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Agenda

• Today’s Objective
• Reviewing Entities
• Documentation Errors and Guidance
• Resources and Reminders
Objective

• Reduce billing errors and paid error rates
• Understanding of reviewing entities
  – Provider’s role / Reviewing entities role
  – What’s under review
  – Review process
• Available resources to assist provider
Part B Ambulance Coverage

If patient can travel by other transportation means safely………

Ambulance transport is non-covered

42 CFR §410.10
Medical Necessity Requirements
IOM 100-02, Chapter 10
Sections 10.2, 10.3 & 10.4
Medical Necessity Defined

• Nature of ambulance’s response (whether emergency or not) does not independently establish or support medical necessity for ambulance transport

• Medicare coverage always depends on
  – If service(s) furnished is actually medically reasonable/necessary based on patient’s condition at time of transport
Reviewing Entities

Who’s Reviewing Your Claims?
Medical Review Webpage

MEDICAL REVIEW

Cross Recovery
Documentation Requirements
How To Submit Your ADRs
MR Overview
Order Authentication Requirements

Other Review Entities

Comprehensive Error Rate Testing (CERT)
Office of Inspector General (OIG)
Quality Improvement Organization (QIO)
Recovery Auditor
Supplemental Medical Review Specialty Contractor (SMRC)

Comprehensive Error Rate Testing (CERT) - View program background, request and response timeline, communication used between Noridian and providers, Provider Corrective Actions, responding to a CERT request, contact details, and resources.

Office of Inspector General (OIG) - View OIG Information and access the OIG website.

Quality Improvement Organization (QIO) - View QIO functions and access state QIOs.

Recovery Auditor - View RA program details, contact information, types of reviews and the options available when receiving an RA decision.

Supplemental Medical Review Contractor (SMRC) - Access current and completed projects, the discussion/education period, documentation requests and hot SMRC topics.

ZPIC - View ZPIC functions and non-functions.
MR Service Specific Review

- HCPCS A0428 – BLS, non-emergency transport
- Review dates March 3, 2017 - June 1, 2017

<table>
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<tr>
<th></th>
<th>Northern California</th>
<th>Southern California</th>
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<tr>
<td></td>
<td>1,213 claims reviewed</td>
<td>2,890 claims reviewed</td>
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<tr>
<td></td>
<td>66 claims paid</td>
<td>165 claims paid</td>
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<td></td>
<td>1,147 claims corrected or denied</td>
<td>2,275 claims corrected or denied</td>
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<tr>
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<td>92.21% error rate</td>
<td>93.54% error rate</td>
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Top Denial Reasons

• Failure to submit documentation
• Patient could have traveled safely by other means
• Submitted documentation failed to contain identifiable information:
  – Date of service, beneficiary, rendering provider, service provided
Targeted Probe & Educate (TPE)

- CMS authorized Noridian to conduct TPE Pilot review process
- Targeted by Medical Review
  - Driven by data analysis
  - Educational opportunity for error reduction

Note:
- CR 10073 Targeted Probe & Educate Pilot
  - CMS is expanding to three contractors, Jurisdictions B, D, and E
Comprehensive Error Rate Testing (CERT) Webpage

Comprehensive Error Rate Testing (CERT)

Since 1996, CMS implemented several initiatives to prevent improper payments. CMS' goal is to reduce payment errors by identifying and addressing billing errors concerning coverage and coding. The CERT program is one of the programs created by CMS to assist in eliminating improper payments.

Access the below information from this page.

CERT Program Basics

- CERT Requests, Response Timeline and Noridian Communication
- Contractors
- Provider Corrective Actions
- Provider Mailing Addresses and Points of Contact for CERT Requests
- Respond to a CERT ADR Letter

Billing and Documentation Help for Identified Errors

- Ambulance Services
- Dear Ordering/Referring Physician Letter [PDF]
- Dual-Chamber Cardiac Pacemaker Insertion Billing
- Home Health Care Face-to-Face Visits
- International Normalized Ratio Home Monitoring
- Laboratory Services: Incorrect Billing Identified

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Zone Program Integrity Contractor (ZPIC)

Reviews
Signature Requirements
Why Is My Claim Denied?
CERT Errors for A0425 - A0429

• Missing valid physician order as required by regulation, interpretive manual or LCD
  – Includes physician signature or date
• Valid diagnosis code submitted, this alone was insufficient information
• Records for wrong dates of service submitted
• No signature log or attestation submitted
• Documentation submitted does not adequately describe service defined by code and/or modifier billed
Recovery Auditor Contractor (RAC) Webpage

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Recovery Auditor
Supplemental Medical Review Specialty Contractor (SMRC)
Zone Program Integrity Contractor (ZPIC)

Recovery Auditor

Recovery Auditors identify improper Medicare payments made on healthcare claims. These audits may result in the identification of Medicare overpayments and/or underpayments. Providers that may be reviewed include hospitals, physician practices, nursing homes, home health agencies, durable medical equipment suppliers and any other provider or supplier that bills Medicare Part A and Part B.

