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NHIC

National Heritage Insurance Company
an EDS company

Medicare

Part B

Guide to Nonemergency Ambulance Transport

**THIS BULLETIN MUST BE
SHARED WITH ALL HEALTH
CARE PRACTITIONERS AND
MANAGERIAL MEMBERS OF
THE PROVIDER/SUPPLIER
STAFF. ADDITIONAL NO-COST
COPIES ARE AVAILABLE ON
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HCFA

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Guide to Ambulance Transport for People with Medicare

The ambulance company may hold you liable if Medicare denies payment for your transport. One way to protect yourself from such charges is to know Medicare's ambulance guidelines.

General Coverage

Medicare covers an ambulance transport only when any other form of transportation would have put your health and/or safety at risk. In other words, you can be billed for the charges if you could have safely been transported in a medi-van, medi-car, or other auto, even if you did not have access to such transportation at the time.

Some Common Non-Covered Transports

- **Transportation by other than ambulance**
- **Transportation for convenience of your doctor or family**
- **Transport beyond the closest available facility**

What if Medicare Does Not Pay for My Transport?

If you feel that Medicare denied a transport in error, you can write to us stating the reasons you feel it should have been covered, this is called requesting a review.

When requesting a review, you should include the following:

- **A copy of your Explanation of Medicare Benefits (EOMB)**
- **A brief note stating why you required transport by ambulance**
- **A copy of the trip ticket for the transport**

The ambulance staff usually completes this document. A trip ticket outlines your health status at the time of transport. A copy can be furnished at your request by the ambulance company that provided the transport. The following list contains additional documentation that may prove helpful to Medicare when reviewing your ambulance trip for payment.

- **A letter from your doctor**
- **Hospital admission or discharge records**

Please send your review requests to Medicare at the following address. Be sure to allow two to four weeks to receive a response from Medicare regarding your review decision Medicare Claims Review Chico, CA 95976

Guidelines and Legal Information

Basic Ambulance Coverage

The Medicare Carriers Manual, Section 2120.2A, states that ambulance transport is considered medically necessary and reasonable when the patients condition is such that **use of any other transportation method**

would be contraindicated. In order for an ambulance transport to be considered medically needed, the patient must require specific medical expertise that can only be provided by a licensed Emergency Medical Technician or Paramedic in a fully equipped ambulance.

In addition, one or more of the following conditions will support coverage, if present and documented:

1. The patient is transported in an emergency situation, e.g., as a result of an accident, injury, or acute illness
2. Needs to be restrained
3. Is unconscious or in shock
4. Requires oxygen or other emergency treatment for an acute problem on the way to the destination
5. Has to remain immobile because of a fracture that had not been set or the possibility of a fracture
6. May have an acute stroke or myocardial infarction
7. Is experiencing severe hemorrhage
8. Is bed confined before and after the ambulance trip
9. Can be moved only by stretcher.

The above listed conditions alone do not, by themselves substantiate medical need for transport by ambulance. Remember the first requirement must be met **the patient's condition must be such that use of any other transportation method would be contraindicated.**

Medicare Policy for Nonemergency Transport

As a carrier, our job at NHIC is to follow ambulance guidelines published in the Medicare Carriers Manual and to ensure that Medicare funds are used to pay for ambulance transports that are deemed medically necessary and reasonable by the Health Care Financing Administration.

Summary of Policy

The Medicare Carriers Manual, Sections 2120.2A and 2125, states that ambulance transport is considered medically necessary when “the patient was suffering from an illness or injury, which contraindicated transportation by other means.” This means that the patient must have an active illness or injury **and** requires the type of care that can only be provided in an *ambulance* (see following definition) by certified personnel such as an Emergency Medical Technician (EMT) or paramedic. For purposes of Medicare standards, an ambulance refers to a vehicle which is specifically designed to respond to medical emergencies or to provide acute medical care to transport the sick and injured (2120.1B).

Nonemergency Ambulance Transport

According to the Federal Register, covered nonemergency transport is usually limited to a patient who is **bed confined, and has an additional condition that supports transport**, such as necessary monitoring or other medically appropriate therapy required enroute. The carrier *does have* additional authority to pay for nonemergency ambulance transportation for patients who are *not* bed confined. Whether or not the patient is bed confined, coverage for nonemergency ambulance transport will be considered *only* if the patient has a condition that supports the need for the service.

