

Addressing Ambulance Billing Compliance Challenges



Ambulance billing hosts unique compliance challenges. The ambulance industry has seen a significant number of false claim cases, fraud investigations, Medicare audit activity, and other types of billing-related cases. It is imperative that ambulance billers fully understand the nuances of ambulance reimbursement to be able to successfully sidestep these landmines. In this article, we discussed ambulance billing compliance challenges like medical necessity, signature, and Advanced Life Support (ALS) billing and also suggested ways to address these compliance challenges.

We also referred Medicare guidelines for ambulance billing as most insurance carriers consider these guidelines as standard. You are advised to refer payer-specific billing guidelines and reimbursement policies, when it comes to codes/ modifiers selection and billing exceptions.

Medical Necessity Requirement

As per recent Office of Inspector General (OIG) findings, two-thirds of ambulance services were not medically necessary because alternative transportation would not have endangered the patient's health. Out of unnecessary cases, 70 percent were for non-emergency services such as routine transports for outpatient diagnostic tests or transports between doctors' offices and nursing homes. Medical necessity for ambulance services continues to be the biggest compliance issue in ambulance billing. Ambulance transportation must meet medical

necessity guidelines in order to be covered.

But unique compliance challenge of [ambulance billing](#) is, the medical necessity standards seem to be vague and less defined than in other medical specialties. Federal law defines the medical necessity for ambulance service as when other means of transportation are contraindicated by the patient's condition. While CMS regulations and manuals provide some additional clarification, the medical necessity standards for ambulance transport are centered on whether the patient could safely be transported by other means. A sufficiently detailed and complete Patient Care Report (PCR) must clearly establish that the patient required transport by ambulance.

You must also consider other available documentation in determining medical necessity. For instance, non-emergency ambulance transports generally require a physician certification statement (PCS) supporting medical necessity. While PCS forms are required for most non-emergency ambulance transports to be billable to Medicare, billers must remember that the PCS does not replace the need for a complete, accurate, and well-documented ambulance PCR.

Signature Requirement

Medicare requires the beneficiary's own signature on the claim. If the beneficiary is physically or mentally incapable of signing, CMS allows certain individuals to sign on behalf of the patient, such as a family member, a power of attorney, a caregiver, or a representative payee. If the beneficiary is incapable of signing, the reason must be clearly documented by the crew. If none of the other authorized signers are available or willing to sign, then an ambulance crew member on the transport must sign a statement to that effect, and then also obtain the signature of a receiving facility representative. This is the so-called 'ambulance exception' to the signature rules. To utilize the ambulance exception, both the crew members and the receiving facility representative's signatures must be signed at the time of service.

Medicare regulations also allow for so-called 'lifetime signatures' if the patient has signed an assignment of benefits statement that indicates the signature is valid indefinitely. It is vital that ambulance crew members obtain patient signatures at the time of service whenever possible. Patient signatures can be obtained after the time of service, but this creates more work for ambulance billers and can cause significant delays in the ambulance revenue cycle.

Advanced Life Support (ALS) Billing

Another key compliance risk area in ambulance billing is the use of higher-paying advanced life support (ALS) codes in cases where lower-reimbursed basic life support (BLS) codes should be used. The biggest area of compliance risk with ALS services, however, has been in the application of the so-called ‘ALS Assessment’ rule. Under this rule, Medicare allows the ALS emergency level of service to be billed when the nature of the ambulance dispatch necessitates an assessment of the patient by an ALS crew, even if the patient does not end up needing ALS interventions. While this rule sounds straightforward on the surface, it has been the subject of much compliance enforcement activity in the ambulance industry in the past few years. The following example will illustrate the proper application of the ALS Assessment rule.

An ambulance is dispatched for a 911 call with a reported condition of ‘chest pain.’ Dispatch protocols would undoubtedly classify this reported condition as an ALS-level call. The ALS ambulance is dispatched and responds emergently. When the crew arrives on the scene, the patient denies chest pain but complains of abdominal pain and nausea. The crew assesses the patient and determines that he does not require any ALS interventions, and transports the patient while administering supplemental oxygen through a nasal cannula as the only treatment. Although the administration of oxygen is only a BLS-level skill, the call qualifies for ALS-level billing (provided that medical necessity and other coverage criteria are met, of course) by virtue of the ALS-level dispatch and the immediate response by an ALS crew that was necessitated by the nature of the ‘chest pain’ 911 call.

Some ambulance billers improperly conclude that all 911 calls are billable at the ALS level whenever there is a paramedic or other ALS provider responding on the ambulance. This results in significant overbilling, or ‘up coding,’ of BLS claims to the ALS level. It is not the mere presence of an ALS provider that triggers the ALS assessment rule; an ALS-level emergency call is also required under the EMS system’s dispatch protocols. So, ambulance billers must not assume that every ambulance call with a paramedic on board qualifies for an ALS level of billing.

To Summarize,

You can efficiently address ambulance billing compliance challenges with the help of proper documentation and a well-trained ambulance biller. It is dangerous to assume that billing and coding knowledge from other medical specialties is automatically applicable to ambulance billing. If you don’t have a skilled and experienced ambulance billing team then don’t worry, we can assist you.

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Reference: [Healthcare Business Management Association](#)