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Part A Ambulance Transport: Understanding the Basics

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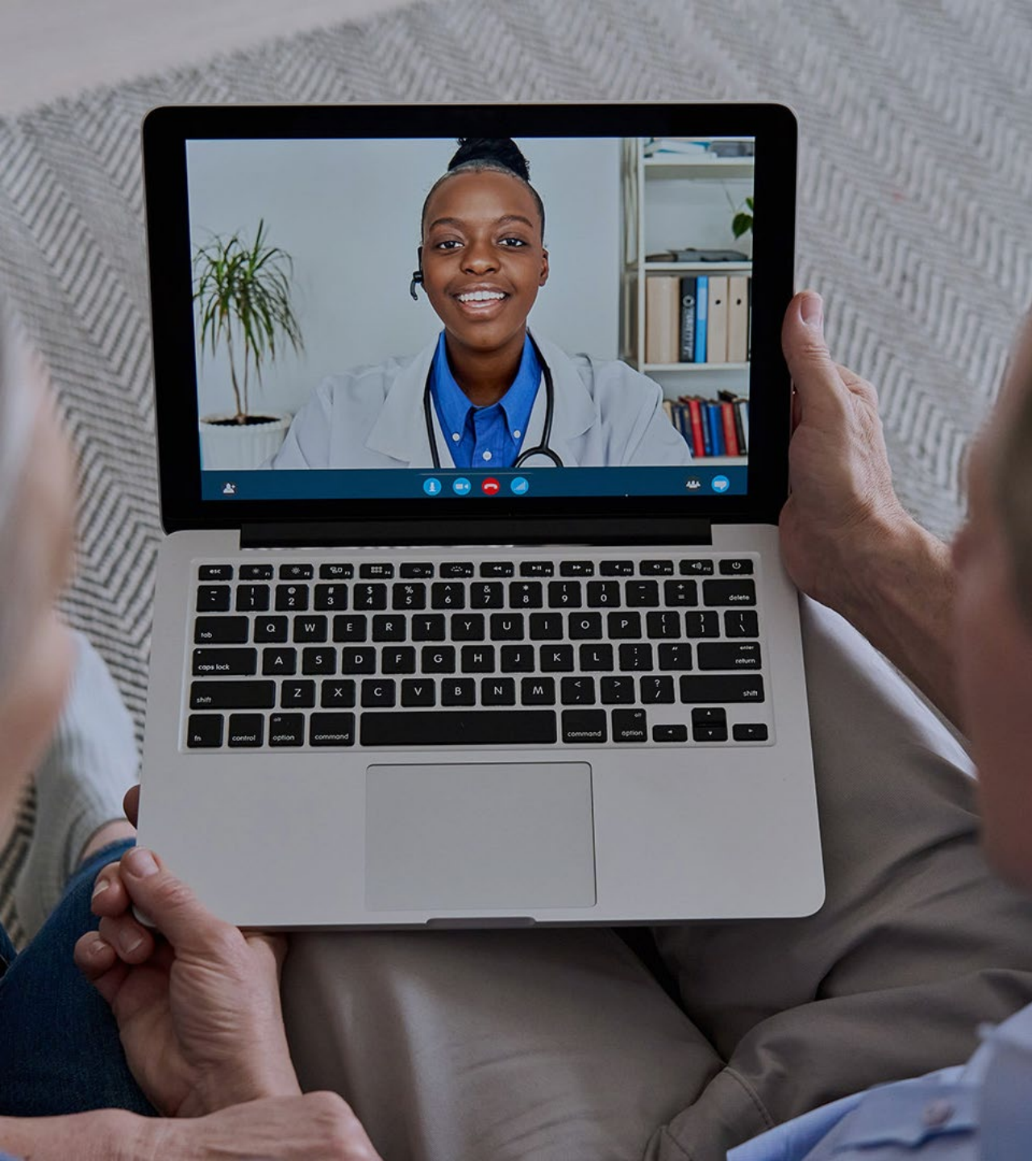

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Objective

The purpose of this presentation is to give Medicare providers of ambulance and skilled nursing facility services a better understanding of who is responsible to report services to Medicare.

