

Rolling with Medicare Ambulance Requirements



Presented by

**WPS Government Health Administrators (GHA)
Provider Outreach and Education**

Table of Contents

Review Findings	4
Office of Inspector General (OIG).....	4
Comprehensive Error Rate Testing Program.....	5
WPS GHA Medical Review	8
Documentation.....	8
Documentation Requirements.....	11
Types of Transports	15
Ground Transport.....	15
Air Transport.....	18
Coverage Exclusions.....	19
Billing	20
Facility vs. Private Ambulance	20
Diagnosis.....	20
Emergent vs. Non-emergent	20
Nearest Appropriate Facility.....	21
Paramedic Intercept	22
Hospital to Hospital Transports	22
Modifiers.....	23
CMS Resources.....	27

Disclaimers:

While this book does contain some information for ambulance suppliers billing on UB-04 or its electronic equivalent, the book is designed for ambulance companies billing Medicare Part B on a CMS 1500 or its electronic equivalent.

The information presented and responses to the questions posed are not intended to serve as coding or legal advice. Many variables affect coding decisions and any response to the limited information provided in a question is intended only to provide general information that might be considered in resolving coding issues. All coding must be considered on a case-by-case basis and must be supported by appropriate documentation in the medical record. The CPT codes that are utilized in coding claims are produced and copyrighted by the American Medical Association (AMA). Specific questions regarding the use of CPT codes may be directed to the AMA.

Review Findings

Office of Inspector General (OIG)

In a September 2015 report to CMS, the OIG reported ambulance errors and recommendations for avoiding/fixing the errors.

OIG analysis criteria

- 7.3 million transports analyzed
- \$2.9 billion in payments
- 15,164 providers
- Service dates January 1 – June 30, 2012

OIG findings

- \$24 million paid for transports not meeting Medicare requirements
- \$30 million potentially inappropriate where the beneficiary did not receive service within 24 hours at origin or destination facility
- 1 in 5 ambulance suppliers had questionable billing

OIG recommendations

- Determine whether a temporary moratorium on ambulance supplier enrollment in additional geographic areas is warranted
- Require ambulance suppliers to include the National Provider Identifier (NPI) of the certifying physician on transport claims that require certification
- Increase its monitoring of ambulance billing
- Determine the appropriateness of claims billed by ambulance suppliers identified in the report and take appropriate action
- Implement new claims processing edits or improve existing edits to prevent inappropriate payments for ambulance transports
- Educate physicians who certify dialysis-related ambulance transports on Medicare's coverage requirements

CMS' Response to the OIG recommendations

- CMS fully agreed with the first 4 recommendation and partially agreed with the 5th and 6th
 - Imposed temporary enrollment moratoria on new ambulance suppliers in two metropolitan areas
 - Monitoring of geographic areas for a significant potential for fraud, waste, or abuse, and will impose additional temporary moratoria if warranted
 - Explore the best way to implement the requirement of ambulance suppliers to include the certifying physician's NPI on transport claims requiring certification

Notes:

- Conduct an analysis of the claims identified in this report and determine the appropriate number of claims to review
- Continue current monitoring of ambulance billing
- Review claims data identified in this report
 - Use the results of its review to implement new, or modify existing, claims processing edits needed to prevent inappropriate payments.

Comprehensive Error Rate Testing Program

The CERT contractor continues to review ambulance claims and the errors found show ambulance providers into the top 10 Part B provider types. A few of the errors have included:

- Medically Unnecessary Service or Treatment
 - Patient called to be taken for Tylenol
 - Missing MD order for non-emergent patient transport
- Service incorrectly coded
 - Billed for 2 miles, when the claim should have been billed for 1.2 miles
 - Origin modifier incorrectly coded as E - Residential, Domiciliary, custodial facility for a patient in SNF stay. Correct origin code for the SNF is N - Skilled Nursing Facility

25 - Medically Unnecessary Service or Treatment	
Error Examples	How to prevent this type of error
<p>Billed HCPCS A0425/SH and A0427/SH - Ambulance service, advanced life support, emergency transport, level 1 and mileage, 2 miles for date of service 10/9/2011. Submitted transport records state that patient called to be taken to for some Tylenol. Patient was uncooperative and hostile to EMS. Found walking at the scene, alert, no trauma, no breathing difficulty, no sign of decreased LOC. Patient refused to sign transport form. This form has printed, block letters indicating the first name of nurse above typed nurse's name. Does not identify where the nurse is from. Medical necessity for ambulance transportation was not supported with submitted information.</p>	<p>Services billed to Medicare must be documented and medically necessary to be considered for payment. In addition, when a provider/supplier is unable to obtain the signature of the beneficiary, or that of his or her representative, at the time of transport, it may obtain this signature any time prior to submitting the claim to Medicare for payment.</p> <p>Medical necessity of an ambulance transport 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. In all cases, the appropriate documentation must be kept on file and, upon request, presented to the carrier/intermediary. It is important to note that the presence (or absence) of a physician's order for a transport by ambulance does not necessarily prove (or disprove) whether the transport was medically necessary. The ambulance service must meet all program coverage criteria in order for payment to be made.</p> <p>For more information, please refer to the CMS IOM, Publication 100-</p>

