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Medicare Part B Ambulance Coverage, Basics and Billing

1/24/2024

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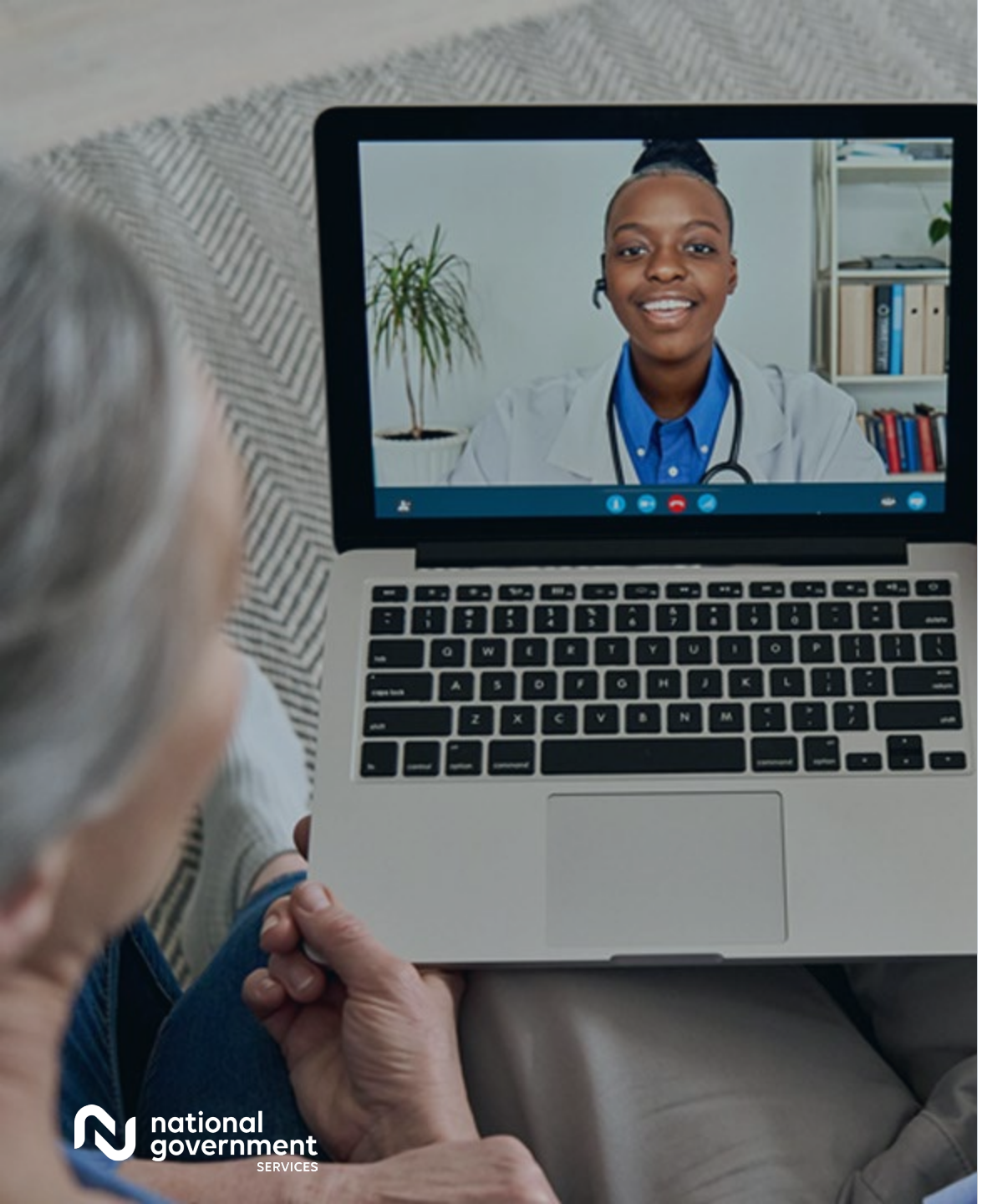

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Objective

Deliver basic coverage and billing guidelines to assist ambulance suppliers in submitting their claims correctly the first time.

