients obtain as much information as possible and assist in the billing process. As such, it is important to document specific testing, procedures, or treatments being performed, in conjunction with the reason, in order to provide appropriate depth and accuracy. This form does not guarantee payment, nor should it be construed as legal guidance, or any kind of template approach to ensuring reimbursement. Cornerstone makes no such claims, and bears no responsibility for the use of this form.

Call Intake

- For Medicare beneficiary to be eligible for coverage under Part A:
  - Must have been hospital inpatient for at least three (3) consecutive calendar days
  - Transferred to a participating SNF, usually within thirty (30) days after discharge from hospital
    - Observation stays do not count
    - Day of admission counts, but not day of discharge

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Call Intake

- Beneficiaries must receive treatment at SNF for a condition they were receiving treatment for during their qualifying hospital stay, or for an additional condition that arose while in SNF.
- Benefit period, or "spell of illness," begins day beneficiary admitted to hospital, and ends when he/she has been out of hospital or has not received SNF care for at least sixty (60) days in a row.

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Call Intake

- Assuming sixty (60) days have transpired, Part A typically renews
- For beneficiary to receive benefits during a covered 100-day period, he/she must
  - Be able and willing to participate in prescribed therapies, and must be progressing in treatment
- If patient's condition stabilizes, he/she may lose coverage, even if not able to care for him or herself
  - Medicaid may pick up coverage, and facility may become responsible if patient is a resident, depending on state law

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Physician Certification Statement (PCS)

- Medicare mandates a PCS be completed and on file for repetitive and non-repetitive, scheduled and unscheduled non-emergency transports for a resident of a facility
  - Transports from a residence are excluded
- Must be completed by requesting facility

- *A sample of the most commonly used version is provided on the next slide*

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Physician Certification Statement for Non-Emergency Ambulance Services – OPTION A

SECTION I – GENERAL INFORMATION

Patient's Name: _____ Date of Birth: _____ Medicare #: _____

Transport Date: _____ (PCS is valid for round trips on this date and for all repetitive trips in the 60-day range as noted below.)

Origin: _____ Destination: _____

Is the pt's stay covered under Medicare Part A (PPS/DRG?) ☐ YES ☐ NO

Closest appropriate facility? ☐ YES ☐ NO If no, why is transport to more distant facility required? _____

If hospital to hospital transfer, describe services needed at 2nd facility not available at 1st facility: _____

If hospice pt, is this transport related to pt's terminal illness? ☐ YES ☐ NO Describe: _____

SECTION II – MEDICAL NECESSITY QUESTIONNAIRE

Ambulance Transportation is medically necessary only if other means of transport are contraindicated or would be potentially harmful to the patient. To meet this requirement, the patient must be either "bed confined" or suffer from a condition such that transport by means other than ambulance is contraindicated by the patient's condition **The following questions must be answered by the medical professional signing below for this form to be valid:**

1) Describe the MEDICAL CONDITION (physical and/or mental) of this patient AT THE TIME OF AMBULANCE TRANSPORT that requires the patient to be transported in an ambulance and why transport by other means is contraindicated by the patient's condition:

_____

_____

_____

2) Is this patient "bed confined" as defined below? ☐ Yes ☐ No
To be "bed confined" the patient must satisfy all three of the following conditions: (1) *unable* to get up from bed without Assistance; AND (2) *unable* to ambulate; AND (3) *unable* to sit in a chair or wheelchair

3) Can this patient safely be transported by car or wheelchair van (i.e., seated during transport, without a medical attendant or monitoring?) ☐ Yes ☐ No

4) ***In addition*** to completing questions 1-3 above, please check any of the following conditions that apply*:
**Note: supporting documentation for any boxes checked must be maintained in the patient's medical records*

☐ Contractures ☐ Non-healed fractures ☐ Patient is confused ☐ Patient is comatose ☐ Moderate/severe pain on movement

☐ Danger to self/other ☐ IV meds/fluids required ☐ Patient is combative ☐ Need or possible need for restraints

☐ DVT requires elevation of a lower extremity ☐ Medical attendant required ☐ Requires oxygen – unable to self administer

☐ Special handling/isolation/infection control precautions required ☐ Unable to tolerate seated position for time needed to transport

☐ Hemodynamic monitoring required en route ☐ Unable to sit in a chair or wheelchair due to decubitus ulcers or other wounds

☐ Cardiac monitoring required en route ☐ Morbid obesity requires additional personnel/equipment to safely handle patient

☐ Orthopedic device (backboard, halo, pins, traction, brace, wedge, etc.) requiring special handling during transport

☐ Other (specify) _____

SECTION III – SIGNATURE OF PHYSICIAN OR HEALTHCARE PROFESSIONAL

I certify that the above information is true and correct based on my evaluation of this patient, and represent that the patient requires transport by ambulance and that other forms of transport are contraindicated. I understand that this information will be used by the Centers for Medicare and Medicaid Services (CMS) to support the determination of medical necessity for ambulance services, and I represent that I have personal knowledge of the patient's condition at the time of transport.