Notes:

	<p>02, Chapter 10, section 10.2.1- Ambulance Necessity of Service and section 20.1.2- Beneficiary Signature Requirement.</p>
<p>Billed HCPCS A0428 and A0425. Missing MD order certifying medical necessity or documentation of attempt at obtaining certification of medical necessity for non-emergency ambulance transport of patient from facility to wound care clinic date. Special rule for non-emergent ambulance service: Need MD order certifying medical necessity or documentation of attempt at obtaining certification of medical necessity. The physician's order must be dated no earlier than 60 days before the date the service is furnished." Received signed documentation of transport date of claim 01/03/2012.</p>	<p>To avoid this type of denial, it is important to understand the documentation requirements for these services. Medicare covers medically necessary nonemergency, scheduled, repetitive ambulance services if the ambulance provider or supplier, before furnishing the service to the beneficiary, obtains a written order from the beneficiary's attending physician certifying that the medical necessity requirements are met.</p> <p>A PCS is statement that certifies that in a physician's opinion an ambulance transport is required. There is no specific form required for physician certification as long as the certification requirement is met.</p> <p>In accordance with CMS IOM Publication 100-02, Chapter 10, Section 10.2.4, the presence or absence of a signed physician order for ambulance transport neither proves nor disproves medical necessity of transport. The ambulance service must meet all program coverage criteria in order for payment to be rendered.</p> <p style="text-align: center;">Requiring a PCS</p> <p>A PCS is required for the following ambulance services:</p> <ol style="list-style-type: none"> 1) Non-emergency, scheduled, repetitive ambulance services; and 2) Unscheduled, non-emergency ambulance services or non-emergency ambulance services scheduled on a non-repetitive basis for a resident of a facility who is under the care of a physician. <p>Note: For non-emergency, scheduled, repetitive ambulance services, the physician's order must be dated no earlier than 60 days before the date that the service is furnished.</p> <p style="text-align: center;">Unable to obtain a portion of the PCS</p> <p>If unable to obtain the physician's signature, it is acceptable to obtain a signed certification statement from the physician assistant, nurse practitioner, registered nurse, clinical nurse specialist, or discharge planner, who has personal knowledge of the beneficiary's condition at the time the ambulance transport is ordered or the service is furnished. This individual must be employed by the beneficiary's attending physician or by the hospital or facility where the beneficiary is being treated and from which the beneficiary is transported.</p> <p>For non-emergency services that are either unscheduled or that are scheduled on a non-repetitive basis, the PCS must be obtained within 48 hours of providing the service.</p> <p>If unable to obtain the written order within the 48-hour limit, the supplier may attempt to obtain the order from one of the alternatives listed above. If after 21 days the supplier is unable to</p>

Notes:

	<p>get the PCS, then a certified letter with a return receipt requested or other proof of mailing can be used to document the attempt.</p> <p>This requirement also applies in a situation where the supplier responds to a non-emergency call and upon arrival the condition of the beneficiary requires emergency care. The claim for this type of service would not qualify for "emergency transport."</p> <p>All non-emergency, scheduled and non-scheduled, transports must have a physician's certification statement on file certifying the need for ambulance transport. The presence or absence of the form will not affect the medical necessity decision.</p> <p style="text-align: center;">Exception</p> <p>Transports for patients not under the care of a physician do not require the PCS.</p> <p>A good faith response to an emergency subsequently down coded to a nonemergency</p> <p>More information on coverage and documentation of these services can be found on the Ambulance page of our WPS GHA website.</p>
--	---

31 - Service Incorrectly Coded

Error Examples

How to prevent this type of error

Billed HCPCS A0425/HI (**2 miles**). Same provider has been paid on one claim for services (A0425-RH and A0427-RI). That claim was for transport from the patient's home to the hospital (RH modifiers). This claim is from the hospital to airport or helipad (HI modifiers). Claim history shows the claim from home to initial hospital paid on another claim (RH modifiers). There is a detailed EMS run form for transport from the residence to the initial hospital corresponding with the other paid claim. There is an EMS call form for "pick-up of flight crew" 1.9 miles from their pick-up point to the hospital and back to the airport. There is a detailed EMS run form for the transport from the <ER> to the airport - helicopter. The flight crew run sheet says 2210 that corresponds with time the ambulance left the airport. Mileage 35101.9 on arrival at transferring hospital; 35103.1 on leaving the airport. **Mileage should be 1.2 miles.** The additional 0.8 mile billed for pick-up of flight crew is not loaded miles and therefore would not be paid.

The CMS Internet-Only Manual, [Publication 100-02, Chapter 10](#), section 10.2.5 - **Transport of Persons Other Than the Beneficiary** states:

"No payment may be made for the transport of ambulance staff or other personnel when the beneficiary is not onboard the ambulance (e.g., an ambulance transport to pick up a specialty care unit from one hospital to provide services to a beneficiary at another hospital). This policy applies to both ground and air ambulance transports."

To prevent this type of error, billers must be aware of Medicare coverage criteria and billing requirements. For more information, refer to the [Ambulance](#) page of the WPS GHA website for articles, training, FAQs and more!