Today's Presenters

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Agenda

- Types of Ambulance Transports
- Ground and Air Transports
- Ambulance Modifiers
- Coverage Requirements
- Beneficiary Signature Requirements
- Transportation Indicators
- Advanced Beneficiary Notice of Noncoverage
- Physicians Certification Statement
- Claims Data Analysis
- Resources

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Types of Ambulance Transports

Basic Life Support

- A0428 – Ambulance service, basic life support, nonemergency transport
- A0429 – Ambulance service, basic life support, emergency transport
- Transportation by ground ambulance vehicle and provision of medically necessary supplies and services
  - Including BLS ambulance services as defined state
- Ambulance must be staffed by at least two individuals
  - One must be qualified in accordance with state and local laws as an EMT-basic
  - Legally authorized to operate all lifesaving and life-sustaining equipment on board vehicle

Nonemergency ALS1

- A0426
  - Transportation by ground ambulance vehicle provision of medically necessary supplies and services including provision of ALS assessment or at least one ALS intervention
    - ✓ Ambulance must be staffed by at least two individuals, one of whom must be qualified in accordance with state and local laws as EMT-intermediate or an EMT-paramedic

Emergency ALS1

- A0427
  - An ALS assessment is performed by an ALS crew as part of an emergency response that was necessary because patient's reported condition at time of dispatch was such that only an ALS crew was qualified to perform assessment
    - ✓ **Note**: An ALS assessment does not necessarily result in a determination that patient requires an ALS level of service

1. Advance Life Support ALS2

- A0433
  - Transportation by ground ambulance vehicle and provision of medically necessary supplies and services including
    - ✓ At least three separate administrations of one or more medications by intravenous push/bolus or by continuous infusion (excluding crystalloid fluids) or

2. ALS2

- Ground ambulance transport, medically necessary supplies and services and provision of at least one of the ALS2 procedures
  - Manual defibrillation/cardioversion
  - Endotracheal intubation
  - Central venous line
  - Cardiac pacing
  - Chest decompression
  - Surgical airway or
  - Intraosseous line

Specialty Care Transport

- A0434
  - Interfacility transport of critically injured/ill patient by ground ambulance
    - ✓ Includes provision of medically necessary supplies/services, at level of service beyond scope of EMT-paramedic
  - Necessary when patient's condition requires ongoing care that must be furnished by one or more health professionals in an appropriate specialty area
    - ✓ **Example:** emergency or critical care nursing, emergency medicine, respiratory care, cardiovascular care or a paramedic with additional training

Ambulance Claim Edits – SCT A0434

- Modifiers HH, HN, IH or NH
  - editing on these combinations will not apply; payment will be made according to policy guidelines
- Modifier HI claims suspend for review of history to determine if another ambulance claim for same date of service/modifier billed
- All other situations will auto deny as noncovered charges, leaving a patient liability

Gurney/Wheelchair Van Transports

- Gurney and wheelchair vans do not meet staff, vehicle and equipment requirements to meet Medicare coverage guidelines
  - Transportation provided in a gurney or wheelchair van is not covered by Medicare
  - If beneficiary requires a denial, submit HCPCS A0999 (unlisted ambulance service) and a “GY” modifier

Hospice Transportation

- Transports unrelated to beneficiary's terminal illness or on same day as either start or end date of hospice care is allowed
- Submit claim with origin and destination modifiers and GW modifier
  - All other criteria for ambulance transports must be met
  - Transports related to terminal illness billed to Medicare Part A

Destinations

- Medicare covers ambulance transports meeting all requirements for coverage to appropriate facilities
  - Hospital/CAH
  - SNF
  - From a SNF to nearest supplier of medically necessary services
    - ✓ Services not available at SNF where patient is resident
    - ✓ Not in a covered Part A stay, including return trip
  - Beneficiary's home
  - Dialysis facility for ESRD patient who requires dialysis
  - A physician's office is not a covered destination
    - ✓ Under special circumstances an ambulance transport may temporarily stop at a physician's office without affecting coverage status of transport

