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Ambulance Services and Establishing Medical Necessity for Part B Providers

1/25/2024

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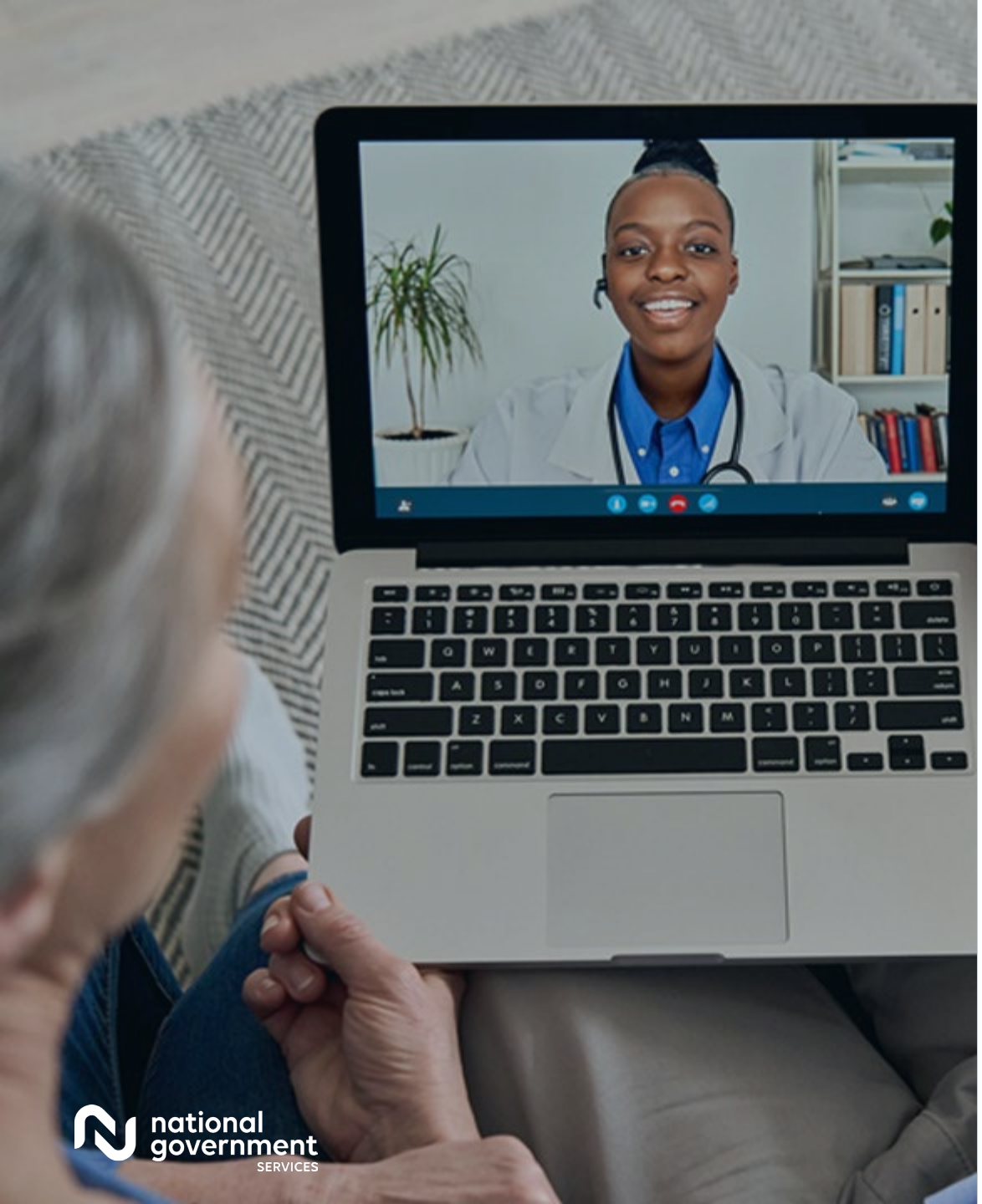

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Objective

To help the ambulance community understand the importance of medical necessity as it pertains to Medicare's coverage guidelines.