☐ **If this box is checked**, I also certify that the patient is physically or mentally incapable of signing the ambulance service's claim and that the institution with which I am affiliated has furnished care, services or assistance to the patient. My signature below is made on behalf of the patient pursuant to 42 CFR §424.36(b)(4). In accordance with 42 CFR §424.37, ***the specific reason(s) that the patient is physically or mentally incapable of signing the claim form is as follows***:

_____

_____ _____

Signature of Physician* or Healthcare Professional | Date Signed (For scheduled repetitive transport, this form is not valid for transports performed more than 60 days after this date).

_____

Printed Name and Credentials of Physician or Healthcare Professional (MD, DO, RN, etc.)

**Form must be signed only by patient's attending physician for scheduled, repetitive transports. For non-repetitive, unscheduled ambulance transports, if unable to obtain the signature of the attending physician, any of the following may sign (please check appropriate box below):*

☐ Physician Assistant ☐ Clinical Nurse Specialist ☐ Registered Nurse
☐ Nurse Practitioner ☐ Discharge Planner

Physician Certification Statement (PCS)

Repetitive	Non-Repetitive
Three or more times during a 10-day period, *or* at least once per week for at least three weeks	All other scenarios
Must be obtained *prior* to service	Should be obtained at the time of service; however, a 48-hour window is afforded after the services are furnished **Alternate claim filing methods are granted in cases when a completed PCS cannot be obtained*
PCS must be signed by the *attending physician only* and is valid for 60 days from the date signed	PCS may be signed by either the attending physician, physician assistant, nurse practitioner, clinical nurse specialist, registered nurse, or discharge planner (who is employed by hospital or facility where patient is being treated)

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Physician Certification Statement (PCS)

- Medical Necessity Questionnaire
  - Patient's condition should be accurately described and all applicable check boxes indicated
  - If bed confinement is noted, ensure all three criteria are met:
    - Unable to get out of bed without assistance, **and**
    - Unable to ambulate, **and**
    - Unable to sit in a chair or wheelchair

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Physician Certification Statement (PCS)

- Form must be dated
- Appropriate person must sign and indicate credentials
  - Note: "Dr." is a title, not a credential
- Signature and credentials must be in appropriate fields
- Signature and credentials must be legible

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Physician Certification Statement (PCS)

- If signature is not legible, the following may be considered acceptable:
  - Illegible signature over printed/typed name
  - Illegible signature accompanied by signature log or attestation statement
  - Initials over a printed name
- Electronic signatures are acceptable, but stamped signatures are not acceptable
- *See companion handout for sample signature log and attestation statement forms*

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Signature Log – PCS Signers

[For signatures of persons signing a PCS from facilities]

Professional's Name	Signature Specimen	Initials Specimen	Credentials/ Title	Facility Name

Model Attestation Statement – Authorized PCS Signers

Name of Patient: _____

Patient ID Number: _____

"I, _____ [print full name of the physician/ practitioner that signed the PCS or other document in question], hereby attest that the document dated _____ [date of signing PCR or other document in question] accurately reflects signatures/notations that I made in my capacity as_____ [insert provider credentials, e.g., M.D., D.O., RN, etc.] when I certified that the above listed Medicare beneficiary required ambulance transport. I do hereby attest that this information is true, accurate and complete to the best of my knowledge and I understand that any falsification, omission, or concealment of material fact may subject me to administrative, civil, or criminal liability."

_____

Signature

_____

Print Name

_____

Date

Covered Destinations & Closest Appropriate Facility

- Transports that meet all other program requirements for coverage are covered when the destination is a:
  - Hospital
  - Critical Access Hospital
  - Skilled Nursing Facility
  - Beneficiary's home
  - Dialysis facility for ESRD patient who requires dialysis (more on this in a moment)

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Covered Destinations & Closest Appropriate Facility

- A physician's office is not a covered destination
  - Under special circumstances an ambulance transport may temporarily stop at a physician's office without affecting the coverage status of the transport

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Covered Destinations & Closest Appropriate Facility

- The term "locality" with respect to ambulance means the area surrounding the institution to which individuals normally travel or are expected to travel to receive hospital or skilled nursing services

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Covered Destinations & Closest Appropriate Facility

- As a general rule, only local transportation by ambulance is covered, and therefore, only mileage to the nearest appropriate facility equipped to treat the patient is covered. However, if two or more facilities that meet the destination requirements can treat the patient appropriately and the locality of each facility encompasses the place where the ambulance transportation of the patient began, then the full mileage to any one of the facilities to which the beneficiary is taken is covered.