Repetitive Transportations

- Medically necessary transportation furnished three or more times during a ten-day period or at least once per week for at least three weeks (quantitative standard)
  - Dialysis and respiratory therapy are types of treatment for which repetitive ambulance services are often necessary
  - Regularly scheduled ambulance services
    - ✓ follow-up visits whether routine or unexpected are not “repetitive” for purposes of requirement
    - ✓ unless one of quantitative standards are met (three or more times during a ten-day period or at least once per week for at least three weeks)
  - CMS’ RSNAT model – Prior Authorization of Repetitive, Scheduled Non-Emergent Ambulance Transport

Ground and Air Transports

Ground Coverage Requirements

- Ground ambulance transports
  - Service is medically reasonable and necessary
  - A beneficiary is transported
  - Destination is local
  - Facility is appropriate
- Service is medically reasonable and necessary
  - Beneficiary's condition is such use of any other method of transportation is contraindicated

Ground Mileage

- A0425
  - Only actual number of “loaded” miles where patient is picked up to destination can be reported as mileage charges
    - ✓ Separate charges for unloaded miles not covered
    - ✓ May not separately bill patient
    - ✓ Miles must be reported as fractional units
    - ✓ Destination must be local
    - ✓ Only mileage to nearest appropriate facility equipped to treat beneficiary will be covered
    - ✓ If two or more facilities meet local requirement and can treat beneficiary, full mileage to either will be covered

Ground Mileage – Medical Necessity

- Claims billed over 60 miles will suspend for medical necessity
- Appropriate reasons for ground transportations over 60 loaded miles are
  - Indication hospital initiated a transfer for either higher or lower level of care with destination being nearest appropriate facility

  OR
  - Beneficiary being discharged from a hospital or SNF to a residence

Noncovered Ambulance Mileage

- A0888 - noncovered ambulance miles, per mile
  - Example of incorrect way
    - ✓ Line 01: A0425 x 10 units of service – billed for mileage to the closest facility
    - ✓ Line 02: A0425-GY x 30 units of service – billed for mileage beyond the closest facility (this line always denies as a duplicate to the other line billed)
  - Example of correct way
    - ✓ Line 01: A0425 x 10 units of service – billed for mileage to the closest facility
    - ✓ Line 02: A0888 x 30 units of service – billed for mileage beyond the closest facility

Air Ambulance Transports

- A0430 – Ambulance service, conventional air services, transport, one way, fixed wing
  - A0435 mileage, per statute mile
- A0431 – Ambulance service, conventional air services, transport one way, rotary wing
  - A0436 mileage, per statute mile

Air Ambulance Transports

- Medically appropriate air ambulance transportation is covered only if beneficiary's medical condition is such that transportation by either BLS or ALS ground ambulance is not appropriate
- Air ambulance services may be paid only for ambulance services to an acute care hospital
  - Other destinations such as SNF, physician's office or patient's home may not be paid

Ambulance Modifiers

Origin/Destination Modifiers

- Appropriate ambulance modifiers
  - D – Diagnostic or therapeutic site other than “P” or “H” (includes free-standing facilities)
  - E – Residential, domiciliary, custodial facility (includes nonparticipating facilities)
  - G – Hospital-based dialysis facility (hospital or hospital-related)
  - H – Hospital (includes outpatient department or emergency room)
  - I – Site of transfer (e.g., airport or helicopter pad) between modes of ambulance transfer
  - J – Nonhospital based dialysis facility (freestanding)
  - N – Skilled nursing facility (Medicare participating only)
  - P – Physician’s office
  - R – Residence
  - S – Scene of accident or acute event
  - X – Immediate stop at physician’s office on the way to the hospital (destination only)

Modifier – GY

- Submit “no-pay bills” to Medicare for statutorily-excluded ambulance transportation and transportation-related services
  - Attach “GY” modifier to HCPCS code identifying service to obtain a “Medicare denial”
  - Use Medicare denial to submit to a beneficiary’s secondary insurance for coordination of benefits purposes

