



*Member Alert*

## MEMBER ALERT

June 30, 2010

### **Palmetto Announces Probe Review of Ground and Air Ambulance Services in Southern California**

Palmetto GBA, the Medicare Administrative Contractor for California, has posted a notice on its website, and has provided special notice to the California Ambulance Association (“CAA”), that its medical review department will be performing “service-specific probe reviews” of ground and air ambulance services in Southern California. The reviews will focus on all ambulance codes and modifiers. For each code, Palmetto’s medical review department will review a sample of 100 claims from the Southern California region. For the claims selected, Palmetto will seek additional information from the provider through an Additional Development Request (“ADR”) letter.

Full compliance with this audit is in best interest of both ambulance providers and the industry. Adverse audit results may eventually lead to providers being placed on pre-payment review.

In the special notification to the CAA, Palmetto’s ombudsman for ambulance services, Kathy Montoya, provided the following advice to CAA members:

“When responding to an ADR, providers should respond as promptly as possible submitting any and all [of the following] documentation that substantiates the transport.

Dispatch notes

Trip ticket

Physician Certification Statement (PCS)

5150 documentation

Hospital, SNF or NF notes if applicable, pertinent and accessible

If transportation of a deceased beneficiary documentation to reflect the time of dispatch and time of death.

Be sure to include information from the patient's records that demonstrates all aspects of the transport such as:

- "Why an ambulance." In other words, what was it about the patient's condition that prohibited them from being transported in any other way (such as car, taxi, gurney or wheelchair van)
- Documentation to reference the patient's condition at the time of the call and transport as the basis for the information that was submitted
- For transports beyond what would be considered as "the closest facility" please submit the documentation regarding the exception
- For ALS services (A0426 and A0427) documentation should be present to show that an ALS assessment was performed or that one or more ALS interventions were performed
- For ALS 2 (A0433) documentation should be present to show the either 3 separate administrations of drugs or one or more ALS procedures (per definition of ALS 2)
- For SCT (A0434) documentation should be present to indicate the provision of medically necessary supplies and services, at a level of service beyond the scope of the EMT-Paramedic. SCT documentation should show the beneficiary's condition required ongoing care that was furnished by one or more health professionals in an appropriate specialty area, for example, emergency or critical care nursing, emergency medicine, respiratory care, cardiovascular care, or a paramedic with additional training.
- For facility to facility transfers documentation should be present to reflect the fact that the patient was discharged from 1st facility and admitted to 2nd. In addition the documents should reflect the Facility names and the reason for transfer, listing the exact procedure, equipment or treatment that the patient needed that wasn't available at the first facility."

As a further suggestion, the CAA recommends that providers consider preparing a summary sheet for each claim that highlights the pertinent information from the source documents referred to above demonstrating medical necessity for the claim. CAA members will be notified of an upcoming "Webinar" to identify key criteria in completing summary sheets.

Palmetto's notice states that if providers have any questions about general coverage criteria, medical review development requests,

status of claims in the system, receipt of documentation by medical review or claims denials, they should call the J1 Part B Provider Contact Center at (866) 931-3901. Following the completion of the review, the results will be posted to the Palmetto GBA J1 website.

Palmetto indicates that it determined the need for this review based on its Comprehensive Error rate Testing (“CERT”) data analysis indicating increased utilization of ambulance codes. The CERT Program is a national audit program undertaken by CMS in order to determine the percentage of total dollars that all Medicare-Fee-For-Service contractors erroneously pay or deny on an annual basis. CERT audits are mandated by Congress pursuant to the Improper Payments Act of 2002.

The CAA has asked Palmetto a number of questions regarding the review, including:

How will the claims to be reviewed be selected? For example, will it be completely random or will it be based on the number of claims submitted by providers (i.e., such that larger providers will be most impacted)?

Will the claims be reviewed post-payment or prepayment?

If the claims are reviewed post-payment, what time period will be covered by the claims sampled?

Why are all ambulance codes being reviewed? The notice says the review was triggered by utilization concerns, which suggests it would only cover certain codes.

When will the ADR letters start going out?

Upon receipt of answers to these questions, the CAA will provide this information to its members.

Thank you to the following individuals for authoring this member alert: V. Matthew Marchese, Managing Member, Healthcare Compliance On-Call, LLC ([vmarchese@mac.com](mailto:vmarchese@mac.com)) and R. Michael Scarano, Partner, Foley & Lardner, LLP, ([mscarano@foley.com](mailto:mscarano@foley.com)).



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