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Covered Destinations & Closest Appropriate Facility

- Many of the Medicare Administrative Contractors (MACs) have stated their position that only a fraction of End Stage Renal Disease (ESRD) patients on chronic dialysis require ambulance transportation to and from sessions
  - In short, the presence of ESRD and the requirement for dialysis do not alone qualify a patient for ambulance transportation

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Covered Destinations & Closest Appropriate Facility

- To be considered reasonable and necessary, patients transported to and from dialysis centers must have other medical conditions and adequate documentation of those conditions must be in the EMS provider's PCR and in the medical records of other providers involved with the patient's care
  - As many of these patients are considered "repetitive" this leads into the CMS Prior Authorization Demonstration Program

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CMS Prior Authorization Program

- Deployed in December 2014
- Started in PA, NJ, and SC
  - Areas with highest ratio of suppliers to beneficiaries
  - Phased expansion by January 2016 into DE, DC, MD, NC, VA and WV; could go nationwide
  - Location determined by where an ambulance is garaged
- Part of an initiative to protect the integrity of the Medicare Trust Fund by reviewing documentation prior to accepting a claim, and then deciding whether or not the potential (or in some cases, already-performed) transport is demonstrated to be necessary

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CMS Prior Authorization Program

- Not related to the pre-authorizations we just looked at
- Applies to ambulance suppliers
  - Does not apply to hospital-based providers
- Specific to "repetitive" patients
  - Medically necessary, scheduled non-emergency transportation furnished three or more times during a ten day period *or* at least once per week for at least three weeks

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CMS Prior Authorization Program

- At first, CMS did very little to educate physicians, placing the responsibility on the ambulance transport suppliers
- CMS then issued a letter, which makes clear that corroborating reasons must be explicitly stated
  - Simple statements like "patient is bed confined" are no good.
  - Even providing a diagnosis in and of itself is not sufficient. It must be substantiated with evidence from the medical record.
- *Here is a copy of that letter…*

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DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard,
Baltimore, Maryland 21244-1850

Dear Physician/Practitioner:

The Medicare Fee-For-Service Program has implemented a three year **prior authorization program for repetitive scheduled non-emergent ambulance transports**. The goal of this program is to ensure that beneficiaries continue to receive medically necessary care while reducing expenditures and minimizing the risk of improper payments.

The prior authorization process for repetitive scheduled non-emergent ambulance transports began on December 1, 2014 in New Jersey, Pennsylvania, and South Carolina. On January 1, 2016, the program expands to Delaware, the District of Columbia, Maryland, North Carolina, Virginia, and West Virginia.

A repetitive ambulance service is defined as medically necessary ambulance transportation that is furnished 3 or more times during a 10-day period; or at least once per week for at least 3 weeks. Medicare may cover repetitive, scheduled, non-emergent transportation by ambulance if

- Medical necessity requirements are met, and
- The ambulance supplier, before furnishing the service to the beneficiary, obtains a written order from the beneficiary's attending physician certifying that those medical necessity requirements were met.[1]

What You Need to Know

It is important to keep in mind that the prior authorization program does not create new documentation requirements for physicians/practitioners or suppliers – it simply requires the documentation to be submitted earlier in the claims process. **As the ordering physician/practitioner, you are required to supply the ambulance supplier or beneficiary the physician certification statement as well as any other documentation that supports medical necessity for the repetitive scheduled non-emergent ambulance transports.**

The non-emergent ambulance prior authorization program applies to the following Healthcare Common Procedure Coding System (HCPCS) codes:

- A0426 - Ambulance service, Advanced Life Support (ALS), non-emergency transport, Level 1, and
- A0428 - Ambulance service, Basic Life Support (BLS), non-emergency transport.

[1] Per 42 C.F.R. § 410.40(d)(2), the physician's order must be dated no earlier than 60 days before the date the service is furnished.

The ambulance supplier or beneficiary submits the prior authorization request with accompanying documentation to the appropriate Medicare Administrative Contractor (MAC).

The prior authorization request must include **all relevant documentation to support Medicare coverage of the transport.** This includes, but is not limited to:

- Documentation from the medical record to support the medical necessity of repetitive scheduled non-emergent ambulance transport
    - Documentation must show transportation by other means is contraindicated
    - Vague statements, such as "patient is bed-confined", are insufficient
    - Diagnosis of disease or illness may not be enough without corroborating evidence/statements
    - Attestation statements concerning the patient's requirements for ambulance transportation are not sufficient without corroborating evidence in the medical documentation
- Physician Certification Statement (PCS), including the certifying physician's name, National Provider Identifier and address
    - The PCS must be supported by the medical documentation
    - Bed-confinement or need for transportation cannot only be stated on the PCS
- Procedure codes
- Number of transports requested
    - The prior authorization decision, justified by the beneficiary's condition, may affirm up to 40 round trips per prior authorization request in a 60-day period
- Information on the origin and destination of the transports
- Any other relevant document as deemed necessary by the MAC to process the prior authorization

For more information on coverage and documentation requirements, please refer to:

- MAC Jurisdiction M Palmetto Ambulance Information or
- MAC Jurisdiction L Novitas Local Coverage Determination (L35162).