Today's Presenters

Provider Outreach and Education Consultants

- Gail Toussaint

- Lori Langevin

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Agenda

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Coverage Requirements

Medical Necessity – 42CFR 140.40(d)(1)

- "Medical necessity is established when the patient's condition is such that use of any other method of transportation is contraindicated. In any case in which some means of transportation other than an ambulance could be used without endangering the individual's health, whether or not such other transportation is actually available, no payment may be made for ambulance services."
- CMS IOM Publication 100-02, *Medical Benefit Policy Manual*, Chapter 10, "Ambulance Services," Section 10.2.1

Medically Necessary Versus Reasonableness

- Medical necessity refers to whether the patient medically requires transport by ambulance
- Reasonableness refers to whether the transport was appropriate in the first place
- CMS IOM Publication 100-02, *Medicare Benefit Policy Manual*, Chapter 10, Ambulance Services, Section 10.2.2 – Reasonableness of the Ambulance

Ground Coverage Requirements

- Service is medically reasonable and necessary
- A beneficiary is transported
- Destination is local
- Facility is appropriate
  - Hospital/CAH; SNF; beneficiary's home; dialysis facility for ESRD patients who require dialysis

Air Coverage Requirements

- Vehicle/crew requirements are met
- Beneficiary's medical condition is such that transportation by ground ambulance is not appropriate
- May be paid only for services to an acute care hospital
  - Other destinations such as SNF or physician's office may not be paid

General Requirements for Coverage

- Services 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 thoroughly document their observations of patient's condition
- Transportation is to a Medicare-approved destination

General 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 in order for payment to be made

Medical Necessity Examples

- 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

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 a higher or lower level of care with destination being nearest appropriate facility

  or

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

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”

Bed Confined

- A narrative description describing reason term “bed confined” is being used should be provided on claim, e.g.
  - Required advanced airway management
  - Required restraints to prevent injury to self/others
  - Patient morbidly obese which requires additional personnel/equipment to handle
  - Required to remain immobile due to fracture/possibility of fracture

Documentation

Document! Document! Document!

- Fully document evidence to support claim
  - Without establishing medical necessity, service may be noncovered
  - Either pre or postpayment
- Ambulance supplier's responsibility to maintain complete/accurate documentation of patient's condition to prove medical necessity

Trip/Run Sheet

- Used as a medical record of encounter with patient
- Complete/legible – every page must include patient information (complete name; DOS)
- Must “paint a picture” of patient’s condition and be consistent with documentation found in other supporting medical record documentation (PCS included)

Trip/Run Sheet

- Must include reason for transport
  - Explanation of symptoms reported by patient/observers
  - Detail patient's physical assessments that clearly demonstrate required ambulance transport
  - Relevant history (if available)
  - Observations/findings
  - Description of traumatic event if basis for suspected injury
  - Explanation of special precautions taken

Trip/Run Sheet

- Assessment/clinical evaluations
  - Vitals
  - Neurological assessment
  - Cardiac information
- Procedures/supplies provided, e.g.
  - Intubation
  - Cardiopulmonary resuscitation
  - Restraints
- Demonstrate medical necessity of required or ordered monitoring/treatment

Trip/Run Sheet

- Point of Pickup
  - Destination (identify place and complete address)
- Signatures, with credentials and date to identify provider of service(s)
  - See CMS IOM Publication 100-02, *Medicare Benefit Policy Manual*, Chapter 10, Section 20.1.2 and CFRs referenced for additional information on signature requirements related to ambulance services
- Beneficiary or authorized signature

Trip/Run Sheet (if known)

- Medications
- Allergies
- Family/social history
- Name of person initiating 911 call
- Relationship of caller to patient

Trip/Run Sheet – Supporting Loaded Miles

- Trip odometer reading
- GPS system
- Navigation system
- MapQuest/Google Maps (or other appropriate mapping program)

Vague Statements

- Statements that do not provide a clear explanation for medical necessity
  - Patient has pain
  - Patient cannot tolerate wheelchair
  - Patient has dementia or is forgetful
  - Unable to support self in wheelchair
  - Family requested ambulance transport

Claim Examples Not Meeting Medical Necessity

Claim Example One

- Patient transported from scene of accident to site of transfer (SI modifier)
  - Diagnosis code(s) used (defined): joint pain, pelvis; headache; fall NOS (not otherwise specified)
  - Extra narrative comments: blood pressure and other vitals provided; left hip pain; small bump top right-side of head