Notes:

<p>Billed ambulance service, advanced life support, emergency transport, level 1 (A0427) with modifier EH (Residential, Domiciliary, custodial facility to Hospital) for date of service 01/12. Claim history shows beneficiary was in a Medicare covered SNF episode of care TOB 212 from 01/11 - 01/31. Billed for date of service while beneficiary was in Medicare covered SNF stay. Submitted documentation includes a copy of the patient care report that supports ambulance pick up point location and destination to hospital. The ambulance transport meets medical necessity for this beneficiary who fell out of the bed and complaining of "right hip and shoulder pain" with transport to the hospital for evaluation. Note also supports beneficiary being placed on oxygen due to oxygen saturation level of 82%. Documentation supports recode of modifier from EH (Residential, domiciliary, custodial facility to Hospital) to NH (Skilled Nursing Facility to Hospital).</p>	<p>To ensure correct claim processing it is important to bill services using the appropriate modifier which accurately reflects the services provided. To avoid claim adjustments or billing questions for this reason, we recommend periodic self-audits of documentation and billing processes.</p> <p>For more information, refer to our WPS GHA web page for Ambulance Modifiers.</p>
--	---

WPS GHA Medical Review

WPS GHA continues to review ambulance claims. Our findings include:

- Mileage not payable to facility
 - Patient preference
 - Higher level care available at facility
- Air ambulance not required based on patient condition
- Missing patient signature
 - No documentation to support patient unable to sign
- Legibility

Documentation

In all cases, the appropriate documentation must be kept on file and, upon request, presented to the contractor. It is important to note that neither the presence nor absence of a signed physician's order for an ambulance transport necessarily proves (or disproves) whether the transport was medically necessary. The ambulance service must meet all program coverage criteria in order for payment to be made.

Notes:

As defined in title XVIII of the Social Security Act in §1861(s)(7)

- “Ambulance service where the use of other methods of transportation is contraindicated by the individual's condition, but only to the extent provided in regulations.”

This provides the need for documentation. Ambulance suppliers must show in writing that their services meet the definition under the law. The documentation must be provided to the contractor if requested.

Contraindicated

Under the Medicare ambulance regulations, the term contraindicated means an individual could safely be transported by another method without endangering the individual's health, even if the other method is not available. The EMT assesses the patient's need upon arrival at the scene. Here are some things to consider:

- Is the patient able to ambulate?
- Is the patient conscious?
- Is the patient bed-confined?
- Can the patient sit or bend?
- Is the patient a threat to themselves or others?

Remember: Medicare is not saying “do not transport the patient”, instead you must decide whether or not to transport based on the answers the questions above. If the patient could safely be transported by other means, do not bill Medicare or bill Medicare with the appropriate modifier indicating the service did not meet the definition in the law.

Lower Level of Service

Documentation can support the medical necessity for the serviced billed, without supporting the level of care. The level of care can be downgraded or upgraded.

A provider cannot bill ALS1 if the only thing performed is an ALS assessment which proved that an ALS service was not required.

The above statement comes from a variety of references.

IOM 100-02 Chapter 10, Section 10.2.2 states:

*Under the FS (Fee Schedule), payment is made according to the level of medically necessary services actually furnished. That is, **payment is based on the level of service furnished** (provided they were medically necessary), not simply on the vehicle used. Even if a local government requires an ALS response for all calls, payment under the FS is made only for the level of service furnished, and then only when the service is medically necessary.*

Notes:

In terms of ALS Assessment, WPS GHA follows the above reference and the definition of ALS assessment in 100-02 Chapter 10, Section 30.1.1 that states:

Definition: *An advanced life support (ALS) assessment is an assessment performed by an ALS crew as part of an emergency response that was necessary because the patient's reported condition at the time of dispatch was such that only an ALS crew was qualified to perform the assessment. An ALS assessment does not necessarily result in a determination that the patient requires an ALS level of service.*

Application: *The determination to respond emergently with an ALS ambulance must be in accord with the local 911 or equivalent service dispatch protocol. If the call came in directly to the ambulance provider/supplier, then the provider's/supplier's dispatch protocol must meet, at a minimum, the standards of the dispatch protocol of the local 911 or equivalent service. In areas that do not have a local 911 or equivalent service, then the protocol must meet, at a minimum, the standards of a dispatch protocol in another similar jurisdiction within the State or, if there is no similar jurisdiction within the State, then the standards of any other dispatch protocol within the State. Where the dispatch was inconsistent with this standard of protocol, including where no protocol was used, the beneficiary's condition (for example, symptoms) at the scene determines the appropriate level of payment.*

Section 1862 (1) (A) of the Social Security Act states:

Notwithstanding any other provision of this title, no payment may be made under part A or part B for any expenses incurred for items or services which...are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member.

Physician Order/Physician Certification Statement (PCS)

Physician orders and Physician Certification Statements (PCS) do not prove the medical necessity for an ambulance service. The responding personnel must document why the service is needed.

Alcohol Related

Some areas in the country have rules allowing for ambulance transports of intoxicated people in order to avoid incarceration. In this situation, the documentation must support the need for the ambulance. Transport solely to avoid jail does not mean they could not have safely gone by another means.