Additional information about the program is available at http://go.cms.gov/PAAmbulance.

If your patient does not qualify for Medicare transportation services, there are state and local services that may be able to help. Beneficiaries, case managers and care givers may receive help locating other transportation services by contacting Eldercare at 1-800-677-1116 or their local State Health Insurance Assistance Program. Beneficiaries can also find additional information in the Ambulance Prior Authorization Introductory letter posted on the program website listed above.

If you have specific questions that are not addressed on this website please submit questions via e-mail to AmbulancePA@cms.hhs.gov.

CMS Prior Authorization Program

- Documentation that Medicare requires includes:
  - Physician Certification Statement (PCS)
  - Information on the certifying physician (NPI)
  - Number of transports being requested and date range
  - Pertinent documents from patient's medical record
- Medicare issues an "affirmed" or "non-affirmed" decision
  - Both types of decisions result in a Unique Tracking Number, or UTN

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CMS Prior Authorization Program

- An affirmed decision can approve up to 40 round trips in a 60-day period
- Transports exceeding this criteria require an additional prior authorization request
- Claims can be submitted outside of this process, but they will automatically deny
  - Normal appeal rights apply

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CMS Prior Authorization Program

- Primary reasons for non-affirmed decisions
  - PCS
    - Not dated
    - Not signed
    - Not signed by attending physician
    - Signature is illegible
    - No credentials indicated
    - Credentials indicated but are illegible
    - Credentials indicated and legible but not in appropriate field
    - Signature greater than 60 days prior to 1st requested date of service

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CMS Prior Authorization Program

- Primary reasons for non-affirmed decisions
  - Documentation from medical record
    - Does not demonstrate medical necessity
    - Conflicting information between documents
      - One states bed confinement, but another illustrates the opposite
    - Information is dated greater than 60 days prior to 1st requested date of service

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CMS Prior Authorization Program

- So what improves chances of obtaining an affirmed decision?
  - Patient's Minimum Data Set (MDS) form
    - Closest to the start of the first requested date of service
  - PT/OT notes
  - Nurse's progress notes
  - Properly executed PCS from PCP with independently corroborating PCS from nephrologist, oncologist, etc.

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CMS Prior Authorization Program

- And of course, all documentation must be legible, signed, with credentials, cannot conflict with other documentation from within the medical record, and must be dated within the acceptable 60-day window of time leading up to the initial DOS.

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Consolidated Billing

- Medicare introduced the Skilled Nursing Facility (SNF) Prospective Payment System (PPS) in 1998. It changed not only the way a SNF is reimbursed but also the way a SNF must work with suppliers, physicians, transport services, and other practitioners.

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Consolidated Billing

- The SNF Consolidated Billing provision assigns a SNF the Medicare billing responsibility for *virtually all* of the services that a SNF resident receives during the course of a covered Part A stay. Payment for this full range of services is included in the SNF PPS global per diem (per stay) rate.

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Consolidated Billing

- A small number of services are excluded from the Part A Consolidated Billing provision.
  - Initial admission to a SNF
  - SNF to hospital for admission
  - Hospital to SNF after discharge
  - SNF to dialysis if dialysis treatment is done at a free standing or hospital-based facility
  - SNF to hospital for emergency care
- ***Remember call intake!***

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Consolidated Billing

- Ambulance payment for the following outpatient services is paid under Part B if the closest appropriate facility to perform these services is in a hospital setting:
  - Cardiac Catheterization
  - Computerized axial tomography imaging (CT) scans
  - Magnetic Resonance Imaging (MRI) services
  - Ambulatory surgery involving the use of an operating room
  - Emergency room services
  - Radiation therapy
  - Angiography
  - Lymphatic and venous procedures

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Consolidated Billing

- Misunderstanding Consolidated Billing can lead to inappropriate billing. Commonly, this means billing once to Part A, and then again to Part B.
- There is more scrutiny than ever before on EMS, much of it as a result of unintentional (and an alarming amount of intentional) fraud and abuse.

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Consolidated Billing

Facility (for transports under Part A)

- ✓ Beneficiary to Residence (returns same day)
- ✓ Transports SNF to SNF (discharging SNF)
- ✓ Transports to a Physician's Office
- ✓ Transports to any Medicare Provider for Chemotherapy, Chemotherapy Administration, Radioisotopes, Customized Prosthetic Devices, Barium Swallow, Hyperbaric Oxygen, Transfusions.
- ✓ Transports for outpatient services such as: Physical, Occupational or Speech Therapy, Diagnostic Test, Evaluations or Treatment Services.

