The 2018 Oklahoma Ambulance Association Spring Conference

May 23, 2018

INNOVATION IN ACTION

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Acronym List 1

Acronym	Definition
ADR	Additional Development Request
ALS	Advanced Life Support
CD	Compact Disc
CERT	Comprehensive Error Rate Testing
CMS	Center for Medicare and Medicaid Services
CR	Change Request
DVD	Digital Video Disc
EFT	Electronic Funds Transfer
esMD	Electronic Submission of Medical Documentation System
HCPCS	Healthcare Common Procedure Coding System
IVR	Interactive Voice Response
IOM	Internet Only Manual
LCA	Local Coverage Article

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Acronym List 2

Acronym	Definition
LCD	Local Coverage Determination
MAC	Medicare Administrative Contractor
MBI	Medicare Beneficiary Identifier
MLN	Medicare Learning Network
MR	Medical Review
NPI	National Provider Identifier
PCS	Physician Certification Statement
P.O.	Post Office
PTAN	Provider Transaction Access Number
RA	Recovery Auditor
TPE	Targeted Probe and Educate
UPIC	Unified Program Integrity Contractor
ZPIC	Zone Program Integrity Contractor

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Agenda

- Targeted Probe and Educate (TPE)
- Ambulance Policy and Requirements for Coverage
- Overview of Basic Life Support (BLS) Services and Mileage
- Physician Certification Statement (PCS)
- Trip Record Documentation Requirements
- Updates and Reminders
- Self-Service Options

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Targeted Probe and Educate

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Targeted Probe and Educate (TPE)

- Change Request # 10249:
  - Effective: October 1, 2017
  - Implementation: October 1, 2017
- Key Point:
  - CMS has authorized MACs to conduct the TPE review process and Novitas will select the topics for review:
    - ✓ Based on existing data analysis and CERT data
  - TPE review process includes three rounds (if warranted) of prepayment probe review with education:
    - ✓ Sample limited for each probe “round” to a minimum of twenty (20) and a maximum of forty (40) claims

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What is Targeted Probe and Educate

- CMS believes the results of this program have been favorable, based on evidence of decreased claim errors
- CMS is moving towards a more targeted approach
- TPE process provides opportunity to educate providers before, during and after the probe:
  - Pre-education will take place before ADRs are sent and providers will be notified of the review
  - Intra-education will continue during the probe if easily resolvable issues are found and can be corrected eliminating the need for appeal
  - Post-education will be provided once the probe has been completed; a results letter will be mailed to the provider with a detail report. An educational teleconference will be provided to any providers receiving a moderate or major error classification
- TPE process will consist of three rounds of prepayment probe review with education – if error rates warrant

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Medical Review Process Change

- Novitas Solutions has initiated a Targeted Probe and Educate (TPE) under the direction of CMS to reduce provider burden
- Medical review process has moved to TPE:
  - Proved successful in lowering providers payment error rates
  - Involves the review of 20-40 claims per provider/supplier, per item or service
  - Will allow for time after education to correct errors before next "round"
- Novitas will focus on specific providers/suppliers:
  - That bill a particular item or service rather than all providers/suppliers billing a particular item or service
  - Who have the highest claim denial rates or who have billing practices that vary significantly from their peers:
    - ✓ Based on Data Analysis & CERT error rates
- Automated reviews and prior authorizations are not part of the TPE program

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TPE Rounds of Review Process

TPE Process	Round 1 Initial Probe	Round 2	Round 3	CMS Corrective Actions After Round 3
Provider Notification	X	X	X	N/A
Pre-Probe Education	X	X	X	N/A
ADR request	X	X	X	N/A
Medical Review (education if necessary)	X	X	X	N/A
Results letter	X	X	X	N/A
Post-Probe Education	X	X	X	N/A
Referral (if applicable)	N/A	N/A	X	N/A
Extrapolation, referral to ZPIC, UPIC or RA or 100% prepay review	N/A	N/A	N/A	X

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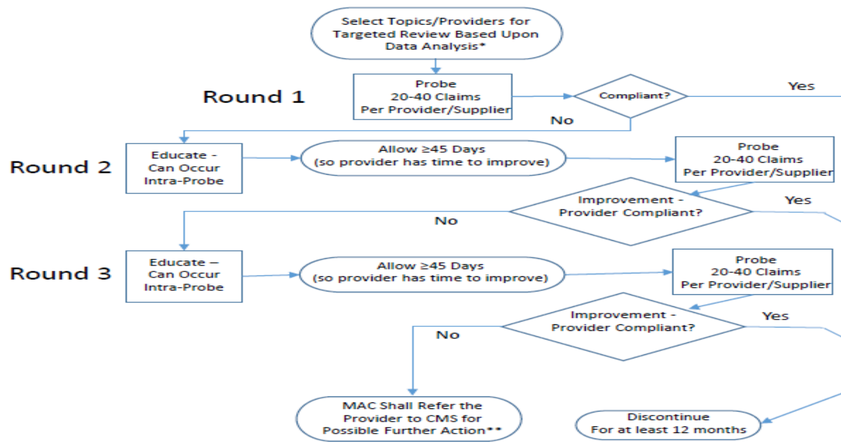
Targeted Probe & Educate Flow Chart