Bed Confined Status

The final rule revised the medical necessity requirements to include a national definition of the term “bed confined.” The criteria outlined in the preamble of the final rule¹¹ states that in order to fit the definition of the term “bed confined” the beneficiary is: “Unable to get up from bed without assistance, unable to ambulate, and is unable to sit in a chair or wheelchair.” As defined in the preamble to the final rule the term “bed confined” is not synonymous with “bed rest” or “nonambulatory.” In addition, a “bed confined” status, as defined in the final rule, is USUALLY required for nonemergency transport coverage. However, the requirement is not to be used as the sole criterion in determining medical necessity. It is one factor that will be considered when making medical necessity determinations.

Qualifying Conditions for Transport

The following are acceptable additional qualifying conditions for transport for both bed confined and patient who are not bed confined:

1. Patients requiring **monitoring** during transport (i.e. the absence of monitoring presents a health hazard to the patient). Examples include:
 - ❑ Patient’s whose airway needs to be monitored during transport, such as with a partially paralyzed
 - ❑ patient on a ventilator
2. Patients requiring **therapy** en route. Examples include:
 - ❑ Airway suctioning
 - ❑ Adjusting blood pressure support medication
 - ❑ • Patients who *require* IV therapy en route.
3. The transport is for a medically appropriate purpose (such as when the patient is being discharged from a hospital to a SNF)
4. The transport is not already covered under Medicare Part A (such as a transport from SNF to an emergency department and back to the SNF without discharge from the SNF).

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Documentation requirements:

1. If the patient is bed confined, report on the claim any relevant additional conditions that validate that the transport is reasonable and necessary.
2. If the patient is not bed confined, report on the claim an explanation of why the transport should be covered or otherwise validated as reasonable and necessary. For example, can the patient tolerate being out of bed for more than few minutes?

Physician Certification for Nonemergency Ambulance Transport

Sections 42 CFR 410.40(d)(2), *A Special Rule for Nonemergency, Scheduled Ambulance Services*, and 410.40 (d)(3), *Special Rule for Nonemergency, Unscheduled Ambulance Services*, specifies the circumstances under which the attending physician must provide a written order certifying the medical necessity of requested ambulance transports.

- 410.40(d)(2): **Nonemergency, scheduled ambulance services** are covered if, before furnishing the service to the beneficiary, the ambulance supplier obtains a written order from the beneficiary attending physician

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certifying that the medical necessity criteria has been met. The written order must be dated no earlier than 60 days in advance of the transport for repetitive patients whose transportation is scheduled in advance;

- 410.40(d)(3): For residents in facilities where they are under the direct care of a physician, ambulance suppliers can obtain written orders from the attending physician, certifying that the medical necessity criteria have been met, within 48-hours after the transport.
- We have further clarified that the physician order may be signed by a physician assistant (PA), nurse practitioner (NP), or clinical nurse specialist (CNS) (where all applicable State licensure or certification requirements are met).
- In addition, for **nonemergency unscheduled ambulance transports**, a registered nurse (RN) who is employed by the attending physician or who is an employee of the hospital or facility where the patient is being treated may sign a physician certification statement on oral orders from the physician (or other qualified practitioner, i.e., PA, NP, CNS). The RN's signature is acceptable in instances where nonemergency, unscheduled ambulance transportation is required and the attending physician is not physically present in the facility, but is in consultation with the RN at the time medically necessary transport is required. The physician must later countersign the written order. Before the billing for the service, the ambulance supplier is responsible for obtaining the signed written order for nonemergency ambulance transportation for patients who are *not* bed confined.

Whether or not the patient is bed confined, coverage for nonemergency ambulance transport will be considered *only* if the patient has a condition that supports the need for the service.

To order copies of the complete applicable Final Rule send your request to:

*New Orders, Superintendent of Documents
PO Box 371954
Pittsburgh, PA 15250-79454*

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Specify the date of the requested issue (January 25, 1999) and enclose a check or money order payable to the Superintendent of Documents, or enclose your VISA or MasterCard number and expiration date. Credit card orders can also be placed by calling the order desk at (202) 512-1800 or by faxing to (202) 512-2250. The cost of each copy is \$8. As an alternative, you may also view this regulation via the Federal Register on-line database at www.access.gpo.gov/su_docs/aces/aces140.html In order to view the regulation, you must scroll down and enter "page 3637-3650" at the search prompt.

