COSMOS
Navigate the Compliance Universe

Compliance Today - May 2020
Chasing ambulance compliance

By Patrick K. Kennedy

Patrick K. Kennedy (patrick.kennedy@unchealth.unc.edu) is Executive System Director Hospital Compliance, UNC Healthcare, Chapel Hill, NC.

- linkedin.com/in/patrick-kennedy-30470929/

Identifying and retaining subject matter experts in the compliance profession can be challenging. They face researching, investigating, and opining on very unique topics within healthcare. One such topic is compliance with ambulance transport documentation and billing. Nurses, paramedics, and flight crews focus every day—and during every transport trip—on providing high-quality care in a complex environment and safely delivering patients to their destinations. Ambulance services are a unique compliance subject within the healthcare system that can result in negative compliance outcomes without expertise, solid policies and procedures, and regular attention.

In July 2018, the Department of Health and Human Services Office of Inspector General (OIG) issued an audit report on nonemergency ambulance transports to destinations not covered by Medicare[1] (i.e., from a skilled nursing facility to an outpatient hospital). OIG identified improper payments totaling $8.7 million for nonemergency transports during calendar years 2014 through 2016—$5.5 million for base rate payments and $3.2 million for mileage associated with the noncovered transports. Not only do ambulance service providers have to consider if the patient's originating and destination locations are covered by Medicare, but they must also consider other regulatory factors such as loaded mileage, physician certification for medical necessity, provider or patient/family choice, locality rules, and level of care. As such, Centers for Medicare & Medicaid Services (CMS) has provided a Medicare Learning Network (MLN) booklet[2] that outlines regulatory factors that ambulance providers must be knowledge of to ensure compliant billing and payment under Medicare fee-for-service. The MLN booklet provides covered and noncovered scenarios as well as billing guidelines that depend on the patient's location (origination and destination) and type of transport (ground or air).

This article will focus on two key areas of ambulance compliance that are important for ensuring positive compliance outcomes: (1) accurate charging and billing, including zip codes, mileage, and modifiers; and (2) determining appropriate locality for the transport.

Charging and billing

Charging and billing for ambulance services is unique and requires great attention to detail. It also requires precise entry of transport data elements (e.g., patient-loaded miles into a provider's health record and/or patient accounting system). In most cases, it may be the transport team that needs to determine and document the key billing data elements before, during, and even after the transport is complete.

Determining the level of service as early as possible is of critical importance to providing the right care to a patient during transport. Under the Medicare Ambulance Fee Schedule[3] (MAFS) structure, level of care (advanced life support [ALS] or basic life support [BLS]) affects actual reimbursement by the Medicare

administrative contractor (MAC). There are other factors that go into determining payment under the MAFS, including (1) national uniform base rate or "conversion factor," (2) relative value units for each type of service, (3) geographic adjustment factor, (4) national uniform mileage rate, and (5) additional mileage payment for rural (patient) pick-up points. The same factors exist for air ambulance transports—except the relative value units factor.

Every component has its own Healthcare Common Procedural Coding System (HCPCS)/Current Procedural Terminology (CPT) code for billing purposes, including each level of care, transport type (emergency or nonemergency, ground or air, fixed and rotary wing), and mileage for each. Table 1 outlines the different HCPCS/CPT codes and their descriptions.[4]

HCPCS Code	Description of HCPCS Code for Ground Transport
A0425	BLS mileage (per statute mile)
A0425	ALS mileage (per statute mile)
A0426	Ambulance service, ALS, non-emergency transport, level 1
A0427	Ambulance service, ALS, emergency transport, level 1
A0428	Ambulance service, BLS, non-emergency transport
A0429	Ambulance service, BLS, emergency transport
A0430	Ambulance service, conventional air services, transport, one-way, fixed wing (FW)
A0431	Ambulance service, conventional air services, transport, one-way, rotary wing (RW)
A0432	Paramedic ALS Intercept (PI), rural area transport furnished by a volunteer ambulance company, which is prohibited by state law from billing third party payers
A0433	Ambulance service, ALS, level 2

HCPCS Code	Description of HCPCS Code for Ground Transport
HCPCS Code	Description of HCPCS Code for Air Transport
A0434	Ambulance service, specialty care transport
A0435	Air mileage, FW (per statute mile)
A0436	Air mileage, RW (per statute mile)

Table 1: HCPCS/CPT billing codes

Several other key and unique aspects of ambulance billing to cover are zip codes, mileage, and modifiers. We will briefly touch on each of these in the following sections.