Topics For Review

- All topics for review are listed in a chart on the website with a link to education that will assist in ensuring a successful review
- These lists will be continually updated as new topics are added
- Not all providers will be subject to review
- Topics for Review

Part B JH Ambulance

Ambulance (JH only) A0428	Documentation Checklist	CMS IOM Publication 100-02, Benefit Policy Manual, Chapter 10 CMS IOM Publication 100-04, Claims Processing Manual, Chapter 15 Medicare Ambulance Transports Medicare Payments for Ambulance Transports The Medicare Ambulance Benefit & Statutory Bases for Denial of Claims and Ambulance Transports & ABNs Local Coverage Determination, L35162 Ambulance Services (Ground Ambulance) Ambulance Billing Guide Ambulance Modifiers Trip/Run Record Documentation Physician Certification Statement (PCS)	December 2017

I N N O V A T I O N I N A C T I O N

Provider Notification

- Providers/suppliers targeted for review will be notified with an initial letter
- ADR letters will be generated on each claim selected for review:
  - ADRs will be generated per the usual process
  - Part B providers will receive ADRs mailed to the address listed in MCS or listed for correspondence through Provider Enrollment
- Providers can view the current topics being reviewed on the Novitas website

I N N O V A T I O N I N A C T I O N

Initial Letter and Education

- Initial letter will include:
  - Topic being reviewed
  - Reason for the selection which will be supported by data analysis
  - Number of claims requested for review
  - Documentation checklist
  - Review process
  - Contact information for the reviewer assigned to the probe
- Initial education:
  - Clinical Reviewer will call to:
    - ✓ Establish a contact person
    - ✓ Educate on the documentation requirements
    - ✓ Discuss educational tools available

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Additional Development Request (ADR)

- When a claim is selected for pre payment medical review, an ADR request is made and contains necessary information for the review
  - Claims are placed in a suspended location
- Once an ADR is received a provider should do the following:
  - Collect all requested documentation
  - Verify all documentation requested is included in your submission
  - Verify all documentation submitted is appropriately signed or also include signature attestation
  - Attach the first page of the original ADR request as the cover sheet to the records

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Provider Response to ADRs

- Provider has 45 days to respond to the contractor with medical records
- No response counts as a denial for no records received and will affect the error rate of the entire probe:
  - Non-responders could be referred to the RA, ZPIC, or UPIC
- Options for sending in medical records:
  - US Mail, Fedex or UPS
  - esMD
  - Faxing
  - CD/DVD submission
  - Novitasphere

I N N O V A T I O N   I N   A C T I O N

Novitas Providers Sending ADR Part B Records via US Mail

State	Address
Arkansas, Louisiana, Mississippi, Colorado, New Mexico, Texas, Oklahoma	Novitas Solutions, Inc. JH Part B ADR/Medical Records P.O. Box 3094 Mechanicsburg, PA 17055-1812

I N N O V A T I O N   I N   A C T I O N

Novitas Providers Physical Address, Overnight Delivery and Certified Mail

- For mail that cannot be sent through a P.O. Box please submit documentation to the physical address: (Includes any overnight deliveries or certified mail):
  - Novitas Solutions, Inc.
    Attention: Medical Review/Medical Records Submission
    2020 Technology Parkway, Suite 100
    Mechanicsburg, PA 17050

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Documentation Preparation for sending the Mail

- Do not use staples or paperclips
- Each packet should be bound with a rubber band with the appropriate ADR on top and the correct medical records
- Avoid mixing single and double-sided documents:
  - Make sure you copy both side of the documents
- Return the medical record to the correct address listed on the ADR
- Do not include any other correspondence or claims that do not pertain to your ADR
- Documentation should be legible including physician’s signatures or an attestation of signature should be included in the documentation

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Sending Records via Electronic Submission of Medical Documentation System (esMD)

- Providers can submit requested ADR documentation electronically through the esMD
- Process will allow providers to submit medical documentation over secure electronic means
- Process is secure, time efficient and cost effective
- CMS provides the information to sign up for esMD on their website

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Novitas Faxing Documentation Information

- Original ADR request must be submitted as the cover sheet to the records
- Supporting documentation, or requested medical records, should follow the ADR letter
- Each ADR request must be faxed separately
- Faxes should not exceed 200 pages
- Submit only documentation for date of service and procedure code requested
- Fax image option allows for documentation to be submitted directly to Novitas Solutions
- Available 24 hours a day, 7 days a week
- Fax ADR response to 1-877-439-5479