Claim Requirements for Indicating Certification on Nonemergency Ambulance Transports

NHIC will require that all ambulance suppliers submitting claims for applicable nonemergency claims indicate on each claim (paper or electronic) that physician certification has been obtained and is being kept on file.

HCFA 1500 (paper claim) Reporting

Report physician certification by entering the letter "COF" (Certification on File) in block 19 of the HCFA 1500 claim form.

Electronic Claim Reporting

Report physician certification by entering the letter“COF” in the comment area of yourECS (electronic claim submission) claim. Please contact your software vendor with questions regarding the proper placement of the certification statement in the comment field. Physician Certification must be retained in your files and be available for review at the request of the carrierNHIC. Failure to submit“COF” on applicable claims may result in the delay or denial of your claim.

Physician Certification Form

The Health Care Financing Administration did not impose a format requirement for the physician certification statement. The following page contains a form developed by the California Ambulance Association and approved by NHIC for use. NHIC encourages use of the following form on all applicable nonemergency ambulance transports. Use of this particular form to report physician certification is not required by NHIC; however, the information on the form must be properly documented, maintained in the medical file, and available for carrier review upon request.

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To Be Completed For Each *Nonemergency* Ambulance Transport

[To be completed by ambulance service personnel]

Patient Name: _____ Beneficiary Medicare No.: _____
 Run No.: _____ Transport Date: ____/____/____
 Requested Pick-up Time: _____ Deliver/Appointment Time: _____
 Transported From: _____ Transported To: _____
 Name of Authorizing Physician: _____
 Physician Phone Number: _____

[To Be Completed By Physician Only]

To establish medical necessity for the ambulance transport, please TYPE or PRINT your answers and mark the appropriate box to the following questions:

Coverage and Limitations for Ambulance Service (Medicare Manual 2120.2)

“Necessity for the Service: Medical necessity is established when the patient’s condition is such that the use of any other means of transportation is contraindicated. In any case, in which some means of transportation other than an ambulance could be utilized without endangering the individual’s health, whether or not such other transportation is actually available, no payment may be made for ambulance services. ”

State patient’s primary and secondary diagnosis that is directly related to the need for ambulance:

1. Primary Diagnosis: _____ ICD-9CM: _____
2. Secondary Diagnosis: _____ ICD-9CM: _____
3. Purpose of transport _____

4. Condition of Patient at Time of Transport (Please Mark all that Apply):

- Needed to be restrained (does not include normal restraints applicable to all transports)
- Was unconscious or in shock
- Required Oxygen during transport
- Not capable of self-administration of Oxygen
- Required Oxygen before the transport
- Required Oxygen after the transport

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Had to remain immobile due to fracture and required special skills to maintain immobility and/or positioning.
Specify device used for immobilization: _____

Was bed confined before and after ambulance trip
Bed confined due to (diagnosis): _____ ICD-9CM: _____
Bed confined is defined as:
1) Patient is unable to get up from bed without assistance;
2) Patient is unable to ambulate; AND
3) Patient is unable to sit in a chair, including wheel chair
All three requirements must be met at time of transport.

Could be moved only by stretcher due to: _____

Other (PLEASE SPECIFY): _____

Patient needed special skills of an EMT (SPECIFY SKILL OR PROCEDURE): _____

Additional Comments: _____

Physician 's Signature: _____ Date Signed: ___/___/___

Physician 's Auth. Rep. Signature: _____ Date Signed: ___/___/___

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Gurney Van (Litter Van)

Section 51231.1 of California Department of Health Services states that Litter Van shall be operated by a Certified driver and Attendant and they "Possess at LEAST a current American Red Cross Standard First Aid and Personal Safety Certificate or equivalent." Claims for BLS ambulance services should state the condition of the beneficiary that required the advanced skills of an EMT and how these conditions would not allow SAFE transportation by a gurney van.

5150 and Psychiatric Calls

A 5150 is a legal, 72-hour involuntary hold placed on a person who has been deemed, by a psychiatrist, police or an emergency department physician, to be a danger to himself or others. The nonemergency transport of these patients to a psychiatric institute via BLS ambulance would be a covered service, as they require supervision to maintain their safety. **If you document 5150 on an ambulance claim and you have the 5150 form in your records, you must keep it on file and it must be made available for review upon the carrier's request.**