Claim Example Two

- Patient transported from residence to hospital (RH modifier)
  - Diagnosis code(s) used (defined): abdominal pain right lower quad
  - Extra narrative comments: blood pressure and other vitals provided; pain began after coughing, possible hernia

Claim Example Three

- Patient transported from residence to hospital (RH modifier)
  - Diagnosis code(s) used (defined): age-related physical disability; weakness; hyperglycemia, unspecified; dehydration
  - Extra narrative comments: frail, weakness, hyperglycemia, dehydration

CMS' 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)
  - CMS Transmittal 3240: Medical Conditions List and Transportation Indicators

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
- Patient's condition should be reported on the claim

Transportation Indicators

- Ground only
  - C5: For situations where a patient with an ALS-level condition is encountered, treated and transported by a 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

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

- 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: 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

Advance 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

- 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 FAQ One

- 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 Two

- 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

GA Modifier

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

GX Modifier

- 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

GZ Modifier

- Used when a medical necessity denial is expected but an ABN was not provided to the beneficiary

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
- CMS IOM Publication 100-02, *Medicare Benefit Policy Manual*, Chapter 10, "Ambulance Services"
- Beneficiary Notices Initiative (BNI) ABN Manual Instructions and ABN Form CMS-R-131

Questions?

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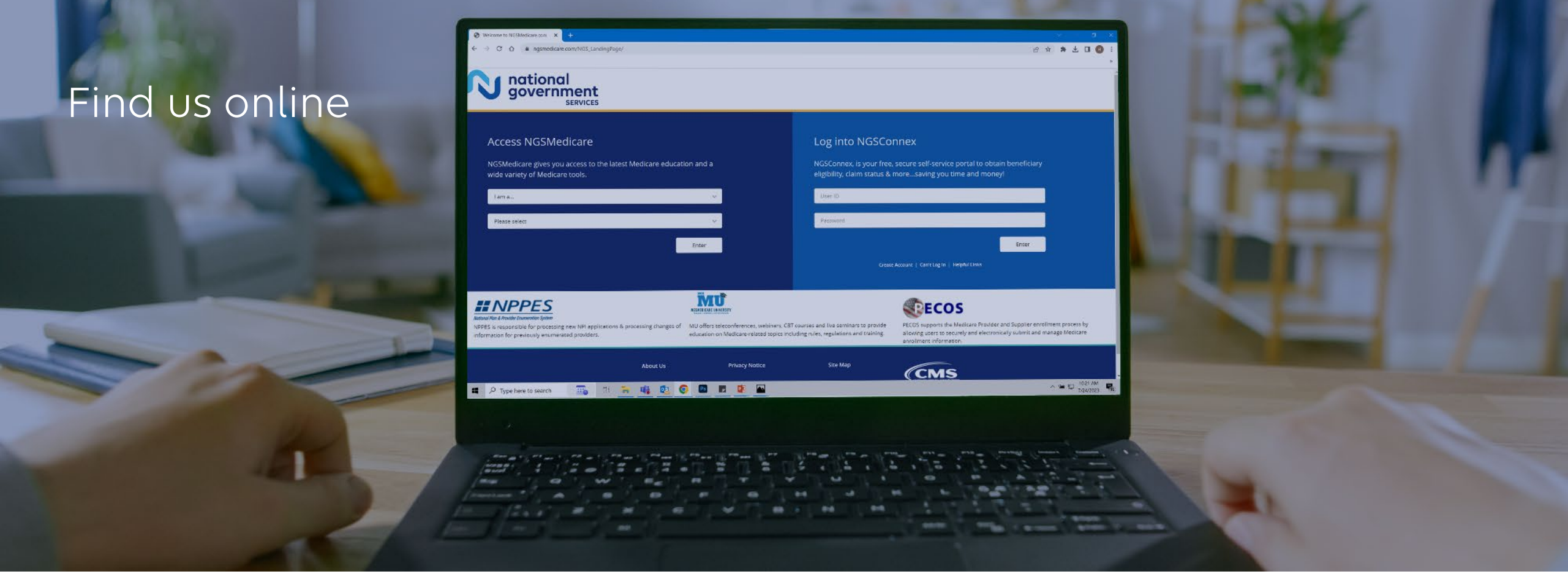

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