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Sending Records via CD/DVD

- Sending records via password protected CD/DVD:
  - CD/DVD must be password protected, send an email:
    - ✓ SECUREPSWD@novitas-solutions.com
  - Include the following information in your email:
    - ✓ Subject- CD/DVD Password, Beneficiary Name/Provider Name
    - ✓ Body of email- Provider name, Provider Number (PTAN) and the DCN/ICNs or ADR letter applicable to the CD/DVD, and the password
    - ✓ If you are responding to multiple MR ADR requests, clearly separate the documentation for each claim

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Sending Records via Novitasphere

Eligibility
Secure Message
Medical Review Records
Audit & Reimbursement
Prior Authorization Requests
Submission History
Claims Submission/ERA
MailBox
My Account

Medical Review Record Submission

Tuesday, July 11, 2017 3:14 PM

Please enter the required information in the fields below. When submitting the requested documentation please ensure that you have placed the first page of the corresponding ADR or fax cover sheet on top of the documentation associated with the identified claim number.
Note:Record submissions that have been password protected by the provider and are uploaded cannot be processed. You will be alerted if your submission exceeds the size limit of 200MB.
*Indicates a required field.

*Claim Number (DCN)
*File to upload Browse... Clear
Add More Documentation
Comment

Submit Reset Form

INNOVATION IN ACTION

Medical Review Record Submission Confirmation

Medical Review Record Submission

Thank you for your submission

Thank you for your Medical Review Record Submission! You will receive confirmation in your portal mailbox. The confirmation number of your submission is:

Remember, you can track the status of your submission using this confirmation number.

I N N O V A T I O N   I N   A C T I O N

Medical Review Claims

Eligibility
Claims Submission/ERA
(Opens in new tab/Disable pop-up blocker)
Medical Review Claims
Secure Message
MailBox
My Account Profile

Medical Review Claims

Friday, April 6, 2018 1:04 PM

This screen can be used to perform a search for medically reviewed claims. You must provide at least one of the following pieces of information to search: MR Case Number, Control Number, Medicare Beneficiary ID, or Date.

Note: * Indicates a required field. Dates may be entered as MMDDYY or MMDDYYYY. Forward slashes will be populated automatically.

NPI:* Select One
PTAN:* Select One
State:* Select One
Case Number:
Control Number:
Medicare Beneficiary ID:
ADR Status: Select One
Search Date By: Select One

Submit   Clear

I N N O V A T I O N   I N   A C T I O N

Medical Review Claim Details – ADR Tab

Medical Review Claim Details

Tuesday, April 10, 2018 12:43 PM

CLAIM INFORMATION

DCN
Medicare Beneficiary ID
Case Number
Date of Service From 01/27/2018
Date of Service To 01/30/2018

ADR | REVIEW | EDUCATION

If an ADR response was not submitted utilizing the standard methods as outlined in the ADR, the status update for the claim may be delayed.

Additional Documentation Request Information

Delivery Mechanism	Status	Letter Sent Date	Response/Medical Records Submission Due Date	Received Date	Document
Mail	Received	04/04/2018	05/19/2018	04/05/2018	PDF

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INNOVATION IN ACTION

Medical Review Claim Details – Review Tab

Medical Review Claim Details

Tuesday, April 10, 2018 12:44 PM

CLAIM INFORMATION

DCN
Medicare Beneficiary ID
Case Number
Date of Service From 01/27/2018
Date of Service To 01/30/2018

ADR | REVIEW | EDUCATION

Review Information

MR Begin Date	04/05/2018
MR Completed Date	04/05/2018
Review Status	Review Completed
Review Outcome	Full Denial
Review Findings and Rationales	04/05/2018 50174 Full denial. Medical Records do not include sufficient documentation to support medical necessity. No admission order RN/RN
Review Results Sent Date	02/20/2017
Review Results Code	NA
Review Results Code Descriptors	NA

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Education Tab

Medical Review Claim Details

CLAIM INFORMATION

ICN	
Medicare Beneficiary ID	
Case Number	
Date of Service From	04/14/2017
Date of Service To	04/14/2017

ADR | REVIEW | EDUCATION

Education Information

Type of Education	Post Probe Education Provided - 1:1 telephonic
Date of Educational Call to Provider	03/20/2018

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Intra Probe Education

- Clinical Reviewer may provide Intra Probe Education when needed to correct resolvable issues:
  - Examples:
    - ✓ All ADR documentation is missing a required document:
      - ➢ i.e. signed order for services billed
- Providers are given an opportunity to submit the missing documentation

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Provider Results Letter and Education