Oxygen Administration on Ambulance Transports

Under State of California regulations, the administration of oxygen is a skilled service. When a patient requires oxygen during a transport, and cannot self-administer the oxygen, the need for nonemergency ambulance transport is validated by the oxygen administration. The valid need for the oxygen must also be present. This need is validated when the patient is on oxygen under a physician's order, immediately before, during, and after the transport. Typically, patients who usually self-administer their own oxygen, such as by use of a portable tank, may self-administer oxygen during a transport. Under these circumstances, the need for an ambulance transport is not validated based on the need for oxygen. Reasonable exceptions to this general carrier guideline will be considered on a case-by-case basis, when appropriate supporting documentation is submitted. The documentation must show the reason the patient could not self-administer the oxygen during

the specific transport in question. Covered non-emergency ambulance transports, with or without oxygen, must be for a reasonable medical need, as explained elsewhere in this document.

Claim Information Claim Information

Electronic Claims

NHIC encourages you to utilize the option of Electronic Claim Submission (ECS). Some of the benefits of ECS claim reporting are as follows:

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Priority Processing of Your Claims

Your electronically submitted claims go directly to our computer-processing unit, ensuring fast turnaround. Claims can be submitted 24 hours a day, 7 days a week, excluding holidays and maintenance windows.

Acknowledgment of Your Electronic Claim Submission

You receive an immediate electronic verification that your ECS claims have been received and are being processed by our claim system. 24 hours after your submission, another confirmation report is generated that informs you that your claims have successfully passed our pre-edits. No verification is mailed out on paper claims. For paper, you must either call Medicare to confirm receipt or wait until your Remittance Advice arrives.

Quicker Claim Payment

Your electronically submitted claims are paid much faster than paper claims. With electronic billing, clean claims are paid as early as 14 days. With paper billing, there is a minimum of 27 days to receive payment.

Access to Beneficiary Eligibility Information

If you are a participating provider sending claims electronically, you can check beneficiary eligibility to verify if your patients are eligible for Medicare Part B, if they have met their deductible, or if they are locked into an HMO. You must have software that will support Electronic Eligibility Inquiry and Response.

Access to Electronic Funds Transfer (EFT)

Medicare payments can be deposited directly into your bank account. No more waiting for a paper check to arrive in the mail.

Use of Comment (Narrative) Field for Electronic Ambulance Claims

Do you ever find when submitting claims electronically that you do not have enough room to list all pertinent

information? If you answered yes, you will be happy to learn that you have up to **280** characters of free form comment space for every service line on the electronic claim. This field should be used to provide additional information to document medical necessity.

For example:

If you bill Medicare for a transport using a base rate and mileage code, you actually have up to 560 (280 characters per detail line) characters to use on your ECS claim to paint a picture of the patient's condition at the time of transport.

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Since space is limited, you want to make the best use out of your comment field as possible. The comment field should contain information that is specific to the incident. All information should be detailed and reflect the condition of the patient when medical attention arrives on scene. Abbreviations are acceptable in the comment field to utilize space appropriately.

The comment field should be used to demonstrate medical necessity in addition to the Electronic Claim Specialized fields, basic documentation needs, and the appropriate use of diagnosis codes.

Electronic Claim Specialized Fields

NHIC uses the following specialized electronic claim fields for ambulance service. Please remember that use of these fields alone, does not guarantee payment. Use of specialized fields will assist you in painting a picture of the patient's condition at the time of transport; however, the comment field and *CD-9CM* must still indicate a medical need for transport. Any questions you have regarding how you input your claim data in these fields should be directed to your software vendor.

<p>Type of Transport Enter one of the following codes: I = Initial Trip R = Return Trip T = Transfer Trip X = Round Trip If "X" is entered, you must also complete the "Purpose of Round Trip" field.</p>	<p>Bed Confined Before Was the patient bed confined before the ambulance service? Y = Patient was bed confined N = Patient was not bed confined Documentation note: Your answer of Y in this field should be supported by comments in the narrative field.</p>
<p>Bed Confined After Was the patient bed confined after the ambulance service? Y = Patient was bed confined N = Patient was not bed confined</p>	<p>Unconscious/Shock Was the patient unconscious or in shock? Y = Patient was unconscious or in shock N = Patient was not unconscious or in shock Documentation note: Your answer of Y in this field</p>

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<p>Documentation note: Your answer of Y in this field should be supported by comments in the narrative field.</p>	<p>should be supported by comments in the narrative field.</p>
<p>Emergency Situation Was the patient transported in an emergency situation? Y = Emergency Situation N = Not an emergency situation Please note: Do not enter Y in this field for a nonemergency ambulance transport. If you list an answer of Y in this field, the emergent nature of the transport must supported by comments in the narrative field.</p>	<p>Visible Hemorrhaging Did the patient have visible hemorrhaging? Y = Visible hemorrhaging noted N = No visible hemorrhaging Please note: In most cases, it would be inappropriate to enter a Y in this field for nonemergency ambulance transport. If you answer Y in this field, a status of visible hemorrhaging must be supported by comments in the narrative field.</p>

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Hospital Admit

Was the patient admitted to the hospital?