RAs identify specific issues to pursue but are limited to claims approved through the CMS "new issue review" process. In some cases, a small number of "non-posted issue" requests may be requested from providers as the Recovery Auditor requests sample data to supply to CMS on an issue the RA would like approved. Prior to a widespread review, all approved issues are posted on the Recovery Auditor's website. Noridian urges providers to stay informed of the new issues that are identified by the RA contractor.

Contact - HDI, HMS, CMS and Noridian - View contact information including website, address and email.

Types of Reviews - View the three types of Recovery Auditor reviews and the action providers should take.

Recovery Auditor Demand Letters Issued by Medicare Contractors - View information about how to respond to Demand Letters.
RAC Current Review

• Ambulance during inpatient hospital stay
  – Included in facility’s PPS

• SNF to SNF ambulance transfers
  – Discharging SNF financially responsible
    • Ambulance provider seeks payment from transferring SNF
Office of Inspector General (OIG) Webpage

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Office of Inspector General (OIG)

Since its 1976 establishment, the Office of Inspector General of the U.S. Department of Health & Human Services (HHS) has been at the forefront of the Nation's efforts to fight waste, fraud, and abuse in Medicare, Medicaid and more than 300 other HHS programs.

OIG develops and distributes resources to assist the health care industry in its efforts to comply with the Nation's fraud and abuse laws and to educate the public about fraudulent schemes so they can protect themselves and report suspicious activities.

- Organizational Statement
- Work Plan

Audit Findings

- Dental Services

Link to OIG 2017 Work Plan

New Issues

<table>
<thead>
<tr>
<th>Announced or Revised</th>
<th>Agency</th>
<th>Title</th>
<th>Component</th>
<th>Report Number(s)</th>
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<tr>
<td>July 2017</td>
<td>Centers for Medicare &amp; Medicaid Services</td>
<td>Medicare Part B Payments for Ambulance Services Subject to Part A Skilled Nursing Facility Consolidated Billing Requirements</td>
<td>Office of Audit Services</td>
<td>W-00-17-35794; A-01-17-00506</td>
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<td>November 2016</td>
<td>Centers for Medicare &amp; Medicaid Services</td>
<td>Ambulance Services – Supplier Compliance with Payment Requirements</td>
<td>Office of Audit Services</td>
<td>W-00-17-35574; various reviews</td>
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OIG 2015 Report/Findings

- Inappropriate Payments and Questionable Billing for Medicare Part B Ambulance Transports
  - Ambulance transports for beneficiaries who did not receive any Medicare services at point of origin or destination
  - Transports to noncovered destinations
  - Excessive mileage reported on claims for urban transports
  - Medically unnecessary transports to partial hospitalization programs
  - Inappropriate transport service levels
Dialysis Transports – OIG 2013 Report

• Not guaranteed benefit; patient must meet ambulance transport medical necessity
• Although dialysis facility is covered destination, transports to/from does not usually meet medical coverage requirements
# Supplemental Medical Review Specialty Contractor (SMRC)

StrategicHealthSolutions, LLC, was selected by CMS to conduct nationwide medical reviews as directed by CMS. Services/provider specialties to be reviewed will be selected by CMS, Provider Compliance Group/Division of Medical Review and Education (DMRE). The focus of the reviews may include, but is not limited to, vulnerabilities identified by CMS internal data analysis, the Comprehensive Error Rate Testing (CERT) program, professional organizations and Federal oversight agencies. The SMRC evaluates medical records and related documents to determine whether Medicare claims were billed in compliance with coverage, coding, payment and billing practices.

In accordance with 1833 of the Social Security Act, providers/suppliers must provide documentation upon request to support claims for Medicare services. This request complies with the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule, which allows release of information for treatment, payment and healthcare operations.

Access a variety of SMRC related information from the StrategicHealthSolutions links below.