Today's Presenters

- Provider Outreach and Education Consultants
  - Michael Dorris
  - Jean Roberts, RN, BSN

Part A Ambulance Agenda

- Ambulance Providers
- Inpatient Transport
- Ambulance Coverage Requirements
- Ambulance Definitions
- Ambulance Billing & Reimbursement
- Resources
- Questions

Ambulance Providers

Definition of Part A Hospital

- A Medicare-approved hospital that has been certified by CMS to participate in the Medicare program

- This means they meet specific quality and safety standards and are eligible to receive reimbursement from Medicare for the care they provide to eligible beneficiaries

Definition of a Part A SNF

- An institution or a distinct part of an institution, such as a skilled nursing home or rehabilitation center, which has a transfer agreement in effect with one or more participating hospitals
- Is primarily engaged in providing skilled nursing care and related services for residents who require medical or nursing care; or rehabilitation services for the rehabilitation of injured, disabled, or sick persons, and
- Meets the requirements for participation in 1819(a) through 1819 (d) as amended by 4201 of OBRA 1987 of the Social Security Act and in regulations at 42 CFR 483, B

Ambulance Provider

- Part A and Part B of A coverage
  - Provider owns and operates an ambulance transportation service as adjunct to its institutionally-based operations
  - Bills Medicare on CMS-1450 or 837I claim
    - Transport – Medicare Part A bundled payment; not separately reimbursed
    - Part B of A – Medicare separately reimburses facility
  - Provider
    - Hospital, CAH or SNF
    - CORF
    - HHA
    - Hospice

Ambulance Supplier

- Part B supplier
  - Not owned or operated by provider; enrolled in Medicare as independent ambulance supplier
  - Bills Medicare on CMS-1500 or 837P claim
  - Repetitive scheduled non-emergent ambulance transports (RSNAT)
  - Other
    - Volunteer fire and/or ambulance companies
    - Local government ambulance companies
    - Privately-owned and operated ambulance companies
    - Independently-owned and operated ambulance companies

Ambulance: Transport versus Services

- Ambulance transport
  - Part A covers beneficiary transport services furnished either directly or under-arrangement
    - Beneficiary must be formally admitted as inpatient of hospital, CAH, or SNF and require transportation for specialized care
      - Must maintain inpatient status with inpatient provider
      - Under arrangement means the inpatient hospital must bill for arranged services and reimburse entity providing those services
- Ambulance services
  - Separately payable under Part B of A (outpatient)
  - Includes entities owned and operated by, or under arrangement with, a facility such as hospital, CAH, or SNF

Inpatient Transport

Part A Ambulance Transport

- Beneficiary considered inpatient under Part A when formally admitted to
  - Hospital
  - SNF
    - Transportation outside of SNF may be required while beneficiary maintains their inpatient status
- Transport covered and payable under Part A cannot be classified and paid for as an ambulance service under Part B
  - Includes intra-campus transfers
- Reminder: If beneficiary is on LOA (OSC 74) when ambulance services are provided, then ambulance is not included on inpatient claim and is billed to Part B

Air Ambulance

- Requirements for Part A coverage must be met
- Air ambulance transport is covered for transfer of a patient from one ACH to another ACH if medical appropriateness criteria met
- Two categories:
  - Fixed wing (FW) e.g. airplane
  - Rotary wing (RW) e.g. helicopter

Part A Inpatient Transportation

- When ambulance is used for the transportation of a hospital inpatient to another facility for diagnostic tests or special treatment the ambulance transportation is considered part of the DRG

Part A Inpatient Payment

- When IPPS hospital provides transportation for a hospital inpatient to another facility, the ambulance transport is considered part of the DRG, and not separately billable
  - Bill cost of transport to line item that required transportation
    - Do not bill revenue code 540 (ambulance)
  - Transport cannot be classified and paid as an ambulance service under Part B