- Detailed results letter at the conclusion of each round will include:
  - Error rate and error classification
  - Detailed summary of claims denied and reasons why
  - Education information
  - Next steps in the TPE process (Major/Moderates will move to next round, Minors will not)
  - Appeals rights
  - Contact information of Clinical Reviewer
- Post Education:
  - Minor error classification will receive one-on-one educational call to discuss issues found during the probe
  - Moderate/Major error classification will receive a teleconference educational call to discuss issues found during the probe:
    - ✓ Contact person from provider should invite anyone they feel would benefit from education

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TPE Results

- Providers will have 45 days between rounds giving them time to implement any changes they feel are necessary after education
- Results for each round will be posted on the Novitas website including:
  - Common denial reasons
  - How many major, moderate and minor probe results

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Novitas Part B ADR Address Change

- Providers may change the address listed in MCS (Part B) by filling out the appropriate CMS Enrollment form:
  - Step-by-step instructions on how to change the address for the Individual providers CMS-855I and the Group/Organization providers CMS-855B
- You may also contact Customer Contact Center for assistance:
  - JH Providers must call 1-855-252-8782

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Novitas Resources

- Medical Review Center
- Targeted Probe and Educate Information
- Medical Review Additional Development Request Process

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CMS Targeted Probe and Educate Resources

- CMS Internet Only Manual (IOM), Publication 100-08, Medicare Program Integrity Manual, Chapter 2
- CMS Targeted Probe and Educate Center
- CMS Targeted Probe and Educate FAQs
- CMS "Reducing Provider Burden"
- CMS TPE Flow Chart

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Ambulance Policy and Requirements for Coverage

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CMS National Policy

- Covered only if furnished to a beneficiary whose medical condition at the time of transport is such that transportation by other means would endanger the patient's health
- Not covered when the patient's condition permits transport in any type of vehicle other than an ambulance
- Payment dependent on patient's condition at actual time of transport regardless of diagnosis
- Patient must require the transportation and level of service provided

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Additional CMS National Policy

- Medicare covers both emergency ambulance transportation and non-emergency ambulance transportation based on medical necessity:
  - Patient's condition requires the vehicle itself and/or the specialized services of the trained ambulance personnel
  - The needed services of the ambulance personnel were provided and clear clinical documentation validates medical need and their provision in the record of the service (usually the run sheet)
- Actual transportation of the beneficiary occurs
- Services must be reasonable and necessary
- Transportation is to the closest appropriate facility

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CMS Definition of Bed-Confinement

- Definition:
  - Unable to get up from bed without assistance
  - Unable to ambulate
  - Unable to sit in a chair or wheelchair
- Note:
  - All three must be meet and documentation must support all
  - The term "bed confined" is not synonymous with "bed rest" or "non-ambulatory"
  - Bed-confinement, by itself, is neither sufficient nor is it necessary to determine the coverage for Medicare ambulance benefits
  - It is simply one element of the beneficiary's condition that may be taken into account in the MAC's determination of whether means of transport other than an ambulance were contraindicated

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Novitas Ambulance LCD/Article

- Novitas has a Local Coverage Determination (L35162) and Local Coverage Article (A54574).
- The policy:
  - Repeats the CMS National Ambulance policy
  - Lists the documentation requirements that is required for covered transports
  - Provides the PCS requirements
- JH and JL Providers/Suppliers should comply with the policy

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Ambulance Transports Require Dual Diagnoses

- All ground ambulance transports require dual diagnoses
- Providers should report the most appropriate ICD-10-CM code that adequately describes the patient's medical condition at the time of transport as the primary diagnosis
  - One diagnosis from the ambulance article or a valid ICD-10-CM code:
    - ✓ LCA– Ground Ambulance Services – A54574
  - A secondary diagnosis must be reported from the LCD:
    - ✓ LCD- Ground Ambulance Services - L35162
  - No order is required as long as one primary diagnosis code from the LCD article or a valid ICD-10 code and one secondary diagnosis code from the LCD is reported on the claim

I N N O V A T I O N I N A C T I O N

Ambulance Coverage Destinations

- Only to the following destinations:
  - Hospital
  - Critical Access Hospital (CAH)
  - Skilled Nursing Facility (SNF)
  - Beneficiary's home.
  - Dialysis facility for End Stage Renal Disease (ESRD) patient who requires dialysis
- Covered to the nearest appropriate facility
- Mileage to the nearest appropriate facility covered

I N N O V A T I O N I N A C T I O N

Appropriate Facilities

- The term appropriate facilities means that the institution is generally equipped to provide the needed hospital or skilled nursing care for the illness or injury involved
- In the case of a hospital, it also means that a physician or a physician specialist is available to provide the necessary care required to treat the patient’s condition