- **Completed Projects** - View completed medical record review projects
- **Current Projects** - View current medical record reviews projects
- **Discussion/Education Period** - View discussion and education period timeframes and request requirements
- **Documentation Requests** - View examples of documentation requests. Such as:
Supplemental Medical Review Contractor (SMRC)

- Project Y3P0443 — Ambulance
- Project started due to September 2015 OIG finding document
  - Inappropriate Payments and Questionable Billing for Medicare Part B Ambulance Transports
Dear Medicare Physician/Provider/Supplier:

The Centers for Medicare & Medicaid Services (CMS) through the Medicare fee-for-service (FFS) Medical Review program, carries out the task of requesting, receiving and reviewing medical records through its Medicare Contractors. The Supplemental Medical Review Contractor (SMRC), Strategic Health Solutions, LLC (Strategic), is a specialty review contractor for CMS. The SMRC reviews selected Medicare A, B and DME claims to identify possible improperly paid claims. For more information regarding the SMRC, please visit https://strategichs.com/smrcc/

Reason for Selection
CMS has directed this review. The SMRC is conducting medical review based on the analysis of national claims data and one or more of your Medicare claims has been selected for review. Additional information about this project can be found on the website at https://strategichs.com/smrcc/

Action: Medical Records Required
Federal law requires that providers/suppliers submit medical record documentation to support claims for Medicare services upon request. Providers/suppliers are required to send supporting medical records to the SMRC. Providing medical records of Medicare patients to the SMRC does not violate the Health Insurance Portability and Accountability Act (HIPAA). Patient authorization is not required to respond to this request. Providers/suppliers are responsible for obtaining and providing the documentation as identified in the SMRC Additional Request for
Documentation Errors and Guidance
Medical Documentation Which Supports Coverage

• Patient medical status/stability at time of transport:
  – Vital signs, including oxygen saturations
  – IV fluids infusing during transport
  – Medications infused during transport
  – Equipment used by patient during transport
    • I.E. wound vac, ventilator, feeding tube
  – How did patient get to/from ambulance gurney
  – Assessment
    • Neuro status, respiratory status, mental status, level of responsiveness, etc.
  – Pain levels
Medical Documentation Which Does Not Support Coverage

• Trip sheet statements which do NOT provide clear explanation of why needed transport or monitoring by skilled personnel:
  – Patient cannot tolerate wheelchair
  – Patient unable to support self in wheelchair
  – Patient has dementia or patient forgetful
  – Patient has pain
  – Needs monitoring or oxygen
  – Cabulance not available
  – Family requests ambulance transport
Trip Report

• Patient’s condition at transport
• Patient signs/symptoms during assessment and transport
• Assessment/evaluation/progress notes
• How was patient transferred to gurney
• Services provided
Physician Certification Statement (PCS)

• Attending physician written form for non-emergency ambulance trips (scheduled or non-scheduled) in ADVANCE for repetitive services
• Does not guarantee coverage
• Date is no more than 60 days prior

Note: Ensure PCS and trip report match
BLS or ALS Level

- Medicare payment based on level of service furnished (if medically necessary)
  - Not simply on vehicle used
  - May include ALS intervention and/or assessment if dispatched ALS emergent
- Medicare MAY allow ALS emergent if based on protocol; even if no ALS intervention
  - If county protocol/local government requires completed ALS dispatch & ALS assessment
  - If ALS unit dispatched non-emergent to scene (e.g., sick call), ALS assessment must indicate ALS intervention needed and run lights/siren to facility for ALS emergent
Bed Confinement

• All 3 must be met for bed confinement
  – Unable to get up from bed without assistance; and
  – Unable to ambulate; and
  – Unable to sit in chair or wheelchair

• Bed confined by itself may not warrant transport
  – Need medical condition requiring monitoring by EMT or Paramedic
  – Not synonymous with bedrest, non-ambulatory, bedridden, etc.
Dementia or Alzheimer’s

• Diagnosis alone may not cover transport
• Must meet all coverage criteria
• Past behavior does NOT necessarily warrant current transport
• Document condition at time of 911 call and transport
• Document patient’s “behavioral status”
  – Is patient combative or having other potentially dangerous behavioral issues at time of transport
Oxygen

• Oxygen administration alone does not necessarily allow ambulance transport
• Document why respiratory status may be compromised:
  – Oxygen application route
  – Sp02 (blood oxygen level) taken by EMT/Paramedic
  – Respiratory rate and lung sounds
• Need for skilled personnel to monitor enroute
• Continued use of home oxygen doesn’t warrant BLS/ALS intervention, unless acute changes
Specialty Care Transport (SCT) A0434