SNF

- Ambulance is not categorically excluded from SNF CB
  - Ambulance trips must meet medical necessity
  - Ambulance associated with Major Category I
    - CMS IOM Publication 100-04, *Medicare Claims Processing Manual*, Chapter 6, Section 20.3.1
- Round trip ambulance to/from a hospital OPD, physician's office, etc. is included in SNF PPS rate
- Transfer from SNF one to SNF two for admission before midnight on same DOS
  - Ambulance bundled back to SNF one
  - Beneficiary considered patient of SNF one until admitted to SNF two

Ambulance Coverage Requirements

Coverage Requirements

- Medically reasonable and necessary when condition is such that use of any other method of transportation is contraindicated
- Origin to nearest appropriate facility capable of furnishing required level and type of care when medically reasonable and necessity
  - Local Medicare approved destination
- Actually occurred and provided by approved ambulance provider

Coverage Requirements

- Transport must
  - Medically reasonable and necessary when condition is such that use of any other method of transportation is contraindicated
  - Origin to nearest appropriate facility capable of furnishing required level and type of care when medically reasonable and necessity
    - Local Medicare approved destination
  - Actually occurred and provided by approved ambulance provider

Coverage Requirements (2)

- Must be fully documented, meet all program coverage criteria, and documentation must be kept on file and provided upon request from any Medicare contractor
  - **Note:** Presence or absence of physician's order for ambulance transport does not definitively prove or disprove whether transport was medically necessary
- Payment basis
  - Level of service furnished (provided services were medically necessary)
  - Not based simply on vehicle used

Ambulance Definitions

BLS Ground Ambulance

- Vehicle and crew requirements are subject to state and local laws where services are furnished
- BLS
  - Staffed by minimum of two crew with minimum EMT-basic certification
  - Legally authorized to operate all lifesaving and life-sustaining equipment on board
  - Medically necessary services and supplies

Advanced Life Support (ALS) Ground Ambulance

- Staffed by minimum of two crew meeting BLS requirements and certified as EMT-intermediate or EMT-paramedic
- Three levels of ALS
  - Non-emergency ALS1
    - Medically necessary supplies and services including delivery of ALS assessment or at least one ALS intervention
  - Emergency ALS1
    - Medically necessary supplies and services including ALS assessment performed by ALS crew as part of emergency response necessitated by patient's reported condition at time of dispatch indicating only an ALS crew was qualified to perform assessment
      - **Note:** An ALS assessment does not necessarily result in determination that patient requires ALS level of service

ALS Ground Ambulance 2

- Emergency ALS2
  - ALS assessment performed by ALS crew as part of emergency response with 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 administration of prehospital blood transfusion (PHBT) which includes low titer O+/O- whole blood transfusion therapy, packed red blood cells (PRBCs), plasma, or a combination of PRBCs and plasma
    - And provision of at least one ALS2 procedure
      - Manual defibrillation/cardioversion, endotracheal intubation, central venous line, cardiac pacing, chest decompression, surgical airway or intraosseous line

Specialty Care Transport (SCT)

- 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

Paramedic Intercept (PI)

- ALS services provided by entity that does not provide ambulance transport (tiered approach)
  - Example: Local volunteer ambulance only able to provide BLS transport but patient requires ALS services
    - Other entity dispatches paramedic to meet BLS ambulance and ALS paramedic then provides services to patient

Air Ambulance

- Medically appropriate air ambulance transportation is covered only when beneficiary's medical condition is such that transportation by either BLS or ALS ground ambulance is not appropriate
  - Requires rapid transport but great distances or other obstacles prevent rapid delivery to the nearest appropriate facility or when point of pickup is inaccessible by ground or water ambulance vehicle
  - Destination must be nearest appropriate hospital
- Two categories:
  - FW air ambulance: e.g. airplane
  - RW air ambulance: e.g. helicopter

Noncovered Transportation

- Any vehicle that does not meet staff, vehicle and equipment requirements as per Medicare coverage guidelines and/or state and local laws where services are furnished
- Examples
  - Wheelchair van
  - Gurney van
  - Ambulette
  - Litter van