➢ *Note: If the service is not specifically listed as billable to Part A, it is the responsibility of the facility.*

Medicare (for transports under Part B)

- ✓ For Initial Admission to SNF
- ✓ Beneficiary to Home (no return same day)
- ✓ To Hospital from SNF for admission
- ✓ To SNF from Hospital Discharge
- ✓ Transports to/from Dialysis
- ✓ Transports for *outpatient* services such as: Emergencies, Cardiac Catheterizations, CT Scans, MRIs, Ambulatory Surgeries (involving an operation room – including PEG tube procedures), Angiographies, Lymphatic and Venous Procedures, & radiation therapy

➢ *Note: To be covered separately by Medicare, the services listed above must be performed at a hospital and not a free-standing facility, except for dialysis. If the closest appropriate facility is any other setting, the SNF is responsible.*

Building Relationships: Patient Transportation, Facilities & Reimbursement

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SNF Consolidated Billing for Ambulance Services During the Prospective Payment System Period

Types of Transports Billed to Medicare	Bill to Medicare
Initial admission to SNF	✓
Final discharge from SNF to home (does not return in the same day)	✓
Inpatient hospital admission: from SNF to hospital for admission	✓
Inpatient hospital discharge: from hospital to SNF for hospital discharge	✓
Transports to and from dialysis	✓
Transport to beneficiary's home for Medicare Home Health Services	✓
Transports to a hospital for **outpatient** services related to: - Ambulatory surgery involving an operating room, including PEG tube procedures, even if performed in a hospital GI suite or endoscopy suite (** Minor procedures that can safely be performed by SNF are not billable to Part B) - Angiographies - Cardiac catheterizations - CT scans - Emergencies - Lymphatic and venuous procedures - MRIs - Radiation therapy Note: To be covered separately by Medicare, all services listed in this section must be performed at the hospital and not a free-standing facility, or else the SNF is responsible.	✓

Types of Transports Billed to the Facility	Bill to Facility
Final discharge from SNF to home with a return to the same SNF in the same day	✓
Final discharge from SNF to another SNF, includes for elevated level of care (discharge facility is responsible)	✓
Transports to hospital for **outpatient** services related to: – Physical, occupational, or speech therapy – Diagnostic tests or services routinely provided by SNFS – Evaluation or treatment services (other than a hospital admission)	✓
Transports to any Medicare provider for: - Barium swallow - Chemotherapy - Customized prosthetic devices - Hyperbaric oxygen - Radioisotopes - Transfusions	✓
Transports to a physician's office (during Part A stay only)	✓

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

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Skilled Nursing Facility Consolidated Billing As It Relates to Ambulance Services

Note: This article was revised on November 14, 2013, to add clarifying language regarding "Transfers between Two SNFs" on page 4. All other information is unchanged.

Provider Types Affected

Skilled Nursing Facilities (SNFs), physicians, ambulance suppliers, and providers submitting claims to Medicare Administrative Contractors (MACs) should review this article.

Provider Action Needed

This Special Edition article describes SNF Consolidated Billing (CB) as it applies to ambulance services for SNF residents.

Clarification: The SNF CB requirement makes the SNF responsible for including on the Part A bill that it submits to its MAC almost all of the services that a resident receives during the course of a Medicare-covered stay, except for a small number of services that are specifically excluded from this provision. These "excluded" services can be separately furnished to the resident and billed under Medicare Part B by a variety of outside sources. These sources can include other providers of service (such as hospitals), which would submit the bill for Part B services to their MAC, as well as practitioners and suppliers who would generally submit their bills to a MAC. (Bills for certain types of items or equipment would be submitted by the supplier to their DME MAC.

Background

When the SNF Prospective Payment System (PPS) was introduced in 1998, it changed not only the way SNFs are paid but also the way SNFs must work with suppliers, physicians, and other practitioners. CB assigns the SNF the Medicare billing responsibility for virtually all of the services that the SNF residents receive during the course of a covered Part A stay. Payment for this full range of service is included in the SNF PPS global per diem rate.

The only exceptions are those services that are specifically excluded from this provision, which remain separately billable to Medicare Part B by the entity that actually furnished the service. See MLN Matters® Article SE0431 for a detailed overview of SNF CB, including a section on services excluded from SNF CB. This instruction can be found at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE0431.pdf on the Centers for Medicare & Medicaid Services (CMS) website.

Ambulance services have not been identified as a type of service that is categorically excluded from the CB provisions. However, certain types of ambulance transportation have been identified as being separately billable in specific situations (i.e. based on the reason the ambulance service is needed). This policy is comparable to the one governing ambulance services furnished in the inpatient hospital setting, which has been subject to a similar comprehensive Medicare billing or "bundling" requirement since 1983. Since the law describes CB in terms of services that are furnished to a "resident" of a SNF, the initial ambulance trip that brings a beneficiary to a SNF is not subject to CB, as the beneficiary has not yet been admitted to the SNF as a resident at that point.