Transport from a SNF

Many SNFs have an internal policy to transfer all their residents via ambulance regardless of the destination. For Medicare purposes, medical necessity must still be shown before payment will be made.

Bed-Confined

Notes:

The contractor may presume the medical necessity is met when the patient is bed-confined before and after the ambulance trip. Medicare uses the following to determine if a patient is bed-confined:

- Unable to get up from bed without assistance;
- Unable to ambulate; and
- Unable to sit in a chair or wheelchair.

The term "bed confined" is not synonymous with "bed rest" or "nonambulatory". Bed-confinement, by itself, is neither sufficient nor is it necessary to determine the coverage for Medicare ambulance benefits. It is simply one element of the beneficiary's condition that may be taken into account in the contractor's determination of whether another means of transport was contraindicated.

Documentation Requirements

To support medical necessity for ambulance services, the documentation must contain the following:

Patient Complaint	Professional Signatures
Point of Pick-up	Patient Signature
Point of Drop-off	Physician Certification Statement (if required)
EMT Observation	Advance Beneficiary Notice of Noncoverage (if required)
Mileage	

Documentation may contain other relevant information from the EMT.

Patient Complaint

The complaint from the patient must be in the records. It will be given at the time of dispatch and EMTs may receive an additional (or different) complaint when they encounter the patient. It is important to note the complaint determines emergent or non-emergent dispatches.

Emergent versus non-emergent dispatches are based on local protocol. The complaint given to the dispatcher is the basis for this level; however, if you arrive on the scene of an emergent dispatch and the situation is clearly not an emergency, a non-emergent billing may be required. A non-emergent dispatch is not able to be upgraded to an emergent dispatch, due to the time frame given for response.

Note: All scheduled transports are considered non-emergent by Medicare.

Point of Pick-up (POP)

Notes:

Medicare requires the POP on all claims. The POP is an address or as close to an actual address as possible. It must contain a valid 5 digit ZIP code, as the ZIP code is used determine the geographical payment and additional Urban, Rural or Super Rural adjustments.

Point of Drop-off (POD)

Medicare requires the address of the receiving facility which must contain:

- Facility name
- Facility street address
- Facility city, state, and ZIP code

Medicare recognizes the following as appropriate facilities:

- Hospital
- Critical Access Hospital (CAH)
- Skilled Nursing Facility (SNF)
- Beneficiary's home
- Dialysis facility for ESRD patient who requires dialysis
- A physician's office

While Medicare recognizes a physician's office as a drop-off location, there are specific situations in which it is covered. In order for coverage to occur, suppliers must document:

- The ambulance transport is enroute to a Medicare covered destination and
- During the transport, the ambulance stops at a physician's office because of the patient's dire need for professional attention, and immediately thereafter, the ambulance continues to the covered destination.

EMT Observation

Medicare relies on what the paramedic observes at the scene to show medical necessity. The EMT's observations include:

- Sight
- Sound
- Smell
- Touch
- General impression

Mileage

Medicare pays mileage to the nearest appropriate facility, which is not always the closest in physical proximity to the POP. This is defined as:

- Closest facility for treatment of patient's injury or illness
 - Bed available

Notes:

- Staff available
- Equipment required or needed to treat patient is available

If the patient (or another provider) requests that the ambulance supplier bypass a facility that meets the requirements for nearest appropriate facility, Medicare may pay for mileage to the nearest appropriate facility, and the patient would be responsible for any additional mileage to their chosen facility.

WPS GHA prefers mileage as recorded directly from the vehicle; however, this is not always possible. In situations where the provider is unable to submit the vehicle's recorded mileage, we recommend using an alternate internet source, such as MapQuest, Google Maps, etc.

Fractional Mileage

- CR7065
- Under 100 miles identify to the 10th of a mile
- 100 or more billed to nearest whole mile

Tips for Billing Mileage

- Make sure the decimal is in place
- If billing paper, check space and color

Professional Signatures

The signatures of the EMT and personnel at the receiving facility are considered professional signatures. Typically, they are obtained at the time of transport. Here is a list of considerations:

- Legible Signatures
 - Written or electronic
- EMT or personnel
- Any ordering medical staff
- Receiving facility personnel
- No block printing
- No signature stamps

Patient Signatures

Medicare requires the patient to sign for each transport, but the signature does not have to be obtained at the time of transport. The supplier must get the signature before submitting the claim to Medicare. Medicare does not recognize lifetime or one-time signatures for ambulance claims.

Emergency situations arise that may prevent the patient or patient's representative from signing the claim. In these situations, suppliers need the following:

- Statement from transport personnel

Notes:

- Patient unable to sign due to physical or mental issue
- Date
- Time
- Name and address of receiving facility
- One of:
 - A signed statement from the receiving facility representative documenting the name of the beneficiary, the time and date the facility received the patient
 - Requested information from a representative of the facility using a secondary form of verification obtained at a later date, but prior to submitting the claim to Medicare for payment

Physician Certification Statement

A Physician Certification Statement (PCS) is a written statement indicating why the medical professional feels the transport is necessary. It does not always make the transport medically necessary for Medicare payment. Here are things to remember with a PCS:

- Physician justification for transport
- Required for non-emergency scheduled transports
 - Dialysis transports
- Does not prove medical necessity
- Legible signature
- No specific form
- Attending physician

Advance Beneficiary Notice of Noncoverage (ABN)

CMS requires providers to give the ABN when they anticipate a medical necessity denial, as long as the patient is not under great duress. If a provider does not supply the ABN, and Medicare denies the services based on medical necessity, then they cannot charge the patient. Ambulance suppliers are no exception.