Modifier – QL

- Used when the patient is pronounced deceased after the ambulance is called/dispatched
  - Patient is pronounced dead after the ambulance is called but before transport
  - Ground providers can bill a BLS (A0428/A0429) service along with the QL modifier
  - Air providers can use the appropriate air base rate code (A0430 fixed/A0431 rotary) with the QL modifier
- No rural adjustment or mileage would be paid

Modifier – GM

- Used when more than one patient is transported in an ambulance
  - Used by both ground and air transports
  - Document details of the transport
    - ✓ Total number of patients
    - ✓ MBI of each Medicare patient
- Change Request 6621: *Billing for an Ambulance Transport with More than One Patient Onboard*

Coverage Requirements

Requirements for Coverage

- Service must be medically necessary
- Condition of patient would not allow transportation by other means
- A diagnosis or a detailed description of patient's condition must be on claim
  - Ambulance personnel should document their observations of patient's condition
- Transportation is to a Medicare-approved destination

Requirements for Coverage

- Transportation to a hospital from another hospital when a patient's needs cannot be met at first hospital and patient is admitted to second hospital
- Transportation is provided by an approved supplier/provider of ambulance services
- Transportation is not part of a Part A (inpatient) service
- Transportation is to closest appropriate facility

Medical Necessity

- Condition is such that use of any other method of transportation is contraindicated
- Documentation must be kept on file and, upon request, presented to carrier
- Presence (or absence) of a physician's order for transport by ambulance does not prove (or disprove) whether transport was medically necessary
  - Must meet all program coverage criteria for payment to be made

Medical Necessity Examples

- Transported as a result of an accident/injury
- Severe hemorrhaging
- Unconscious/shock
- Must remain immobile due to broken bone(s)
- Stroke/heart attack
- Needs to be restrained
- Can only be moved by a stretcher
- Condition resulting in bed confinement

Bed Confined Defined

- Patient must meet following criteria to be considered bed confined
  - Inability to ambulate on their own
  - Inability to sit in a chair/wheelchair
  - Inability to get up from a bed without assistance
  - Important note: “bed rest” and/or “nonambulatory” do not indicate “bed confined”
- A narrative description describing reason term “bed confined” is being used should be provided on claim

Beneficiary Signature Requirements

Signature Requirements

- Signature of beneficiary or representative required – does not have to be at time of transport
  - If unable to sign, the following may sign on behalf of beneficiary
    - ✓ Legal guardian
    - ✓ Relative/other who receives social security/government benefits on behalf of beneficiary
    - ✓ Relative/other who arranges for beneficiary's treatment or responsible for their affairs
    - ✓ Representative of agency/institution that furnished other care not on claim
    - ✓ Representative of provider claiming payment for services furnished
      - If unable to have claim signed in accordance with 42 CFR 424.36(b) (1–4)
    - ✓ Representative of ambulance company present during transport
      - Must maintain documentation in records to show the beneficiary is unable to sign and there is no other person who could, for at least four years from DOS – cannot request payment otherwise

Signature Requirements

- If beneficiary/representative refuses to sign, Medicare cannot be billed
  - May bill beneficiary (or estate) full charges for ambulance service
  - If beneficiary/representative reconsiders and wants Medicare billed, a signature is required, and ambulance company must afford them this option within claims filing period

Transportation Indicators

Transportation Indicators

- Help to indicate why it was necessary for the patient to be transported in a particular way or circumstance
  - Place the transportation indicator in the “Extra Narrative” field (1500: block 19; EMC: Loop 2300/2400)

Transportation Indicators

- Air and ground
  - C1: Interfacility transport (to higher level of care)
  - C2: Transport from one facility to another because service/therapy not available at originating facility
  - C3: Included as a secondary code where a response was made to a major incident or mechanism of injury
  - C4: Medically necessary transport, but number of miles appears to be excessive