Similarly, an ambulance trip that conveys a beneficiary from the SNF at the end of a stay is not subject to CB when it occurs in connection with one of the events specified in regulations at 42 CFR 411.15(p)(3)(i)-(iv) as ending the beneficiary's SNF "resident" status. The events are as follows:

- A trip for an inpatient admission to a Medicare-participating hospital or critical access hospital (CAH) (See discussion below regarding an ambulance trip made for the purpose of transferring a beneficiary from the discharging SNF to an inpatient admission at another SNF.);
- A trip to the beneficiary's home to receive services from a Medicare-participating home health agency under a plan of care;

- A trip to a Medicare-participating hospital or CAH for the specific purpose of receiving emergency services or certain other intensive outpatient services that are not included in the SNF's comprehensive care plan (see further explanation below); or
- A formal discharge (or other departure) from the SNF that is not followed by readmission to that or another SNF by midnight of that same day.

Ambulance Trips to Receive Excluded Outpatient Hospital Services

The regulations specify the receipt of certain exceptionally intensive or emergency services furnished during an outpatient visit to a hospital as one circumstance that ends a beneficiary's status as an SNF resident for CB purposes. Such outpatient hospital services are, themselves, excluded from the CB requirement, on the basis that they are well beyond the typical scope of the SNF care plan.

Currently, only those categories of outpatient hospital services that are specifically identified in Program Memorandum (PM) No. A-98-37, November 1998 (reissued as PM No. A-00-01, January 2000) are excluded from CB on this basis. These services are the following:

- Cardiac catheterization;
- Computerized Axial Tomography Imaging (CT) scans;
- Magnetic Resonance Imaging (MRI) services;
- Ambulatory surgery involving the use of an operating room (the ambulatory surgical exclusion includes the insertion of percutaneous esophageal gastrostomy (PEG) tubes in a gastrointestinal or endoscopy suite);
- Emergency room services;
- Radiation therapy;
- Angiography; and
- Lymphatic and venous procedures.

Since a beneficiary's departure from the SNF to receive one of these excluded types of outpatient hospital services is considered to end the beneficiary's status as an SNF resident for CB purposes with respect to those services, any associated ambulance trips are, themselves, excluded from CB as well. Therefore, an ambulance trip from the SNF to the hospital for the receipt of such services should be billed separately under Part B by the outside supplier. Moreover, once the beneficiary's SNF resident status has ended in this situation, it does not resume until the point at which the beneficiary actually arrives back at the SNF; accordingly, the return ambulance trip from the hospital to the SNF would also be excluded from CB.

Other Ambulance Trips

By contrast, when a beneficiary leaves the SNF to receive offsite services other than the excluded types of outpatient hospital services described above and then returns to the SNF, he or she retains the status of a SNF resident with respect to the services furnished during the absence from the SNF. Accordingly, ambulance services furnished in connection with such an outpatient visit would remain subject to CB, even if the purpose of the trip is to receive a particular type of service (such as a physician service) that is, itself, categorically excluded from the CB requirement.

However, effective April 1, 2000, the Balanced Budget Refinement Act of 1999 (BBRA 1999, Section 103) excluded from SNF CB those ambulance services that are necessary to transport an SNF resident offsite to receive Part B dialysis services (Social Security Act, Section 1888(e)(2)(A)(iii)(I)).

Transfers Between Two SNFs

When an individual leaves a SNF via ambulance and does not return to that or another SNF by midnight, the day is not a covered Part A day and, accordingly, CB would not apply. However, a beneficiary's departure from an SNF is not considered to be a "final" departure for CB purposes if he or she is readmitted to that or another SNF by midnight of the same day (see 42 CFR 411.15(p)(3)(iv)). Therefore, when a beneficiary travels directly from SNF 1 and is admitted to SNF 2 by midnight of the same day, that day is a covered Part A day for the beneficiary, to which CB applies. Accordingly, a medically necessary ambulance trip that conveys the beneficiary would be bundled back to SNF 1 since, under 42 CFR 411.15(p)(3), the beneficiary would continue to be considered a resident of SNF 1 (for CB purposes) up until the actual point of admission to SNF 2.

However, it should be noted that in addition to the "medical necessity" criterion in the regulations at 42 CFR 409.27(c) pertaining specifically to ambulance transports under the SNF benefit (i.e., the patient's medical condition is such that transportation by any means other than ambulance would be contraindicated), coverage in this context also involves the underlying requirement of being reasonable and necessary for diagnosing or treating the patient's condition. For example, a transfer between two SNFs would be considered reasonable and necessary in a situation where needed care is unavailable at the originating SNF, thus necessitating a transfer to the receiving SNF in order to obtain that care. By contrast, an SNF-to-SNF transfer that is prompted by non-medical considerations (such as a patient's personal preference to be placed in the receiving SNF) is not considered reasonable and necessary for diagnosing or treating the patient's condition and, thus, would not be bundled back to the originating SNF.