• To bill A0434, must meet critically injured/ill beneficiary beyond EMT-Paramedic scope
  – Beneficiary’s condition must meet critical care for this inter-facility transport
  – EMT-Paramedic must have “additional training” level set by each state with specialty care certification/qualification
Dialysis Return Trip - Not Meeting SCT Criteria

• 76 year old female to NH after dialysis
• Certification notes patient is on respirator
• Trip report notes, alert, Ox2, vital signs stable, oxygen saturation 98%
• Patient has clear lungs, has trach with 2L oxygen. No vent settings given.
• Claim correctly down coded to A0428
Mileage Beyond Closest Facility

- A0888 - Noncovered mileage
  - E.g. Family would like patient to be closer, additional mileage was incurred
  - May still bill covered mileage A0425 separately
  - Need Origin/Destination and GY modifiers

- Ambulance supplier liable
  - Bill without GY modifier

- Beneficiary liable (E.g. A0888HHGY)
  - Patient liability if billed with GY modifier
Mileage Beyond Closest Facility - Extenuating Circumstances

- Document extenuating circumstances that may prohibit transport to closest facility
  - Extensive road construction
  - Specialist/equipment not available at closest hospital
  - Hospital on diversion (no beds, weather, cannot take new patients)
  - No Fly/Restricted Zone/Medivac
    - Supported by official federal aviation administration (FAA) message of Notice To Airmen (NOTAM) or documented refusal by Air Traffic Controller (ATC)
Ambulance Documentation Checklist

• Beneficiary name/DOS on each page
• Beneficiary or authorized signature
• Trip report/dispatch log/mileage records
• EMT/Paramedic/Physician Signature
  – Legible/complete; log/attestation if needed
• If applicable:
  – Hospital or facility records, if available
  – Patient Care Report (PCR)
  – Transport beyond closest facility
Employee’s Signature Log

- Typed name
- Employment dates
- Position/credentials
- Signature
- Initials
- Retain with internal compliance manual

EMPLOYEE SIGNATURE LOG

Name: Emmett M. Turner
Employed:
  From: 02/01/2010
  To: 9/01/2017
Position: Emergency Medical Technician
Signature & Initials: Emmett M. Turner EMT
Responding to “The Letter”

• Request for documentation:
  – CERT, MR, RAC, SMRC
• Demand letters have a response date
• Verify your address is correct in PECOS
• Gather information quickly and neatly
• Make sure signatures are present and legible
• Ensure information is sent to correct person
Additional Documentation Requests (ADR) Common Errors

- Mileage not documented
- Incorrect date of service or beneficiary
- Missing PCS, if applicable
- Missing beneficiary or authorized representative signature
- Illegible documentation
- Shortest route not taken? Explain why:
  - Car accident, train blocking, etc.
Updating Address for CERT Letters

• CERT sends correspondence to Pay-To address in PECOS

• Update address in PECOS
  – https://pecos.cms.hhs.gov/pecos/login.do#headingLv1
Resources and Reminders
AMBULANCE MLN BOOKLET

MEDICARE AMBULANCE TRANSPORTS

Target Audience: Medicare Fee-For-Service Program (also known as Original Medicare)

The Hyperlink Table, at the end of this document, provides the complete URL for each hyperlink.

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Ambulance Resources

- Medicare Benefit Policy Manual: Chapter 10
- Medicare Benefit Policy Manual: Chapter 15
- 42 CFR 410.40: Coverage of Ambulance Services
- 42 CFR 410.41: Requirements for Ambulance Suppliers
- 42 CFR 410.41: Definitions
- 42 CFR 414.610: Basis of Payment
- Ambulance Fee Schedule website
- Ambulance Fee Schedule Fact Sheet
- Medicare Ambulance Transports Booklet
- CMS Transmittal 9620
New Medicare Card Project

- Social Security Numbers removed from all Medicare cards by April 2019
- Replaced with new Medicare Beneficiary Identifier (MBI)
  - Example 1EG4-TE5-MK73
  - MBI Format Specifications
- Transition period April 1, 2018 through December 31, 2019
  - Beneficiaries may use the new card upon receipt
Redeterminations and Reopenings via NMP Letters

• Medicare Redetermination Notices (MRNs) will *no longer* be mailed

• Providers /suppliers who submit Redetermination or Reopening requests through NMP will receive MRNs via NMP

• Ability to view/print determination letters
Thank you!