Transportation Indicators

- Ground only
  - C5: For situations where a patient with an ALS-level condition is encountered, treated and transported by BLS-level with no ALS level involvement
  - C6: For situations when an ALS-level ambulance would always be the appropriate resource chosen based upon medical dispatch protocols to respond to a request for service
  - C7: IV medications were required

Transportation Indicators

- Air only
  - D1: Long distance – condition requires rapid transportation over a long distance
  - D2: Traffic patterns preclude ground transport at the time the response is required
  - D3: Unstable patient with need to minimize out-of-hospital time or maximize clinical benefits to the patient
  - D4: Pick-up point not accessible by ground transportation

Advanced Beneficiary Notice of Noncoverage

ABN Requirements

- ABNs are rarely used for ambulance services and may only be issued for nonemergency transports
- CMS IOM Publication 100-04, *Medicare Claims Processing Manual*, Chapter 30, "Financial Liability Protections," Section 50.15.2

ABN Requirements

- First requirement, patient is not in a medical emergency or under similar duress
  - Patient has either, no ABN is given

ABN Requirements

- Ambulance providers are to consider
  - Service being provided is a Medicare-covered ambulance benefit
  - Provider believes service may be denied, in part or in full, as “not reasonable and necessary”
  - Ambulance service is being provided in a nonemergency situation

ABN Requirements

- ABN is required if all three criteria met
  - Service is a covered ambulance benefit
  - Part or all of service will be denied because it is not reasonable and necessary
  - Patient is stable and the transport is nonemergent

ABN Example 1

- A beneficiary requires ambulance transportation from her SNF to dialysis but insists on being transported to a new dialysis center ten miles beyond the nearest dialysis facility
- Transport is not to nearest facility
  - Not considered a covered Medicare benefit
  - No ABN is required
  - Courtesy to beneficiary, an ABN could be issued as voluntary notice alerting financial responsibility

ABN Example 2

- A patient requires nonemergent ground transport from a local hospital to nearest tertiary hospital facility; however, family wants patient taken by air ambulance
- Ambulance service is a covered benefit, but level of service (air transport) is not reasonable/necessary for patient's condition
  - ABN must be issued prior to providing service in order to shift liability to beneficiary

ABN Modifier – GA

- Used to indicate a required ABN was provided to the patient

ABN Modifier – GX

- Used to report when a voluntary ABN was issued for a service
  - Service has to be excluded from Medicare coverage by statute
  - Must be submitted with noncovered charges only

ABN Modifier – GZ

- Used when a medical necessity denial is expected but an ABN was not provided to the beneficiary
- Change Request 7228: *Auto Denial of Claim Line(s) Submitted With a GZ Modifier*

ABN FAQ One

- How long do I keep an ABN?
  - ABN must be kept five years from date-of-care delivery
  - No other requirements under state law apply
  - Keep a record of ABN in all cases
    - ✓ Beneficiary declined care
    - ✓ Refused to choose an option, or refused to sign ABN

ABN FAQ Two

- What if beneficiary changes his/her mind after completing and signing ABN?
  - Present previously completed ABN to beneficiary and request that he/she annotate original ABN
  - Annotation must include a clear indication of their new option selection along with their signature and date of annotation

ABN FAQ Three

- What if beneficiary changes his/her mind and you cannot present ABN in person?
  - Annotate form to reflect beneficiary's new choice and immediately forward a copy of annotated ABN to beneficiary to sign, date and return

ABN FAQ Four

- Can a single ABN cover an extended course of transportation?
  - May issue single ABN to cover extended course of transportation
  - ABN identifies all items, services and period of treatment for which you believe Medicare will not pay
  - Beneficiary receives an item or service during course of transportation that you did not list on ABN and Medicare may not cover it, you must issue a separate ABN
  - A single ABN for an extended course of transportation is valid for one year
    - ✓ If course of transportation continues after a year's duration, you must issue a separate ABN