Bed Confinement

- Bed confinement is just one element in determining whether transportation other than an ambulance could be used without endangering the individual's health
  - Not the same as bed rest or non-ambulatory
- Patient is bed confined if
  - Unable to get up from bed without assistance
  - Unable to ambulate and
  - Unable to sit in a chair or wheelchair

Ambulance Billing & Reimbursement

Required Claim Coding

- Part A processes claims for Part B ambulance services when provided under arrangement with hospital or SNF
  - TOB: 13X, 22X, 23X, 85X
  - VC A0 with zip code of geographic location pick up location
    - Report only once per claim
  - May report more than one trip per claim; however, separate claim must be billed when VC A0 location is different
  - VC 32 when more than one patient transported to same destination
  - Revenue code 054X
    - Non-covered revenue codes: 541, 542, 544, 547, 549

Condition Codes

- AK - Air Ambulance Required
- AL - Specialized Treatment/Bed Unavailable (transported to alternate facility)
- AM - Non-Emergency Medically Necessary Stretcher Transport Required
- B2 - Critical Access Hospital (CAH) Ambulance Attestation
  - Attests that meets criteria for exemption from ambulance fee schedule

Ambulance HCPCS Codes

HCPCS	Description	HCPCS	Description
A0426	ALS 1 - non-emergency	A0431	RW air transport
A0427	ALS 1 - emergency	A0432	PI, rural area, volunteer ambulance
A0428	BLS – non-emergency	A0433	ALS 2
A0429	BLS - emergency	A0434	SCT
A0430	FW air transport		

Report one unit per HCPCS code; actual charges

Ambulance Mileage HCPCS Codes

HCPCS	Description
A0425	BLS/ALS mileage
A0435	FW air mileage
A0436	RW air mileage
A0888	Non-covered: Mileage beyond nearest facility

Report loaded miles as fractional units

- Miles < 100, round up to nearest tenth of a mile
- Miles =/> 100, report to nearest whole number
- Miles < one report zero before decimal point (e.g. 0.5)

Note: Only "loaded" miles from point of pickup to nearest appropriate facility (destination) are reported as mileage charges

Origin/Destination Modifiers

Code	Description	Code	Description
D	Diagnostic or therapeutic site other than P or H when these are used as origin codes	N	Skilled nursing facility
E	Residential, domiciliary, custodial facility	P	Physician's office
G	Hospital based ESRD facility	R	Residence
H	Hospital	S	Scene of accident or acute event
I	Site of transfer (e.g. airport or helicopter pad) between modes of ambulance transport	X	Intermediate stop at physician's office on way to hospital (destination code only)
J	Freestanding ESRD facility		

Facility: Required Modifier

- In addition to reporting origin and destination modifiers, institutional providers also report one of the following with every HCPCS code and every 54X revenue code line:
  - QM - Ambulance service provided under arrangement by a provider of services
  - QN - Ambulance service furnished directly by a provider of services

Additional Billing Information

- Point of pickup (POP): Location of patient when placed into ambulance
  - POP Zip code is reported with VC A0
- DOS: Date loaded ambulance departs point of pick-up
  - Patient pronounced dead after vehicle dispatched but before loaded into ambulance then date of dispatch (or takeoff for air ambulance) is DOS

LIDOS

- Must report single DOS on each revenue code line
  - Format: MM/DD/YY
  - Report each service (revenue code) on a separate line item with date service was provided for every occurrence

Revenue code	HCPCS Code	DOS	Units
0540	A0426	051225	1
0540	A0425	051225	95.5

- A0426 = ALS1
- A0425 = miles
- Reminder: Use applicable origin and destination modifiers on each line

Reimbursement

- Inpatient transport from one provider to another are reimbursed via bundled payment
  - Example:
    - Inpatient hospital DRG
    - SNF PPS (RUG) when related to covered SNF service
- Note: Ambulance transports are excluded from three day preadmission payment window
- Outpatient
  - Ambulance fee schedule