Medicare Benefit Policy Manual – Chapter 10 -Ambulance Locality

- MM10110:
  - Effective: September 18, 2017
  - Implementation: September 18, 2017
- Key Points:
  - MACs have the discretion to define “locality” in their service areas
- At this time Novitas will not define the locality in our service areas

Origin and Destination Modifiers

Modifier	Description
D	Diagnostic or therapeutic site other than P or H when these are used as origin codes
E	Residential, domiciliary, custodial facility (other than 1819 facility)
G	Hospital-based ESRD facility
H	Hospital
I	Site of transfer (e.g. airport or helicopter pad) between modes of ambulance transport
J	Freestanding ESRD facility
N	Skilled Nursing Facility
P	Physician's office
R	Residence
S	Scene of accident or acute event
X	Intermediate stop at physician's office on way to hospital (destination code only)

First position equals the origin; Second position equals destination

Example: HN = Hospital (origin) to Skilled Nursing Facility (destination)

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Overview of Basic Life Support (BLS) Services and Mileage

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Emergency Level of Service

- Emergency level depends on how the ambulance was dispatched and how it responded
- Documentation should include the information that was reported to the dispatcher at the time of call
- Emergency does not depend on whether an assessment was furnished after the ambulance arrived
- Covered when medically necessary, meet destination limits of the closest appropriate facilities, and provided by an ambulance service that is licensed by the state

INNOVATION IN ACTION

Emergency Response

- Responding immediately at the BLS or ALS1 level of service to a 911 call or the equivalent in areas without a 911 call system
- Immediate response:
  - An immediate response is one in which the ambulance supplier/provider begins as quickly as possible to take the steps necessary to respond to the call
- Immediate medical condition that could result in the following:
  - Placing the patient's health in serious jeopardy
  - Serious impairment to bodily functions
  - Serious dysfunction of any bodily organ or part

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Non-Emergency Service

- Covered in the absence of an emergency condition:
  - Patient being transported has, at the time of ground transport, a condition such that all other methods of ground transportation (e.g., taxi, private automobile, wheelchair van or other vehicle) are contraindicated; and/or
  - Patient is bed-confined before, during and after transportation

Basic Life Support

- Basic Life Support (BLS) – A0428:
  - The ambulance must be staffed by an individual who is qualified in accordance with state and local laws as an Emergency Medical Technician-Basic (EMT-Basic)
  - These laws may vary from state to state
- Basic Life Support (BLS) – Emergency – A0429:
  - Patient's health in serious jeopardy
  - Serious impairment to bodily functions
  - Serious dysfunction of any bodily organ or part
  - Immediate response

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Ground Mileage

- Ground Mileage, Per Statute Mile – A0425:
  - Mileage can be allowed to the nearest appropriate facility when the ambulance transfer is covered
  - Only the actual number of "loaded" miles from the point of pickup to the point of destination can be reported as mileage
  - Miles must be reported as fractional units

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Reporting Ground Mileage

- Fractional mileage must round the total miles up to the nearest tenth of a mile and report the resulting number with the appropriate HCPCS code for ambulance mileage:
  - Decimal must be used in the appropriate place (e.g., 99.9)
- Trips totaling 100 covered miles and longer report mileage rounded up to the next whole number mile without the use of a decimal:
  - 998.5 miles should be reported as 999
- Tips totaling less than one mile:
  - Enter a "0" before the decimal (e.g., 0.9)
- Fractional mileage reporting applies only to ambulance services billed on a Form CMS-1500 paper claim, ANSI X12N 837P or 837I electronic claims:
  - Note: Does not apply to providers billing on the UB-04 form

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Capture and Document Loaded Mileage

- Mileage can be documented in a number of different ways including:
  - Trip odometer readings
  - GPS systems,
  - Navigation computers
  - Mapping programs (e.g., MapQuest)
- Please ensure that you maintain the acceptable forms of documentation in the patient's record and that the documentation is available to Medicare upon request
- Complete name and address of the origin and destination should be documented in the trip report completed by the ambulance supplier

Non-Covered Mileage

- Non-Covered Mileage – A0888:
  - Miles traveled beyond closest appropriate facility
  - When a beneficiary wishes to be transported to a facility that is not the closest appropriate facility, Medicare does not cover the additional mileage
  - This code will deny when submitted

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Physician Certification Statement (PCS)

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Physician Certification Statement (PCS)

- Required for scheduled and non-scheduled non-emergency transports for patients who are under the direct care of a physician
- Not required:
  - Emergency transports
  - Non-scheduled non-emergency transports of patients residing at home or in facilities where they are not under the direct care of a physician
- Suppliers/providers are required to obtain written orders from the patient's attending physician certifying that the medical necessity requirements are met