ABN FAQ Five

- May I collect payment from beneficiary?
  - Yes, when beneficiary agrees to pay for expenses out-of-pocket or through any insurance other than Medicare, you may bill and collect funds for noncovered services immediately after they sign ABN
  - If Medicare denies payment, you retain funds collected
  - If Medicare pays all or part of services or if Medicare finds you liable, you must refund proper amount within 30 days after you receive remittance or within 15 days after a determination on an appeal

Physician Certification Statement

Physician Certification Statement

- PCS
  - Written order certifies need for ambulance transportation
  - “Scheduled” transport arranged more than 24 hours prior to patient transport
  - “Nonscheduled” transports scheduled less than 24 hours in advance

PCS Guidelines

- If unable to obtain from attending physician, a nonphysician certification must be obtained
- If unable to obtain within 21 calendar days following date of service, document attempts to obtain and submit claim
  - Signed return receipt from USPS/similar service as proof
  - Must keep documentation on file
  - Upon request, present to MAC

Nonphysician PCS

- Must have personal knowledge of patient's condition at time transport is ordered/furnished
- Must be employed by patient's attending physician or by hospital/facility treating patient and transported from
- Is among following individuals
  - Physician assistant, nurse practitioner, clinical nurse specialist, registered nurse, licensed practical nurse, social worker, case manager, discharge planner
  - Applicable state licensure laws apply

PCS Guidelines

- Certification type: Nonemergency, scheduled, repetitive ambulance service
  - Required: Yes
  - Who may sign certification: Attending physician
  - Timeframe: Physician's order must be dated no earlier than 60 days before the date the service is furnished

PCS Guidelines

- Certification type: Nonemergency ambulance service that is either unscheduled or is scheduled on a nonrepetitive basis – resident of a facility under a physician's care
  - Certification required: Yes
  - Who may sign: Physician (MD), PA, NP, CNS, RN or discharge planner
  - Timeframe: The physician order must be obtained within 48 hours after the transport

PCS Guidelines

- PCS not required
  - Emergency
  - Nonemergency, unscheduled ambulance services for a beneficiary who, at time of transport, was residing at home or in a facility and who was not under direct care of a physician

Claims Data Analysis

Automated Ambulance Edit By Modifier/Diagnosis

- Modifiers that suspend for documentation
  - DH, DI, DX, EI, EX, GG, GI, GJ, GX, HG, HH, HI, HJ, II, IX, JG, JI, JX, NI, NN, NR, NX, QL, RI, RX, SI, SX
- Modifiers that have additional diagnosis checks
  - EG, EJ, EN, GE, GN, GR, HE, HN, HR, JE, JN, JR, NE, NG, NJ, RG, RJ, RN

NGS Claims Data

- Item 23 of 1500 claim form should contain ZIP code of patient pick-up location
- Item 32 of 1500 claim form should contain address of drop-off destination
  - Only one name, address and ZIP code may be entered, if additional entries are needed, separate claim forms shall be submitted
  - Claims will be returned if Items 23 and 32 are not completed correctly

Claims Data

- CPT A0434: noncovered mileage
  - Not being billed correctly, patient care reports marked “patient’s choice” incorrectly, billing the GY modifier
  - Providers incorrectly billing this code with modifiers such as RH, SH
  - A0434 should only be billed for specialty care transports with appropriate origin/destination modifiers (HH, NH)
  - A nursing home that is the beneficiary’s residence and does not receive Part A payments from Medicare for any of the beneficiary’s services, is not an eligible SCT origin or destination

Claims Data

- Patient's choice
  - Providers submitting patient care reports (PCR) to support medical necessity but have the PCR stamped or computer- generated with the term "patients choice"
    - ✓ This is incorrect usage of the term to assign patient liability
- GY modifier
  - Indicates transport is statutorily excluded from coverage or does not meet the definition of any Medicare benefit; providers billing GY on every claim
    - ✓ If provider is appealing with the PCR and stating the transport was medically necessary, GY should not have been placed on claim

Claims Data

- Exact duplicate claim/service
  - Same date of service, same beneficiary, same services being provided
- Claim/service not covered by this payer/contractor
  - You must send claim/service to the correct payer/contractor
- Patient cannot be identified as our insured
  - Beneficiary not entitled to Medicare