Roundtrip to a Physician's Office

If a SNF's Part A resident requires transportation to a physician's office and meets the general medical necessity requirement for transport by ambulance (i.e., using any other means of transport would be medically contraindicated) (see 42 CFR 409.27(c)), then the ambulance roundtrip is the responsibility of the SNF and is included in the PPS rate. The preamble to the July 30, 1999 final rule (64 Federal Register 41674-75) clarifies that the scope of the required service bundle furnished to Part A SNF residents under the PPS specifically encompasses coverage of transportation via ambulance

under the conditions described above, rather than more general coverage of other forms of transportation.

NOTE: Confusion sometimes arises over the issue of an ambulance roundtrip that transports an SNF resident to the physician's office, as the separate Part B ambulance benefit does not normally cover transportation to this particular setting. However, the regulations at 42 CFR 409.27(c), which describe the Part A SNF benefit's scope of coverage for ambulance transportation, incorporate by reference *only* the Part B ambulance benefit's *general medical necessity* requirement at 42 CFR 410.40(d)(1) (i.e., that transportation by any other means would be medically contraindicated), and *not* any of the more detailed coverage restrictions that apply under the separate Part B benefit, such as the limitation of coverage to only certain specified destinations (42 CFR 410.40(e)). Thus, if an SNF's Part A resident requires transportation to a physician's office and meets the general medical necessity requirement for transport by ambulance, that ambulance roundtrip would be the responsibility of the SNF.

Noncoverage of Transportation by Any Means Other Than Ambulance

In contrast to the ambulance coverage described previously, Medicare simply does not provide any coverage at all under Part A *or* Part B for any *non-ambulance* forms of transportation, such as ambulette, wheelchair van, or litter van. Further, as noted in the preceding section, in order for the Part A SNF benefit to cover transportation via ambulance, the regulations at 42 CFR 409.27(c) specify that the ambulance transportation must be *medically necessary*--that is, that the patient's condition is such that transportation by any other means would be medically contraindicated.

This means that in a situation where it is medically feasible to transport an SNF resident by means other than an ambulance--for example, via wheelchair van--the wheelchair van would not be covered (because Medicare does not cover any non-ambulance forms of transportation), and an ambulance *also* would not be covered (because the use of an ambulance in such a situation would not be medically necessary). As with any noncovered service for which a resident may be financially liable, the SNF must provide appropriate notification to the resident under the regulations at 42 CFR 483.10(b)(6), which require Medicare-participating SNFs to ". . . inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate."

Additional Information

See MLN Matters® Special Edition SE0431 for a detailed overview of SNF CB. This article lists services excluded from SNF CB and can be found at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE0431.pdf on the CMS website.

The CMS MLN CB website is at http://www.cms.gov/Medicare/Billing/SNFConsolidatedBilling/index.html on the CMS website.

It includes the following relevant information:

- General SNF CB information;
- HCPCS codes that can be separately paid by the MAC (i.e., services not included in CB);
- Therapy codes that must be consolidated in a non-covered stay; and
- All code lists that are subject to quarterly and annual updates and should be reviewed periodically for the latest revisions.

The SNF PPS CB website is available at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/index.html on the CMS website.

It includes the following relevant information:

- Background;
- Historical questions and answers;
- Links to related articles; and
- Links to publications (including transmittals and Federal Register notices).

Consolidated Billing

- Free standing diagnostic facilities and clinics can be located on a hospital campus, or even *inside* the main structure of a hospital, and yet have a separate provider number

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Consolidated Billing

- Inter-facility transports can raise questions about who is responsible for the bill, as facilities may share a provider number, or be located on the same campus
- To address the issue, Medicare provides a three step sequential test

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Consolidated Billing

- Step 1 – Provider Numbers
  - If the Medicare provider numbers of the facilities are different, then the ambulance transport is separately billable to the program (Part B).
  - If the provider number of both facilities is the same, then consider criterion 2, "Campus."

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- Step 2 – Campus
  - Following criterion 1, if the campuses of the two facilities which share a provider number are the same, then the transport is *not* separately billable to Part B.
  - If the campuses of the two facilities are different, consider criterion 3, "Patient Status."
  - Note: Campus means the physical area immediately adjacent to the facility's main buildings, and other areas and structures not strictly contiguous to the main buildings, but located within 250 yards, along with any other area determined on a case by case basis by CMS.

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- Step 3 – Patient Status: Inpatient vs. Outpatient
  - Following criterion 1 and 2, if the patient has inpatient status at both the origin and destination facilities, and the two share a provider number but are located on different campuses, then the transport is *not* separately billable to Part B.