Y = Patient admitted

N = Patient not admitted

Documentation note: Your answer of Y in this field indicates that the patient was admitted as an inpatient, not to the emergency room.

Note: A patient being transported from an emergency room to a diagnostic facility, HD, should have an "N" in this field to show that the patient is not an inpatient at the originating facility.

Transported To/For

Was the patient transported to the nearest facility or for other consideration?

Patient was transported:

A = To nearest facility for care of symptoms and/or complaints

B = For the benefit of a preferred physician

C = For the nearness of a family member

D = For the care of a specialist or for availability of specialized equipment

N = No, services were not available at the first facility

Note: This field only applies when patient is being transported from one facility to another.

Origin Information

Enter the address/location where the transport originated (up to 40 characters). Please be sure to include the facility name as well as the city name when applicable.

Purpose of Round Trip

If “Type of Transport” field is “X”, this field must be completed (up to 80 characters)

Medically Necessary

Was the ambulance service medically necessary?

Y = Medically Necessary

N = Not Medically Necessary

Documentation note: Your answer of Y in this field should be supported by comments in the narrative field.

Services Available

Were services provided at the second facility available at the first facility?

Y = Yes, services were available at the first facility

N = No, services were not available at the first facility

Note: This field only applies when the patient is being transported from one facility to another.

Destination Information

Enter the address/location of the transport destination (up to 40 characters). Be sure to include the facility name as well as the city name when applicable.

Modifiers for Ambulance Service

Two single digit modifiers are required with the ambulance base rate code to identify the points of origin and destination of the ambulance transport. The first modifier indicates the pick-up point and the second indicates the point of destination.

Single Digit Modifiers

Modifier Description

D Diagnostic or therapeutic site

E Residential, custodial facility

G Hospital-based dialysis facility

H Hospital

I Site of transfer between modes of ambulance transfer

J Non-hospital based dialysis facility

N Skilled nursing facility (SNF)

P Physician’s office

R Residence

S Scene of accident or acute event

X Intermediate stop at physician's office on the way to the hospital

Additional Ambulance Modifiers

QL Patient pronounced dead after ambulance called

QM Ambulance service provided under arrangement by a hospital

QN Ambulance service furnished directly by a hospital

Examples of Correct Modifier Coding

Medicare patient, John Doe, is returning to skilled nursing care in a nursing facility following surgery at the local hospital. The modifiers used would be HN as the patient is being transported from a Hospital to a Skilled Nursing Facility.

Medicare patient, Jane Doe, is being transported from her home to Mar's Dialysis Center which is located approximately five blocks from the local hospital. The correct modifiers used would be RJ as the patient is being transported from their residence to a non-hospital based dialysis facility.

Medicare patient, John Doe, was discharged from the local hospital following replacement of a tracheotomy tube. Ambulance transport was ordered to take the patient from the local hospital back to his home and released to the care of his home health nurse. The correct modifiers used would be HR as the patient is being transported from the hospital to their residence.

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Examples of Incorrect Modifier Coding

Medicare patient, John Doe, was discharged from one hospital post surgery and is being transported to another hospital for a skilled nursing facility. We often receive claims with the modifiers incorrectly billed as HH when the modifiers should be coded as HN. The point of pick-up was a hospital and the point of destination was a skilled nursing facility.

Medicare patient, Jane Doe, is being transported from a nursing facility where she is receiving skilled nursing care to the local hospital for a CAT scan. This transport is often billed as RH; when in fact, it should be billed as NH because the patient is being transported from a skilled nursing facility to a hospital. While the patient may reside in the skilled nursing facility, for Medicare purposes the modifier N should be used. This helps indicate the type of care the patient requires on a regular basis.

Medicare patient, John Doe, is transported from Aver's Board and Care Home to a physician's office for treatment of his decubitus ulcers. NHIC often receives claims of this nature with the modifiers NH. The correct modifiers to be used are actually EP. The point of pick up is a residential care facility and the destination is a physician's office.