Claims Data

- Patient/Insured health identification number and name do not match
  - Beneficiary name and Medicare number must match the Medicare Card
- Patient enrolled in hospice
- Time limit for filing has expired
- Care may be covered by another payer per coordination of benefits
  - MSP information available

Resources

Resources

- CMS IOM Publication 100-04, *Medicare Claims Processing Manual*, Chapter 15, "Ambulance"
- CMS Ambulance Services Center
- Ambulance Fee Schedule
- Guidance on Beneficiary Signature Requirements for Ambulance Transportation

Additional Resources

- CMS Medicare Coverage – General Information
  - Information related to coverage and important links
- CMS IOM Publication 100-03, *Medicare National Coverage Determinations (NCD) Manual*
- CMS Beneficiary Notices Initiative (BNI)
  - ABN manual instructions and ABN Form
  - CMS-R-131
- CMS Medicare Coverage Database
  - Latest information related to NCDs and LCDs, local policy articles and proposed NCD decision

Questions?

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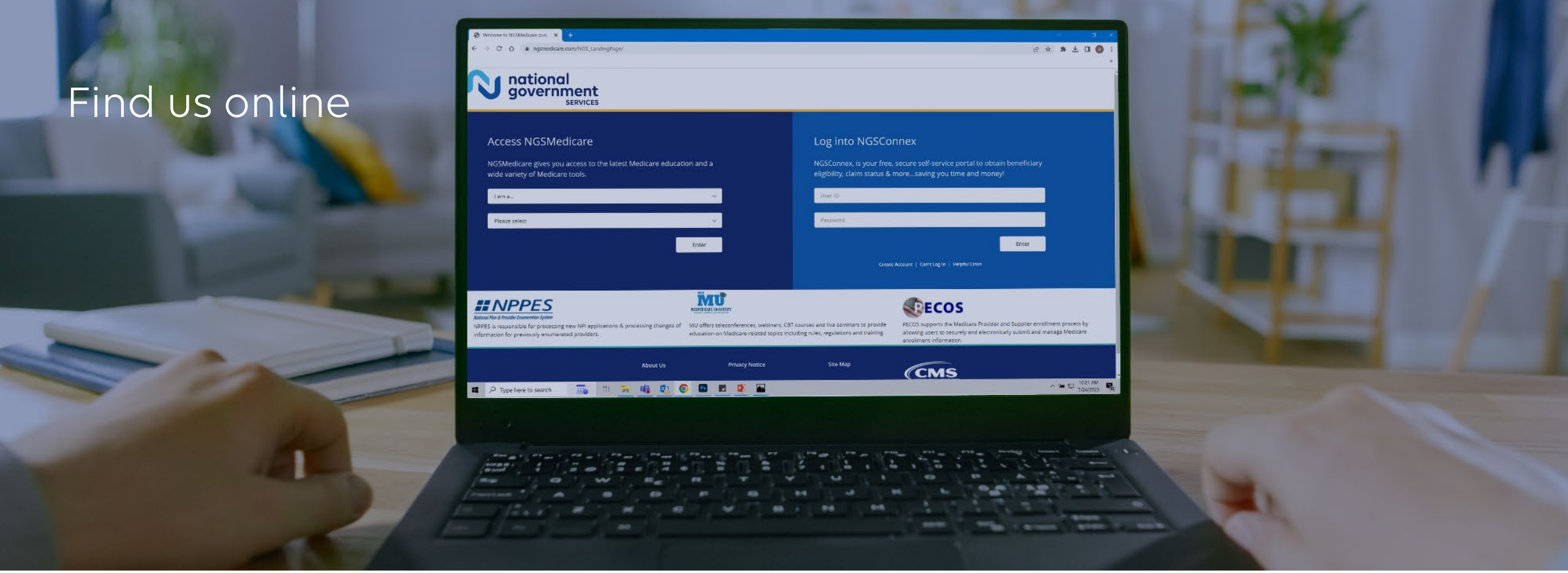

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