Errors that could be Deemed Fraudulent in Ambulance Billing

Medicare has been vulnerable to fraud, and the Ambulance Services has especially come under its rigorous inspection since 2012, when discovered that Medicare Part B paid $5.8 billion for ambulance transports alone! Thereafter, in 2013 and 2014, the Centers for Medicare & Medicaid Services (CMS) imposed temporary moratoria on the enrollment of new ambulance suppliers.

It has been acknowledged that there exist major differences between medical and ambulance coding. Many physicians and hospital coders often take ambulance service coding for granted not realizing that the codes and documentation requirements are unique Due to the financial fraud and loss that Medicare faces due to coding errors, billing shortcomings and very often insufficiently filled claim forms, it has now initiated strict action. Private ambulance service providers concerned about potential enforcement issues are considering voluntary operational, billing and legal audits in an effort to identify shortcomings and stave off possible enforcement. It is in the Ambulance billing however, that major focus needs to be given, so that Revenue Cycle Management (RCM) process does not get affected causing a hit to cash flow.

Here are a few areas where errors in coding and billing may take place and can be improved to avoid fraud and criminal charges.

- **When one bills for "medically unnecessary" ambulance transport:** Care needs to be taken when submitting a claim for a transport, especially when it was ***not*** life-threatening or otherwise routine. Only when all other forms of patient transportation are considered to pose a medical risk, only then will Medicare cover non-emergency ambulance transports. For instance, air transport services are commonly used in rural areas where ground ambulance services are not always readily available. The Medicare criteria should be met when coding and billing:
  - The use of other transportation methods is contraindicated by the condition of the individual requiring care.
  - The individual's medical condition must require the level and type of service reported to have been provided and billed.

- **"Up coding" Ambulance transport:** When changes are made to the severity of the medical necessity of a transport especially from "non-emergency" to "emergency" in order to receive a higher reimbursement.
- **When one bills for services *not* rendered during transport:** In order to increase billing to increase revenues, when "unnecessary" services and/or supplies are billed without actual service rendered or supplies being employed. It may be noted here that billing systems that target optimum efficiency could be predefined with defaults to indicate that a physician's signature was obtained following an emergency room transport. If information is automatically inserted onto a claim submitted for reimbursement, and that information is false, the ambulance supplier's claims will be false. It is very important to note that if, on the claim form, a required field is missing information the system should flag the claim prior to its submission. Now under CMS's new fee schedule, each transport claim that does not have an originating zip code listed should be ''flagged'' by the system. Based on the documented services provided, the ambulance supplier must select and submit the procedure code that describes the provided level of service. The correct origin and destination modifier combination **must** be submitted next to the procedure code.
- **When one "actively' participates in unlawful agreements/scams especially with health care facilities:** This can be the most unlawful way and could lead to criminal charges, especially when ambulance transport services are provided at a lower cost in order to receive more "emergency" referrals.
- **Medicare Part A & B:** Based on the new fee schedule, seven levels of service, including Basic Life Support (BLS), Advanced Life Support, Level 1 (ALS1), Advanced Life Support, Level 2 (ALS2), Specialty Care Transport, Paramedic ALS Intercept, Fixed Wing Air Ambulance, and Rotary Wing Air Ambulance are covered. Most often, Medicare Part B covers ambulance transports if applicable vehicle and staff requirements, medical necessity requirements, billing and reporting requirements, and origin and destination requirements are met. **But,** Medicare Part B will not pay for ambulance services if Part A has paid directly or indirectly for the same services.

Ambulance service providers, if suspected of improper billing can face prepayment stand-offs which can last up to 18 months. This can end up affecting Revenue Cycle Management process, leading to a crunch in cash flow.

"25 percent of ambulance transports did not meet Medicare's program requirements, resulting in an estimated $402 million in improper payments.

Points to Note for Ambulance Service Coding:

- Ambulance coding is unique and coders are specialist, so certified and experienced ambulance coders are a must.
- Coder turnover can and may create revenue cycle peaks-and-valleys.