Documentation Tips

- Documentation should include:
  - A detailed statement of the condition necessitating the ambulance service
  - A statement indicating whether the patient was admitted as an inpatient
    - If yes, the name and address of the facility must be shown
  - Name and address of certifying physician
  - Name and address of physician ordering service if other than certifying physician
  - Point of pickup (identify place and completed address)
  - Destination (identify place and complete address)
  - Number of loaded miles (the number of miles traveled when the beneficiary was in the ambulance)
  - Cost per mile
  - Mileage charge
  - Minimum or base charge; and
  - Explanation of charge for special items or services

Resources

Resources

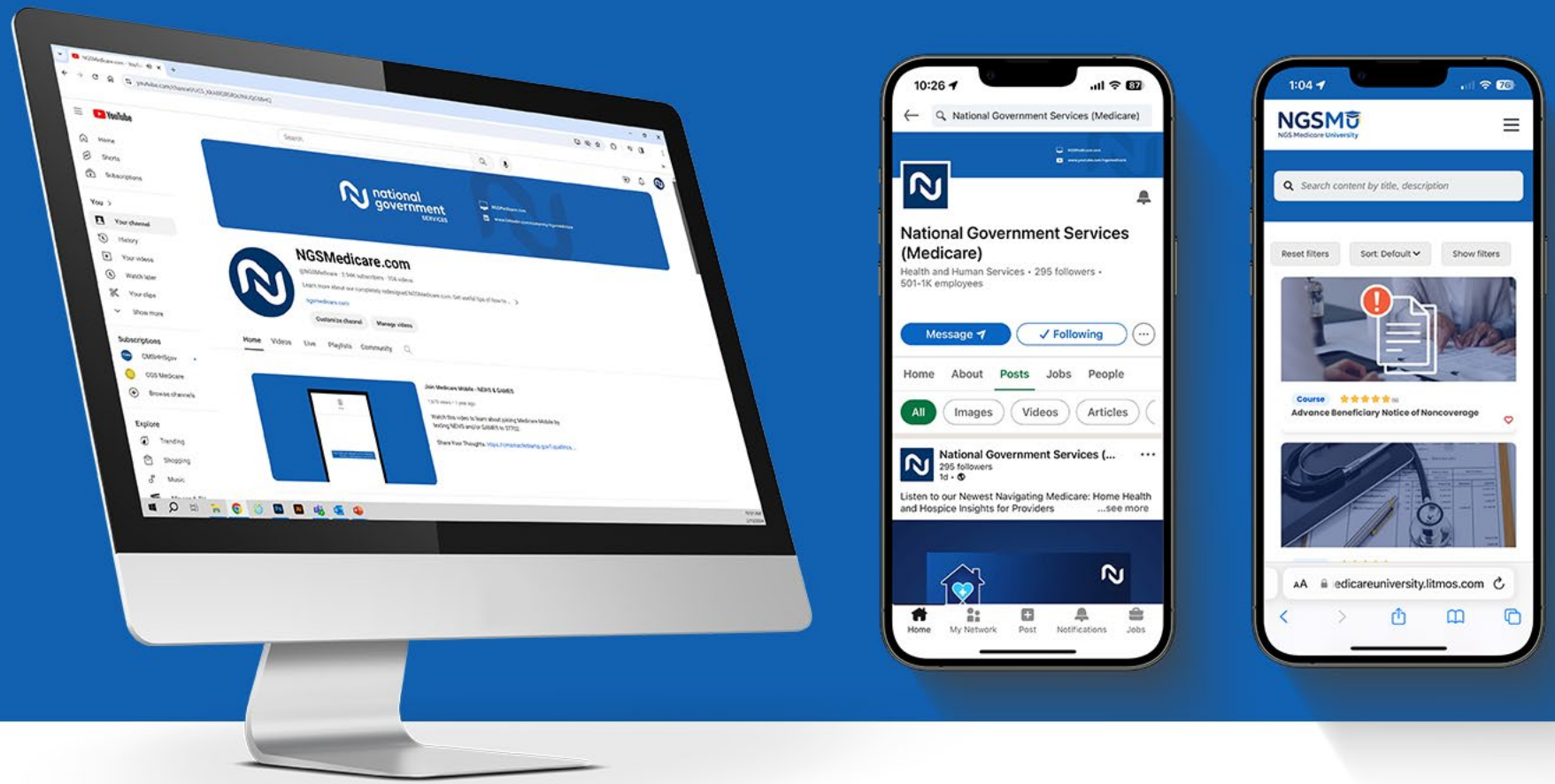
- CMS IOM, Publication
  - 100-04, *Medicare Claims Processing Manual*
    - Chapter 6 - Inpatient Part A Billing and SNF Consolidated Billing
    - Chapter 7 - SNF Part B Billing (Including Inpatient Part B and Outpatient Fee Schedule)
    - Chapter 15 - Ambulance Service
  - 100-02, *Medicare Benefit Policy Manual*
    - Chapter 10 - Ambulance Service