I N N O V A T I O N   I N   A C T I O N

PCS Form

- The signed PCS does not, by itself, demonstrate that the transport was medically necessary and does not absolve the ambulance provider from meeting all other coverage and documentation criteria:
  - Be patient-specific
  - Contain pertinent medical information
  - Confirm or support information on run sheet
  - For repetitive services, the PCS may include the expected length of time ambulance transport would be required but may not exceed 60 days
  - The signature of the medical professional completing the PCS must be legible (or accompanied by a typed or printed name) and include credentials
  - Signatures on the PCS must be dated at the time they are completed

I N N O V A T I O N I N A C T I O N

Requirements for Non-Emergency Non-Scheduled

- Requirements for Non-Emergency Non-Scheduled or Scheduled on a Non-Repetitive Basis Transport:
  - Before submitting the claim, a certification must be signed by the attending physician within 48 hours after the transport
  - If unable to get the attending physician to sign within 48 hours, either a:
    - ✓ Physician Assistant (PA)
    - ✓ Nurse Practitioner (NP)
    - ✓ Clinical Nurse Specialist (CNS)
    - ✓ Registered Nurse (RN)
    - ✓ Discharge planner employed by the facility with knowledge of the patient's condition can sign the form

I N N O V A T I O N I N A C T I O N

Requirements If Unable To Obtain Certification

- Requirements for Non-Emergency Non-Scheduled or Scheduled on a Non-Repetitive Basis Transport:
  - If unable to obtain a signed PCS by the attending physician within 21 days, the ambulance supplier must document efforts to obtain certification
  - Letter via United States Postal Service certified mail with return receipt and proof of mailing or other similar service demonstrating delivery of the letter as evidence of attempt to obtain the PCS
  - United States Postal Service Certificate of Mailing, Form 3817, is acceptable alternative to certified mail

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Requirements for Non-Emergency Scheduled

- Requirements for Non-Emergency Scheduled, Repetitive Transports:
  - The PCS must be signed and dated by the attending physician prior to the transport:
    - ✓ Signature of the medical professional completing the PCS must also be legible (or accompanied by a typed or printed name) and include credentials
  - The PCS must be dated no earlier than 60 days in advance of the transport for those patients who require repetitive transports
  - For repetitive services, the PCS may include the expected length of time ambulance transport would be required but may not exceed 60 days

INNOVATION IN ACTION

Definition of Repetitive Services

- Repetitive Services:
  - Non-emergency ambulance services may be those that are scheduled in advance (scheduled services being either repetitive or non-repeating)
  - A repetitive ambulance service is defined as medically necessary ambulance transportation that is furnished:
    - ✓ Three or more times during a 10-day period or
    - ✓ At least once per week for at least three weeks
- Transportation to hemodialysis is a common example of repetitive ambulance services

INNOVATION IN ACTION

Trip Record Documentation Requirements

INNOVATION IN ACTION

Documentation Requirements

- All documentation must be maintained in the patient's medical record and made available to the contractor upon request
- Every page of the record must be legible and include appropriate patient identification information (e.g., complete name, dates of service(s))
- Documentation must include the legible signature of the person who is responsible for and providing the care to the patient
- Submitted records must support the use of the selected diagnosis and the HCPCS code must describe the services performed

I N N O V A T I O N I N A C T I O N

Trip Documentation Requirements

- Trip documentation:
  - Detailed description of the patient’s condition at the time of transport
  - Documentation must “paint a picture” of the patient’s condition and must be consistent with documentation found in other supporting medical record documentation (including the PCS)
  - Complete and legible information
  - Indication of emergency or non-emergency situation:
    - ✓ This information should come from the reported condition of the patient at the time of dispatch

I N N O V A T I O N I N A C T I O N

Patient's Condition Requirements

- Trip documentation must include:
  - Reason for the transport (why the patient could only travel by ambulance):
    - ✓ Concise explanation of symptoms reported by the patient and/or other observers and details of the patient's physical assessments that explain why the patient requires ambulance transportation and cannot be safely transported by an alternative mode
  - 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 Medicare limitation of coverage for ambulance services
  - Description of the traumatic event when trauma is the basis for suspected injuries
  - Detailed description of existing safety issues
  - Detailed description of special precautions taken (if any) and explanation of the need for such precautions

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Assessment Documentation

- Trip documentation:
  - Description of specific monitoring and treatments required, ordered or performed/administered
  - Assessment and clinical evaluations, which should include:
    - ✓ Vital signs
    - ✓ Neurological assessment
    - ✓ Cardiac information
  - Procedures and supplies provided, such as:
    - ✓ Oxygen administered
    - ✓ Cardiac rhythm monitoring
    - ✓ IV therapy
    - ✓ Respiratory therapy
    - ✓ Intubation
    - ✓ Cardiopulmonary Resuscitation (CPR)
    - ✓ Drug therapy
    - ✓ Restraints
  - Treatment should be medically necessary based on the patient's condition and documentation should reflect the medical necessity