Determining exact zip codes

Zip codes present important factors in ambulance transport. Determining, documenting, and billing the correct zip code when picking up a patient (often referred to as "point of pickup") will help establish accurate payment for services and prevent denials. Under the MAFS, the point of pickup, as identified by the location's zip code, establishes the mileage payment. The zip code of the point of pickup must be reported on every claim to determine both the correct geographic practice cost index and, if applicable, any rural (positive) adjustments (in payment).[5]

Calculating correct mileage

Calculating mileage for transport is fairly simple when reviewing associated Medicare regulations. First, mileage can only be calculated when a patient is onboard the transport vehicle (ground or air). Under Medicare regulations, this is termed "loaded miles," and any cost associated with unloaded miles is included in the overall cost to provide the transport service; unloaded miles billed to Medicare will be denied.[6] Therefore, mileage calculation starts when the patient is placed, or loaded, onto the transport vehicle and stops when the patient reaches their final destination. In terms of destination for air ambulance, specifically fixed wing, the stopping point for calculating mileage would be the receiving acute care hospital—not the point where the aircraft lands at the airport—and would include the distance from taxiway to the runway (and vice versa), takeoff run, and landing rollout in the mileage calculation.[7]

Another important aspect of determining correct mileage is calculating total mileage. According to the *Medicare Claims Processing Manual*,[8] mileage reported on a separate claim line should be rounded to the nearest tenth of a

mile for trips totaling up to 100 miles (e.g., 92.39 would be rounded to 92.4) or rounded to the nearest whole number for trips equal to or greater than 100 miles (e.g., 230.6 would be rounded to 231 miles).[9]

Determining accurate zip codes and mileage for ambulance transports are critical to receiving the right payment up front and keeping the payments coming. While mileage may not have been the primary focus of the OIG's audit report, it was a determining factor in calculating improper payments to providers. To this point, the nonemergency transports that were identified as noncovered resulted in 31,201 claim lines, totaling $3.17 million for mileage that was associated with the transports; and MAC Jurisdiction J (Tennessee, Alabama, and Mississippi) accounted for 58% (18,210 of 31,201) of the paid claim lines for mileage associated with the noncovered transports.

Identifying accurate modifiers

It is well known in healthcare billing, especially that involving Medicare, that modifiers are important for communicating different aspects of care provided to a patient. For example, the use of modifier 59 indicates a separate and distinct service was provided to a patient and should be separately reimbursed from a primary procedure. Likewise, in ambulance billing, modifiers communicate to Medicare and other payers certain important pieces of information about the transport. There are, however, unique aspects for the use of modifiers in ambulance billing by institutional-based providers. As an institutional-based provider, you must report both a point-of-origin modifier and a destination modifier, a list of which is provided by CMS (Table 2), with the appropriate HCPCS code for the type of transport.[10]

Modifiers	Description
D	Diagnostic or therapeutic site other than "p" or "h" when these are used as origin codes
E	Residential, domiciliary, custodial facility
G	Hospital-based ESRD facility
H	Hospital
I	Site of transfer (e.g., airport or helicopter pad)
J	Freestanding ESRD facility
N	Skilled nursing facility

Modifiers	Description
P	Physician's office
R	Residence
S	Scene of accident or acute event
X	Destination code only; intermediate stop at physician's office on the way to the hospital

Table 2: Origin and destination codes and their descriptions

In addition to the above modifiers for origin and destination, there are three modifiers required to be communicated to Medicare. The "QL" modifier is used to report that a patient was pronounced dead after the ambulance was called. Further, if the service was provided under arrangement or directly by the provider, "QM" indicates the arrangement while "QN" indicates direct delivery of the transport service. An example of the sequencing of HCPCS/modifiers combination would be as follows: A0428RHQN ("A0428" BLS, Non-Emergency; "R" point of origin was patient's residence; "H" point of destination was a hospital; and "QN" transport provided directly by the provider and billing agency).

These are only a few key aspects for accurately and correctly charging for institutional-based ambulance services. Providers are encouraged to carefully review Medicare regulatory documents such as the Medicare Claims Processing Manual as well as other publications related to ambulance billing. In addition, providers should use these resources to help establish processes for ensuring compliant billing.

Locality

A second unique aspect of ambulance billing is not as clear-cut or straightforward as identifying the correct HCPCS code, calculating mileage, or selecting the appropriate charge modifiers. Locality is an aspect that many providers struggle with getting correct in terms of calculating mileage to the nearest appropriate facility, especially institutional-based providers. Many institutional-based providers have multiple facilities within their healthcare delivery system. The facilities may include tertiary care centers, sole community hospitals, critical access hospitals, and skilled nursing facilities. Furthermore, integrated systems typically include physicians and other licensed independent practitioners who have established relationships among one another and between the different facilities. Thus, patients and providers alike may desire to be transferred to other facilities within the same integrated delivery system. However, it may not totally match up with regulatory requirements.

In June 2017, CMS issued Transmittal 236, Change Request 10110,[11] which modified locality requirements for properly billing ambulance transports. While the regulatory definition of locality remained the same, discretion was granted to each MAC to define locality in terms of service area. The *Medicare Benefit Policy Manual* defines locality as "the service area surrounding the institution to which individuals normally travel or are expected to

travel to receive hospital or skilled nursing services."[12] It is debatable that one individual's normal travel distance does not differ from that of another. While 60 miles may be comfortable and seem routine for some, others from the same community would never travel that far unless in dire need.

The subjective term in the CMS definition lends itself to many different interpretations, which is likely one reason why we see deference to the MACs for their discretion. MACs could define locality, for instance, in terms of Metropolitan Statistical Area (MSA) as delineated by the federal government, specifically, the Office of Management and Budget. In North Carolina, for example, the Durham-Chapel Hill MSA includes the counties of Chatham, Durham, Orange and Person. Therefore, by the MAC's discretion, we can interpret that any ambulance transport within these counties would be considered local, and full mileage from the patient's point of origin to the destination would be covered, regardless of the nearest appropriate facility.