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Consolidated Billing

- All other combinations are separately billable to Part B
  - Outpatient to inpatient
  - Inpatient to outpatient
  - Outpatient to outpatient

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Consolidated Billing

- Once a beneficiary is admitted to a hospital, critical access hospital, or SNF, it may be necessary to transport the beneficiary to another hospital or other site temporarily for specialized care while the beneficiary maintains inpatient status with the original provider

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Consolidated Billing

- This movement of the patient is generally considered "patient transportation" and is covered as an inpatient hospital or critical access hospital service and as a SNF service when the SNF is furnishing it as a covered SNF service and payment is made under Part A for that service

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Consolidated Billing

- Similarly, intra-campus transfers between different departments of the same hospital, even where the departments are located in separate buildings, are included in consolidated billing and therefore not separately payable under Part B

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Consolidated Billing

- Important to understand any state provisions which may dictate what a facility is or is not responsible for
- Often this pertains to Medicaid
- Consider the following Medicaid-specific guidelines for a state like Pennsylvania

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Consolidated Billing

- Medicaid pays for medically necessary, non-emergency transports (with limitations), except for general assistance recipients and those residing in nursing facilities.
- Facility responsible for non-emergency transports for its Medicaid residents. This includes to and from doctor, dentist and other practitioner appointments, and partial hospitalization treatment programs.
- If ambulance company supplies non-emergency transports to nursing facility residents on Medicaid, the facility must pay. The ambulance company may not bill Medicaid, the recipient, or the recipient's family.

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Contracting & Compliance

- Generally, two laws regulate contracting between ambulance suppliers/providers and facilities
  - Anti-Kickback Statute
  - False Claims Act

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Contracting & Compliance

- Anti-Kickback Statute (AKS)
  - A criminal statute that prohibits the exchange (or offer to exchange), of anything of value, in an effort to induce (or reward) the referral of federal health care program business.
  - Value does not apply to payments only
    - Interest free payment plans can be considered as remuneration
  - The statute applies to *both* parties of the contract
  - As of 2011, violations of AKS constitute false claims under the False Claims Act. This has led to more whistleblowers, who can sound an alarm if they feel improper practices are in place.

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Contracting & Compliance

- Medicare requires that it receive the best possible price
  - Also known as the "most favored nation" clause
- When a SNF receives money from Medicare for Part A stay, it could be considered a kickback if the SNF paid less than the Medicare allowable to the ambulance provider for a transport.
- Common problem is EMS agencies that discount fees not only below the Medicare allowable, but also below their cost, and facilities who in turn "fee shop" and award contracts to those agencies.

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Contracting & Compliance

- Recent case involving management company that owned 12 SNFs, and had to pay $3.199M
  - US Attorney General: "This settlement sends a message to the health care industry *that both sides* of a swapping arrangement can be held responsible for their improper actions, not just the entity that actually bills Medicare or Medicaid for the services." (our emphasis added)

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Contracting & Compliance

- The OIG ruled in Advisory Opinion 03-09 that the "routine waiver of Medicare Part B cost-sharing amounts" was a violation of the AKS.
  - This potentially impacts contracting if the contract is only for 80% of the Medicare fee schedule.
  - Could be construed as a routine waiver of the co-payment.

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Contracting & Compliance

- Under OIG Advisory Opinion 99-2 the concept of "swapping" was found as a violation of the AKS.
  - Swapping is an exchange of transports for which a SNF is responsible, at a discounted price, to obtain transports that can be submitted to federal payers at a higher rate.

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Contracting & Compliance

- In OIG Advisory Opinion 10-26, the issue of an ambulance company discounting below its cost was found to be potentially problematic, as it could serve as an inducement to the facility to refer more lucrative federal business (transport covered under Part B).

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Contracting & Compliance

- While all of these examples pertain to specific situations, each of which must be examined individually, they all deal with a common issue:
  - Where is the line at which price discounting raises a red flag for the government?

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Contracting & Compliance

- There is no strictly defined answer
- AKS violation not determined by size of discount per se, but whether that discount is implicitly or explicitly tied to the referral of federal business
- As a general rule, both the facility and ambulance company should understand that any discount below the company's normal charges could be viewed with suspicion, and especially so when that discount is below cost

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Contracting & Compliance

- Even if agreed upon rates conform to prevailing fee schedules, every contract should be carefully reviewed and understood to ensure it does not pose a violation of the Anti-Kickback Statute
- Any contract where there is a potential intent to induce referrals will carry with it the possibility of governmental scrutiny

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Contracting & Compliance

- Exclusions Database
  - http://exclusions.oig.hhs.gov/
- Criminal Penalties
- Civil Monetary Penalties

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A Relationship that Works

- Pursue compliance together
  - Understand regulations and implications of contracting
- Maintain lines of communication
  - Every day, at all levels
  - Meet to review industry changes
  - Identify educational opportunities
- Prompt attention
  - Mutual commitment to resolve concerns before they become issues

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