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Additional Documentation Requirements

- Trip documentation:
  - Patient's progress (responses to treatment and changes as treatment is given)
  - Point of pickup:
    - ✓ Complete name and address of origin and destination
  - Hospital-to-hospital transports:
    - ✓ Trip record must clearly indicate the precise treatment or procedure that is available only at the receiving hospital
  - Number of loaded miles
  - Date and legible identity of the observer

Additional Documentation Records and Reports

- Ensure you include any additional available documentation that supports medial necessity:
  - Emergency Room report
  - Hospital record
  - SNF record
  - ESRD facility record
  - Dispatch record
  - Documentation supporting the number of loaded miles

Insufficient Documentation Examples

- LCD list examples of insufficient statements to justify medical necessity:
  - Hypertension
  - Chest Pain
  - Patient unable to sit, stand or walk

INNOVATION IN ACTION

Signature Guidelines for Medical Review Purposes

- Special Edition Article SE1419
- Medicare requires that services provided/ordered be authenticated by the author:
  - Method used shall be a handwritten or an electronic signature
  - Stamped signatures are not acceptable
- These guidelines impact the ambulance trip/run sheets and the PCS
- Signature of the medical professional completing the PCS must be:
  - Legible (or accompanied by a type or printed name) and include credentials
  - Dated at the time they are completed
- All signature requirements are effective for CERT
- All signature requirements for Affiliated Contractors (AC), MACs and Zone Program Integrity Contractors (ZPICs) are applicable for reviews conducted

INNOVATION IN ACTION

Additional Signature Guidelines for Medical Review Purposes

- Trip/Run sheet signature requirements:
  - Must contain the date and legible signature of the observer and their credentials
  - Can print their name under the signature
  - Can submit a signature log

Ambulance References

- LCA– Ground Ambulance Services - A54574
- LCD- Ground Ambulance Services - L35162
- CMS Ambulance Service Center
- Ambulance services:
  - IOM 100-2; Chapter 10
  - IOM 100-4; Chapter 15
- Novitas Specialty Ambulance Center

Ambulance Specialty Page

- Novitasphere Portal
- 2018 Medicare Participation
- Appeals
- CERT
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- Electronic Billing-EDI
- Enrollment
- Evaluation & Management
- FAQs
- Fee Schedules
- Forms
- IHS/Urban/Tribal Providers
- IVR
- Join our E-Mail Lists
- Medical Policy / LCDs
- Medical Review
- Publications
- Self-Service Tools
- Specialties / Services
  - Ambulance
  - Chiropractor
  - Influenza Billing
  - Medicare Secondary Payer
  - View All...

COMING IN 2018!
New Medicare cards with new numbers.
Are you ready?
#NewCardNewNumber
LEARN MORE

regarding the Medicare program overall can be found using the topics down your left navigation bar. Please subscribe to our mailing lists to stay current with Medicare.

Articles

- Ambulance Billing Guide
- Ambulance Modifiers
- Ambulance Fee Schedule Fact Sheet
- Ambulance Prior Authorization Claim Submission Guidelines (JL only)
- Ambulance Services and Drug Codes
- Ambulance Services Center
- Attention Ambulance Suppliers – Upcoming Change to the Establishment of Medicare Effective Dates
- Deceased Beneficiary
- Frequently Asked Questions
- Ground Ambulance Transports Dual Diagnoses
- JH Ambulance Mileage Edits
- Local Coverage Article, A54574 Ambulance Services (Ground Ambulance)
- Local Coverage Determination, L35162 Ambulance Services (Ground Ambulance)
- Medicare Ambulance Transports
- Medicare Payments for Ambulance Transports
- k (MLN) Matters Article, MM6372 Clarification of Date of Service (DOS) of Ambulance Services
- e Amounts Submitted on Ambulance Claims
- ccept and Process All Ambulance Transportation Healthcare Common Procedure Coding System (HCPCS) Codes
- ent Reduction for Non-Emergency Basic Life Support (BLS) Transports to and from Renal Dialysis Facilities
- solicited Response (IUR) or Reject for Ambulance SNF to SNF Transfer
- Multiple Patients
- Open Door Forum
- Payment Extended
- Physician Certification Statement (PCS)

Additional Ambulance and Signatures Resources

- Use the following resources to avoid documentation errors:
  - Medicare Ambulance Transports Booklet
  - 42 Code of Federal Regulations 424.36 - Signature Requirements
  - Guidance on Beneficiary Signature Requirements for Ambulance Claims
  - April 2016 Medicare Quarterly Provider Compliance Newsletter
  - Ambulance Fee Schedule Fact Sheet