Origin and Destination

Please remember when you are coding origin and destination on your claims to include the name of the city as

opposed to just the name of the facility. Throughout California, there are several hospitals and nursing facilities that share the same name.

Scenario: You transport a patient from a nursing facility to "Some Hospital". Was the patient transported to "Some Hospital" in Redding or Sacramento? Let us know by indicating the city as well as the facility name.

In order to ensure the proper processing of your claim, you should include the city name and the facility name (i.e. Some Hospital, Sacramento). Failure to include the facility name and city may result in a delay, improper allowance of mileage, or a denial of your claim.

Same Day Ambulance Service

Have you ever received a duplicate denial from Medicare when in fact you transported the patient more than once on the same day? To avoid denials of this nature you must include all same day ambulance trips on the same claim form. Failure to report same day ambulance services on the same claim may result in the delay or possible denial of your claim.

Legible Documentation

One of the significant reasons for denial of paper claims, review requests, and hearing requests is a lack of legible documentation. When we request additional documentation from you, such as a Patient Care Report, please read the report before sending it to Medicare. Often, we receive documentation that may support transport by ambulance; however, we are unable to read it. When we cannot read documentation, we are unable to make a determination about whether or not a transport was medically necessary.

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Documentation Do's

Do read your documentation before sending it to Medicare, including the documentation written by your EMTs or Paramedics. If you cannot read the documentation, most likely we cannot read it either.

Do provide a translation of words that are not legible and attach it to the documentation with a post it note or piece of paper. Be sure to include an explanation.

Do periodically remind ambulance staff to write their Patient Care Reports (PCRs) in a neat and legible fashion. Often, the most important information is found in the pages of the PCR and if we cannot read it, we cannot make a favorable determination.

Documentation Don'ts

Do not highlight information on claim forms or additional documentation (PCR or letters from the patient's physician). When copied, the highlighted information may appear too dark to decipher. This means that the information you really wanted us to see is the exact information we are unable to read. Instead, circle or underline items you would like to emphasize.

Do not minimize or shrink documents when making photocopies. If the entire PCR will not fit on one 8 ½ by 11 inch piece of paper, please copy half of the document on one paper and then make another copy for the rest

of the document.

Do not make copies with the carbon copy when there is information on the back of the form. If the original is too thin, the information on the back shows through on the copy. This causes the document to be obscured and often we are unable to read the pertinent information. Instead, when preparing to make copies, try backing up the thin original with a blank piece of paper, this will help to make sure the information on the reverse side of the original does not show through.

General Help

Basic Documentation Needs

In order for NHIC to make a determination on your claim, we require certain documentation. Following these guidelines will help to ensure that all pertinent information is provided on the claim.

- Describe exactly why the patient requires the specific care of a certified EMT or paramedic in a fully equipped ambulance. Include reasons why transport by other means would endanger the patient's health and/or safety. Paint a picture of the patient's condition that required transport by ambulance.
- When applicable, provide a detailed history surrounding the reasons why the patient requires ambulance transport.
- Include specific medical necessity for the run. Instead of stating unstable vitals, list the specific vital signs (BP reading, O₂ saturation, etc.).
- When transporting a patient requiring immobilization due to fracture which requires special immobilization skills, such as for a post-operative condition, be sure to include the immobilization device used.

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Appropriate Use of ICD-9-CM (Diagnosis) Codes

It is imperative that an appropriate diagnosis code is used on your claim for ambulance transport. NHIC understands that a paramedic or EMT is not authorized to diagnose patients; however, HCFA requires that diagnosis codes are submitted on all claims. If you need help providing a diagnosis code for the patient, you may want to ask the patient's receiving or discharging physician for the patient's diagnosis at the time of transport. Following are some hints that may serve to make the diagnosis code requirement clearer:

- The primary diagnosis (*ICD-9-CM*) code should be the main reason for transport. Block 21 of the paper claim and the "Multiple Diag" field for electronic claims have space for up to four *ICD-9-CM* codes. The first code must be the reason that the patient is being transported by ambulance.
- Other diagnosis codes given should be used to support the present need for ambulance.
- Any relevant present and past medical history should be listed in the narrative field. Past medical history may be of value in judging the medical need for the transport, but past medical history should be clearly differentiated from the current medical conditions.
- You may want to consider using a *ICD-9-CM* code that describes symptoms or signs present, if this is more relevant to the necessity of the transport than a known diagnosis.

