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Compliance Today - January 2020
Non-emergency ambulance services and hospital providers: Evaluating institutional compliance

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Some hospitals may have their own ambulance transportation, but many hospitals still rely upon outside ambulance companies to provide non-emergency ambulance transportation, including transporting the patient to destinations such as a facility with a higher level of care or discharge from the hospital to the patient's residence. It may also include intra-facility transportation to off-campus units of the hospital, such as a patient traveling between the hospital and the hospital's imaging center.

Hospital use of ambulance companies to provide non-emergency ambulance transportation is fraught with regulatory, contractual, and billing considerations. Given the potential exposure to civil and criminal liability, hospitals should be vigilant for continuing compliance with the law and their own policies.

Concerns

In January 2018, the federal government extended a temporary ambulance moratoria that included Florida, Illinois, Michigan, Texas, Pennsylvania, and New Jersey, to prevent and combat fraud, waste, and abuse. This moratorium on the enrollment of new, non-emergency ground ambulance suppliers was prompted by incidents of fraudulent activity involving non-emergency ambulance transportation.[1]

Practices, such as upgrading or upcoding the level of service charges or billing for transport levels that were medically unnecessary,[2] "swapping" arrangements (see definition under Anti-Kickback Statute concerns below), and transporting ambulatory patients who did not require ambulance transportation, are examples of the type of fraud associated with non-emergency ambulance transportation.

Regulatory considerations

For Medicare coverage of non-emergency ambulance services, those services need to be both (1) medically necessary and (2) reasonable. Medicare covers the criteria for coverage of ambulance services in the *Medicare Benefit Policy Manual*, Chapter 10 – Ambulance Services.[3] The *Medicare Claims Processing Manual*, Chapter 15 – Ambulance[4] addresses payment criteria.

Medical necessity

Medical necessity is established when the patient's condition is such that use of any other method of transportation is contraindicated. For example, where a patient is bed-confined before or after the transport, ambulance transportation may be categorized as necessary.

The presence or absence of a physician's order for a transport by ambulance does not necessarily prove or disprove whether the transport was medically necessary. The ambulance service must meet all program coverage

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criteria in order for payment to be made.

In addition, the ambulance transport must be medically necessary. That is, the transport must be to obtain a Medicare covered service, or to return from such a service. For example, an ambulance trip to obtain acupuncture (currently a non-covered service under Medicare) would not be covered.

Repetitive non-emergency transports, such as those that might be needed by patients on dialysis or receiving cancer treatment, represent a subcategory of non-emergency ambulance transports. These transports are medically necessary and are furnished three or more times during a ten-day period, or at least once per week for at least three weeks. Prior authorization is required for repetitive non-emergency ambulance transport; providers should consult with their Medicare Administrative Contractor (MAC) for requirements and coordination of repetitive non-emergency ambulance transportation.

Reasonableness

Using an ambulance with specific capabilities does not determine level of payment; payment is based upon the level of service provided during the transport. Additionally, non-emergency ambulance transportation will *not* be covered in situations where the medical necessity and reasonableness criteria are not met, for example:

- An intra-facility transfer of an inpatient, or
- Transportation from a facility/hospital to another facility/hospital for services that could have been appropriately provided at the originating facility/hospital.

The *Medicare Policy Benefit Manual*, Chapter 10 – Ambulance Services covers separately payable ambulance transport under Part B versus patient transportation that is covered under a packaged institutional service. The criteria to delineate Medicare Part A from Part B services includes the provider numbers of the originating and receiving facility, if the facilities are situated on the same campus, and patient status at the origin and destination of the transport.[5]

Table 1 outlines modes of transportation covered and not covered by Medicare, as long as other program requirements are satisfied.

Covered	Non-covered
Ambulances	Wheelchair vans
Rotary-wing aircraft (helicopters)	Taxis
Fixed-wing aircraft	Ride-sharing services
	Private vehicles

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Covered	Non-covered
Medicare rules	Medicaid rules
Emergency transportation and transplant-related transportation have their own sets of regulations and contracts.	State Medicaid plans may provide coverage in situations where Medicare doesn't.
Repetitive non-emergency transports have particular requirements.	Check in advance with Medicaid for applicable criteria and prior approval requirements.

Table 1: Medicare coverage for various modes of transportation, Medicare and Medicaid rules

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