Here are 3 questions to ask to help you determine if an ABN is required. All 3 criteria must be met.

1. Is this service a covered ambulance benefit?
2. Will payment for part or all of this service be denied because it is not reasonable and necessary?
3. Is the patient stable and the transport non-emergent?

The ABN is optional for statutorily excluded services.

Here some CMS examples in which an ABN is required:

- A transport by air ambulance when the transporting entity has a reasonable basis to believe that the transport can be done safely and effectively by ground ambulance transportation.
- A level of care downgrade, e.g., from Advance Life Support (ALS)-2 to ALS-1, or from ALS to Basic Life Support, when the transport at the lower level of care is a covered transport.

Notes:

- A transport from a residence to a hospital for a service that can be performed more economically in the beneficiary's home.
- A transport of a skilled nursing facility patient to a hospital or to another SNF for a service that can be performed more economically in the first SNF.

Types of Transports

Ground Transport

Vehicle Requirement

CMS states:

Any vehicle used as an ambulance must be designed and equipped to respond to medical emergencies and, in nonemergency situations, be capable of transporting beneficiaries with acute medical conditions. The vehicle must comply with State or local laws governing the licensing and certification of an emergency medical transportation vehicle.

Internet Only Manual (IOM) 100-02, Chapter 10, Section 10.1.1

Must have customary patient care equipment including:

- Stretcher
- Clean linens
- Emergency medical supplies
- Oxygen equipment
- Other safety and lifesaving equipment

Vehicle must be equipped with:

- Emergency warning lights
- Sirens
- Telecommunications equipment required by State or local law

Basic Life Support (BLS)

Basic level of care

- Emergent and Non-emergent
 - Based on dispatch
- Medically necessary supplies and service
- State regulations govern upper levels of care

BLS crew

- Must be staffed by at least two people
 - At least one person must be an Emergency Medical Technician (EMT)

Notes:

- EMT must be certified by the State
- EMT must be legally able to operate all lifesaving and life-sustaining equipment

Advanced Life Support (ALS)

ALS – 1

Definition: ALS1 is the transportation by ground ambulance vehicle and the provision of medically necessary supplies and services including the provision of an ALS assessment or at least one ALS intervention.

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

ALS Intervention definition: A procedure that is in accordance with State and local laws, required to be done by an EMT-Intermediate or EMT-Paramedic.

ALS Intervention application: An ALS intervention must be medically necessary to qualify as an intervention for payment for an ALS level of service. An ALS intervention applies only to ground transports.

ALS – 1 application: The determination to respond emergently with an ALS ambulance must be in accord with the local 911 or equivalent service dispatch protocol. If the call came in directly to the ambulance provider/supplier, then the provider's/supplier's dispatch protocol must meet, at a minimum, the standards of the dispatch protocol of the local 911 or equivalent service. In areas that do not have a local 911 or equivalent service, then the protocol must meet, at a minimum, the standards of a dispatch protocol in another similar jurisdiction within the State or, if there is no similar jurisdiction within the State, then the standards of any other dispatch protocol within the State. Where the dispatch was inconsistent with this standard of protocol, including where no protocol was used, the beneficiary's condition (for example, symptoms) at the scene determines the appropriate level of payment.

ALS – 2

Definition: ALS2 is the transportation by ground ambulance vehicle and the provision of medically necessary supplies and services including (1) at least three separate administrations of one or more medications by intravenous push/bolus or by continuous infusion (excluding crystalloid fluids) or (2) ground ambulance transport, medically necessary supplies and services, and the provision of at least one of the ALS2 procedures listed below:

- a. Manual defibrillation/cardioversion
- b. Endotracheal intubation
- c. Central venous line

Notes:

- d. Cardiac pacing
- e. Chest decompression
- f. Surgical airway
- g. Intraosseous line

ALS – 2 application: Crystalloid fluids include fluids such as 5 percent Dextrose in water, Saline and Lactated Ringer's. Medications that are administered by other means, for example: intramuscular/subcutaneous injection, oral, sublingually or nebulized, do not qualify to determine whether the ALS2 level rate is payable. However, this is not an all-inclusive list. Likewise, a single dose of medication administered fractionally (i.e., one-third of a single dose quantity) on three separate occasions does not qualify for the ALS2 payment rate. The criterion of multiple administrations of the same drug requires a suitable quantity and amount of time between administrations that is in accordance with standard medical practice guidelines. The fractional administration of a single dose (for this purpose meaning a standard or protocol dose) on three separate occasions does not qualify for ALS2 payment.

In other words, the administration of 1/3 of a qualifying dose 3 times does not equate to three qualifying doses for purposes of indicating ALS2 care. One-third of X given 3 times might = X (where X is a standard/protocol drug amount), but the same sequence does not equal 3 times X. Thus, if 3 administrations of the same drug are required to show that ALS2 care was given, each of those administrations must be in accord with local protocols. The run will not qualify on the basis of drug administration if that administration was not according to protocol.