Updates and Reminders

Bipartisan Budget Act of 2018

- Ambulance Add-on Payments:
  - Amends Section 1834(l) of the Social Security Act (42. U.S.C.14 1395m(l)) and extends the 2015 ambulance add-on payments
  - The legislation's provisions include:
    - ✓ The three percent increase in the Ambulance Fee Schedule (AFS) amounts for covered ground ambulance transports that originate in rural areas and the two percent increase for covered ground ambulance transports that originate in urban areas, which is extended through December 31, 2022
    - ✓ The provision relating to payment for ground ambulance services that increases the base rate for transports originating in an area that is within the lowest 25th percentile of all rural areas arrayed by population density (known as the "super rural" bonus), which is extended through December 31, 2022
- Increased Reduction for Non-Emergency End-Stage Renal Disease (ESRD) Ambulance Transports:
  - Amends Section 1834(l)(15) of the Social Security Act (42 U.S.C. 1395m(l)(15)) and mandates an increase in the reduction applied to the ambulance fee schedule payment rates for all non-emergency ambulance transports to and from an ESRD facility beginning with dates of service on and after October 1, 2018
  - The reduction is being increased from 10% to 23%
  - Instructions necessary for implementing this increased payment reduction will be forthcoming in a future CMS Change Request
- Cost Reporting for ground ambulance:
  - CMS must complete the guidelines
  - Starting January 2020 Ambulance suppliers will start submitting the cost reports
  - If not submitted, a 10% reduction will apply
  - There will be exception process

2018 Annual Update of HCPCS for SNF Consolidated Billing

- MM10262:
  - Effective: January 1, 2018
  - Implementation: January 2, 2018
- Key Points:
  - New code files will be posted the first week in December 2017
  - View the “General Explanation of the Major Categories” file in order to understand the Major Categories including additional exclusions not driven by HCPCS codes

SNF Consolidated Billing Ambulance Issues

- MM10262 addressed the January 2018 CWF update to Skilled Nursing Facility (SNF) Consolidated Billing edits
  - Changes to the editing inadvertently caused claims for ambulance services to or from dialysis facilities and to or from hospitals when the patient was in an SNF Part A stay, to deny in error
  - This also cause incorrect overpayments to be issued
- This was not a Novitas issue, it was caused due to the implementation of the CR 10262
- All contractors were affected
- On March 1, 2018, the SNF Consolidated Billing edits were corrected
- Any incorrectly processed claims will be identified and reprocessed by Novitas
- No provider action needed at this time
- Since this is a Common Working File (CWF) issue we must wait until CMS gives us guidance on how to handle the claims denied in error and overpayments that were set up incorrectly

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Part B Current Claim Issues

- Current claim issues link provides you with the most current status of claim processing issues that have been identified
- Listed by current claim issues and archived/resolved claim issues

Self-Service Options

Join Our Email List Today

- Join Our Email List
- Stay current with Medicare by receiving emails twice a week
- Available email lists (not all-inclusive):
  - Jurisdiction H
  - Part B Electronic Billing
  - Novitasphere Portal
  - ABILITY| PC-ACE
  - Medicare Remit Easy Print (MREP) Users

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Website Satisfaction Surveys

Rate Your Website Experience

You've been selected to participate in a customer satisfaction survey to help us improve your website experience.

The survey will take 2-3 minutes, and will appear at the conclusion of your visit.

This survey is conducted by an independent company ForeSee, on behalf of the site you are visiting.

No Thanks | Yes, I'll Help!

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You Can Chat With Us

- We can help you find information on our website though our Chat:
  - For example:
    - ✓ Medical Policies
    - ✓ Medical Review information
    - ✓ Forms
    - ✓ And much more
- Live Chat:
  - Monday-Friday 10:00 a.m.- 2:00 p.m. ET
  - Click the “ Need Help" tab on the right side of your screen to start a chat

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Customer Contact Information

- Providers are required to use the IVR unit to obtain:
  - Claim Status
  - Patient Eligibility
  - Check/Earning
  - Remittance inquiries
- Jurisdiction H:
  - Customer Contact Center- 1-855-252-8782
  - Provider Teletypewriter- 1-855-498-2447
- Patient / Medicare Beneficiary:
  - 1-800-MEDICARE (1-800-633-4227)

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Summary

- Covered the Updates and Reminders
- Reviewed the Medically Unlikely Edits (MUEs) guidelines
- Discussed the Enrollment and Revalidation process
- Reviewed the enrollment to Novitasphere and eligibility options
- Explained the Targeted Probe and Educate (TPE)
- Reviewed the Ambulance policy and coverage requirements
- Discussed the BLS transports and Mileage
- Reviewed the Trip Record documentation requirements
- Listed the Self-Service Options

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Thank You

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