Resources 2

- NGS Ambulance webpage
- CERT and Ambulance Transport
- CMS Ambulance Services Center
- Ambulance Fee Schedule & ZIP Code Files
- Medicare Provider Compliance Tips- Ambulance

Questions?

Thank you!



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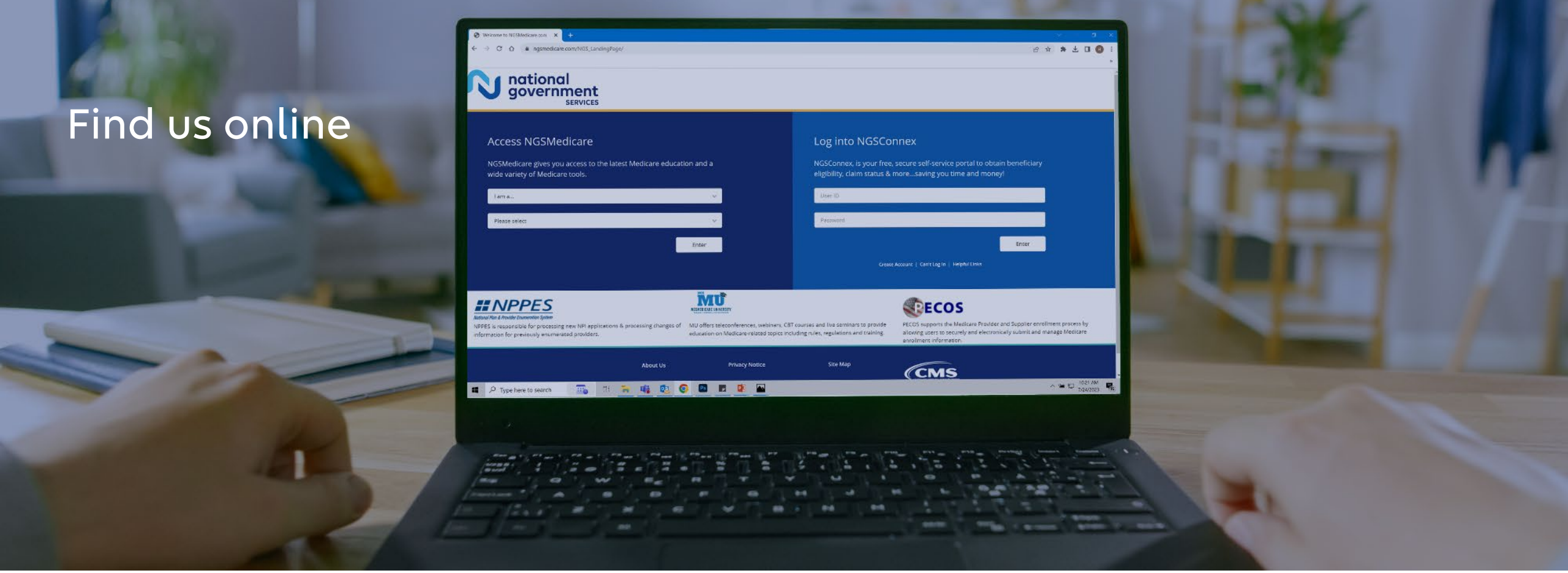

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