For more information on ALS – 2 definitions, see IOM 100-02, Chapter 10, Section 30.1.1.

ALS crew requirements

- Must be staffed by at least two people
 - At least one person must be certified by the State or local authority as an EMT - Intermediate or an EMT- Paramedic
- EMT must be certified by the State
- EMT must be legally able to operate all lifesaving and life-sustaining equipment

Specialty Care Transport (SCT)

Definition: SCT is the interfacility transportation of a critically injured or ill beneficiary by a ground ambulance vehicle, including the provision of medically necessary supplies and services, at a level of service beyond the scope of the EMT-Paramedic. SCT is necessary when a beneficiary's condition requires ongoing care that must be 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.

SCT crew requirements:

- Must be staffed by at least two people
 - At least one person must be certified by the State or local authority as an EMT - Intermediate or an EMT- Paramedic

Notes:

- Received additional State recognized training to work above the level of EMT - Intermediate or an EMT- Paramedic
- EMT must be legally able to operate all lifesaving and life-sustaining equipment
- Could be additional medical staff actively treating the patient

Air Transport

Medicare recognizes two types of air transports: fixed wing and rotary wing. In order for an air transport to be medically necessary, the patient's medical condition(s) is/are such that transportation by either basic or advanced life support ground ambulance is not appropriate.

Things to consider:

- Is it possible to pick that patient up by ground?
- Total travel time
 - Contractors should consider air transportation to be appropriate when it would take a ground ambulance 30-60 minutes or more to transport a beneficiary whose medical condition at the time of pick-up required immediate and rapid transport due to the nature and/or severity of the beneficiary's illness/injury.
- Patient's condition
- Do not consider alone
 - Physician order
 - Protocol

Possible Air Transport Conditions

The list is not inclusive of all situations that justify air transportation, nor is it intended to justify air transportation in all locales in the circumstances listed.

- Intracranial bleeding - requiring neurosurgical intervention
- Cardiogenic shock
- Burns requiring treatment in a burn center
- Conditions requiring treatment in a Hyperbaric Oxygen Unit
- Multiple severe injuries
- Life-threatening trauma

Fixed Wing Air

- Ground transport in whole or part is not appropriate
 - Based on the patient's condition

Generally, transport by fixed wing air ambulance may be necessary because the beneficiary's condition requires rapid transport to a treatment facility, and either great distances or other obstacles (such as heavy traffic) preclude such rapid delivery to the nearest appropriate facility.

Notes:

Transport by fixed wing air ambulance may also be necessary because the beneficiary is inaccessible by a ground or water ambulance vehicle.

Rotary Wing Air

- Ground transport in whole or part is not appropriate
 - Based on the patient's condition

Generally, transport by rotary wing air ambulance may be necessary because the beneficiary's condition requires rapid transport to a treatment facility, and either great distances or other obstacles (such as heavy traffic), preclude such rapid delivery to the nearest appropriate facility. Transport by rotary wing air ambulance may also be necessary because the beneficiary is inaccessible by a ground or water ambulance vehicle.

Coverage Exclusions

Medicare does not pay for ambulance transportation under the following circumstances:

- Medi-Car, Medi-Van, or wheelchair ambulance services
- Trips to or from a funeral home
- Trips made for services such as drawing blood and catheterization which could have been provided at the patient's location
- Transportation of a beneficiary pronounced dead before the ambulance was called. (See Ambulance Services for a Deceased Beneficiary)
- Ambulance service to a physician's office unless:
 - The trip was to a hospital but stopped at a physician's office due to an urgent need for medical attention, or
 - An otherwise covered round trip is made physician's office for diagnostic or therapeutic services. However, the cost is more than bringing the service to the patient.
- Inpatient round trips - when a patient is taken from a hospital to another facility and returned to the same hospital on the same day without a discharge, submit the charges to the hospital the patient is admitted to. The hospital includes the charges in the cost for the reason for the trip (not with Revenue code 54x). Unless the facility is a Critical Access Hospital (CAH), there is no separate reimbursement for the transport.
- Non transport (See Ambulance Services for a Deceased Beneficiary). The Medicare ambulance benefit is a transportation benefit. If no transport of a Medicare patient occurs, then it is not a Medicare-covered service. This applies to situations where the beneficiary refuses to be transported, even if medical services are provided prior to loading the beneficiary on the ambulance.
- Air ambulance services are not covered for transport to a facility that is not an acute care hospital, such as a nursing facility, physician's office, or a beneficiary's home.

Notes:

If a supplier has provided one of the above listed coverage exclusions, a claim does not have to be submitted to Medicare unless the patient requests it. If the service is submitted to Medicare, include modifier GY for statutorily excluded service. However, the supplier can bill the patient for the non-covered services.

An ABN (form CMS-R-131) is optional in this situation to assist suppliers in informing beneficiaries that the services they are receiving are excluded from Medicare benefits.

Billing

Facility vs. Private Ambulance

Facility or institution-based ambulance claims are billed to the Part A office on a UB-04/CMS 1450 (or 837i electronic equivalent). Private ambulance suppliers bill their claims to Part B on a CMS 1500 (or 837p electronic equivalent). Different billing elements are required.

Diagnosis

WPS GHA does not require the diagnosis on an ambulance claim to prove medical necessity. The diagnosis is for informational purposes only. An EMT is not able to diagnosis; however, he/she may report what they observe. For example a patient complains of abdominal pain. The EMT is not able to say if it is an ulcer, appendicitis, indigestion, etc. He/she could report that patient is in the fetal position, unable to elongate the abdomen, the level of pain, etc.

Medicare does not require a diagnosis on an ambulance claim; however, under the Health Insurance Portability and Accountability Act (HIPAA) all claims submitted electronically are required to have a diagnosis. Medicare follows HIPAA standards for electronic claims, but if you are a small provider with a paper claim billing exception you do not need to submit diagnoses.

Emergent vs. Non-emergent

The patient reported condition at the time of dispatch, will lead to the protocol used to dispatch an ambulance as emergent versus non-emergent.

CMS defines an emergency response as:

Notes:

...at the time the ambulance provider or supplier is called, it responds immediately. An immediate response is one in which the ambulance provider/supplier begins as quickly as possible to take the steps necessary to respond to the call.

CMS states an emergent dispatch:

...must be in accord with the local 911 or equivalent service dispatch protocol. If the call came in directly to the ambulance provider/supplier, then the provider's/supplier's dispatch protocol must meet, at a minimum, the standards of the dispatch protocol of the local 911 or equivalent service. In areas that do not have a local 911 or equivalent service, then the protocol must meet, at a minimum, the standards of a dispatch protocol in another similar jurisdiction within the State or, if there is no similar jurisdiction within the State, then the standards of any other dispatch protocol within the State. Where the dispatch was inconsistent with this standard of protocol, including where no protocol was used, the beneficiary's condition (for example, symptoms) at the scene determines the appropriate level of payment.

Remember a scheduled transport can never be upgraded to emergent from non-emergent. The original response based on dispatch is not met per the CMS definition.

Nearest Appropriate Facility

WPS GHA considers nearest appropriate facility to the POP to determine billable mileage. The facility may not always be the closest facility; however, it requires:

- Bed available
- Staff available
- Equipment needed to treat

WPS GHA uses two sources of information to determine the nearest appropriate facility; the American Hospital Association (AHA) Guide and the Medicare enrollment system.

Billing Considerations

If a hospital or CAH is closer but does not have the needed equipment, bed available, and staff available, then ambulance companies can bypass the facility. If you bypass a facility and the AHA and Medicare enrollment systems indicate all services are available, ambulance suppliers should provide a narrative as to why the closer facility could not take the patient. In this case, the total mileage could be payable to the nearest appropriate facility with the needed services.

A0425 vs A0888

There are times when patients, physicians, or family members request a transport beyond the nearest appropriate facility that could treat a patient. Medicare will only pay for the mileage to the nearest appropriate facility. Providers will submit two separate claim lines, one line with

Notes:

procedure code A0425 for the mileage to the nearest appropriate facility and the second line with procedure code A0888 for the mileage beyond the nearest appropriate facility. Medicare will consider payment of the ground mileage (A0425) and the patient will be responsible for payment of the excess mileage (A0888).

Paramedic Intercept

A paramedic intercept (PI) is when an ALS crew boards a BLS transport vehicle and the ALS crew provides the patient care. Medicare requires the BLS supplier providing the vehicle to bill. Medicare coverage is a transport only benefit; therefore, the transport company must bill.

Medicare requires a financial agreement between the two companies for the ALS level to be billed. The agreement is not monitored by Medicare, but must be in place before the service is billed. The BLS company must have a financial responsibility for the ALS crew's services.

PI requirements for direct billing:

- Furnished in a rural area
- Furnished under a contract with one or more volunteer ambulance services
- Medically necessary based on the beneficiary's condition
- Volunteer ambulance service involved must:
 - Meet the ambulance certification requirements
 - Furnish services only at the BLS level at the time of the intercept
- The entity furnishing the ALS paramedic intercept service must:
 - Meet the program's certification requirements for furnishing ALS services

Hospital to Hospital Transports

Medicare does cover hospital to hospital transports. The transports are billed to different entities depending on the patient status. The points below use the patient status to determine who to bill and any special considerations.

- Inpatient
 - Part A transport
 - Bill the hospital
 - Round trip may be allowed, depending on the facility
 - Medically necessary
- Outpatient
 - Part B transport
 - 2 separate trips
 - Higher level of care
 - Care not available

Notes:

- Consider the need for the transfer back
- Medically necessary

Modifiers

Modifiers are required under certain circumstances to more accurately represent the service or item rendered. For this purpose, modifiers are used to add information or change the description of service in order to improve accuracy or specificity.

Origin and Destination

Medicare uses the origin and destination modifiers to identify the POP and POD. Below is the list of ambulance specific modifiers:

Valid origin modifiers

- 1st position origin
 - D – Diagnostic or therapeutic site other than P or H
 - E – Residential, domiciliary, custodial facility (other than 1819 facility)
 - G – Hospital based ESRD facility
 - H – Hospital
 - I – Site of transfer between modes of ambulance transport
 - J – Freestanding ESRD facility
 - N – Skilled nursing facility (1819 facility)
 - P – Physician’s office
 - R – Residence
 - S – Scene of accident or acute event

Valid destination modifiers

- 2nd position destination
 - E – Residential, domiciliary, custodial facility (other than 1819 facility)
 - G – Hospital based ESRD facility
 - H – Hospital
 - I – Site of transfer between modes of ambulance transport
 - J – Freestanding ESRD facility
 - N – Skilled nursing facility (1819 facility)
 - P – Physician’s office
 - R – Residence
 - S – Scene of accident or acute event
 - X – Intermediate stop at physician’s office on way to hospital

Notes:

When Medicare does not have a valid origin modifier, use the one that best fits. If no valid destination modifier fits, then the trip is not payable.

SNF to SNF

If a provider is billing for a SNF to SNF transport, billed as NN modifier, Medicare will not pay for the transport. The transport should be billed to the SNF the patient is departing.

Non-Emergency Renal Dialysis Transport

CMS implemented a 10% payment reduction for all non-emergency BLS renal dialysis transports. The reductions are taken from both the mileage and base rate. The system uses the origin/destination modifier as an indicator. If either location contains the G or J, then the reduction is taken.

Multiple Patients

Medicare reduces the reimbursement amount when more than 1 person is transported per run. When billing, use the following guideline:

- Part A
 - Value Code 32
 - GM modifier
- Part B
 - GM modifier
 - List all patients
 - Add HICN for Medicare patients

Medicare pays:

- 75% of the base rate allowable for 2 people
- 60% of the base rate allowable for 3 or more
- 50% of the mileage charge

Hospice

When a patient is enrolled in hospice, all services related to the hospice condition are payable only to the hospice. The ambulance company submits a bill to the hospice for the transport.

If the service is not related to the hospice condition, the ambulance company bills Medicare. Append the GW modifier to the base rate and mileage codes.

Deceased Patient

Notes:

Medicare has specific regulations for a deceased patient transport and the billable service. First, all transports have to be medically necessary, and/or the pronouncement or knowledge of death has not occurred. Medicare has identified 3 separate scenarios.

1. If the pronouncement or knowledge of death occurs before the dispatch, the transport or time on scene is not payable by Medicare.
2. If the pronouncement or knowledge of death occurs after the dispatch but before transport, a BLS base rate is payable when billed with the QL modifier. There is no billable mileage, as the medical necessity for the transport is not met.
3. If the patient dies during the transport, bill the claim as normal. No modifier is required.

Institutional Only

There are two modifiers required only for suppliers billing on the UB-04 or its electronic equivalent. They are:

- QM - Ambulance service provided under arrangement by a provider of services
- QN - Ambulance service furnished directly by a provider of services

Modifiers GA versus GY

- GA - The provider or supplier has provided an ABN to the patient
- GY - If the service provided is statutorily excluded from the Medicare Program

In situations when Medicare requires providers notify the patient that a service will not be covered due to medical necessity, the providers are required to give an ABN form. Examples of medical necessity not being met are:

- Patient could safely be transported by another means
- Lower level of service

The following items do not prove medical necessity alone:

- Physician order
- Alcohol related
- Transport from a SNF
- Bed confinement

An ABN is required when the service is not medically necessary, and is not required when the Medicare statutes do not cover the service. If a provider fails to provide a properly completed ABN, then patient liability is waived. Use the following to help determine not medically necessary versus not covered.

Not covered services billed with the GY Modifier

Notes:

- The patient could be safely transported by another means
- Mileage beyond the nearest appropriate facility

Not medically necessary services billed with the GA Modifier when the signed ABN is on file

- Down grade of service
 - Air to Ground
 - ALS2 to ALS1
 - ALS1 to BLS

Notes:

CMS Resources

CMS Ambulance Homepage

<http://www.cms.gov/Center/Provider-Type/Ambulances-Services-Center.html>

CMS Ambulance Benefits Policy Internet Only Manual

<http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c10.pdf>

CMS BCRC Website

<http://www.cms.gov/Medicare/Coordination-of-Benefits-and-Recovery/Coordination-of-Benefits-and-Recovery-Overview/Contacts/Contacts-page.html>

CMS Claims Processing Internet Only Manual

<http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c15.pdf>

CMS Fractional Mileage

<http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2010-Transmittals-Items/CMS1241658.html>

CMS Forms Page

<http://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/index.html>

CMS Patient Signature Guidelines

[http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AmbulanceFeeSchedule/Downloads/Guidance on Beneficiary Signature Requirements for Ambulance Claims.pdf](http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AmbulanceFeeSchedule/Downloads/Guidance%20on%20Beneficiary%20Signature%20Requirements%20for%20Ambulance%20Claims.pdf)

CMS Patient Signature Requirements IOM Publication 100-02, Chapter 10, Section 20.1.2

<http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c10.pdf>

CMS Procedure Code Information

<http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM7489.pdf>

CMS Revalidation Article

<http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1126.pdf>

MLN Matters Article, MM8269: Ambulance Payment Reduction for Non-Emergency Basic Life Support (BLS) Transports to and from Renal Dialysis Facilities

<http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM8269.pdf>