Please do not repeat *ICD-9-CM* codes in the narrative field. The narrative can be used for supporting data,

such as symptoms, signs, vitals, etc.

IV Therapy

If using IV therapy as a basis for transport in ambulance, please document the medical need for the IV. Explain the patient's condition that justifies intravenous therapy. A saline or heparin lock is not documentation that IV therapy is necessary en route, nor justification for a Medicare covered ambulance transport.

If large volumes of fluids must be infused to maintain the patient during transport, be sure to include in the narrative the information that reflects the need for volume resuscitation.

Level of Consciousness/Unresponsiveness

When reporting a patient's level of consciousness, be sure to also describe the patient's behavior, when relevant, to help support the necessity for transport by an ambulance.

Supporting factors necessitating transport should be described. For example: an agitated and confused patient must remain immobile s/p hip surgery is being transported back to the SNF via ambulance. The fact that the patient must remain immobile does not, by itself, indicate medical necessity. However, the requirement for immobilization (beyond normal restraints), plus monitoring of the agitated and confused behavior, supports transport by ambulance. If agitation requires gape or wrist restraints, report this.

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Patient Assistance

Assisting a patient in and out of their home does not constitute medical need for a Medicare covered ambulance transport. We receive many claims when the sole reason for ambulance transport was that the patient needed assistance into their home on the second floor. Please do not use patient assistance as the sole reason for transport; be sure to note the patient's condition. Remember, payment is only extended when *transport* by other means would endanger the patient's health and/or safety. The key word here being *transport*, not assistance.

Vital Signs

When documenting claims, stating that vitals were taken does not indicate that an ambulance transport was medically necessary. Instead, indicate the results of vital signs taken and describe any factors related to abnormal vital signs, such as pallor of the skin, duration of symptoms, etc.

Going Home to Die

Please do not use "patient going home to die" as the sole descriptor/reason for ambulance transport. An accurate description of the patient's medical condition that requires specific monitoring by an EMT or paramedic in an ambulance is required to support payment. Ambulance claims will be denied when "going home to die" is the only documented reason for transport.

Nonemergency Claim Examples

The items listed on the following pages are examples of actual claim narratives and ICD-9 CM codes received by NHIC. These have been taken directly from claims received by NHIC. Comments pointing out many of the issues covered are included. Please remember these are non-emergency transports. Medicare assumes the original emergency condition has been treated and the patient's condition is no longer an emergency.

Hospital to Residence

Example:

Diagnosis Code(s): 809 (fracture of trunk bones) and E885 (fall on same level, from slipping, tripping, or stumbling). No comments were given on the Electronic Claim Submission (ECS).

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Comment:

The "fracture of trunk bones" diagnosis is significant; however, with no additional comments indicating that immobilization of the patient was required or the specific device used for immobilization, there is inadequate information for NHIC to make a determination on the claim for a non-emergency transport. Likewise, diagnosis code E885 is defined as a "fall on the same level, from slipping, tripping, or stumbling." This diagnosis helps to indicate the cause of the fracture; however, without comments to clarify the patient care rendered during transport, medical necessity is not indicated since Medicare assumes the fall handled under the emergency has already been treated.

Significant Questions to Ask Prior to Claim Submission:

- Did patient require immobilization?
- Was an immobilization device used?
- What type of immobilization device was utilized?
- What is the patient's level of consciousness/behavior?
- Were any specialized services rendered, if yes, what specialized services?

Example:

718.49 (joint contracture, multiple joints) and 437.8 (cerebrovascular disease, NEC). ECS comments are as follows: "Bed confined due to CVA. "

Comment:

The information given on the initial claim does not indicate a medical need for transport. Remember, Medicare covers transport by ambulance only when transportation by other means would endanger the patient's health.

and/or safety. Eventually, NHIC received more information at the review level, which indicated that the transport met Medicare requirements for coverage. Additional information included the fact that the patient was released to the care of her home health nurse and that the patient's head must remain at a 45 degree angle at all times to prevent aspiration.

Significant Questions to Ask Prior to Claim Submission:

- What specific services were rendered to the patient during transport?
- Was special positioning of the patient required?
- Vital signs taken? If yes, what are the abnormal findings?

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Hospital to Skilled Nursing Facility

Example:

Diagnosis Code(s): 496 (chronic airway obstruction, NEC) and 786.09 (respiratory abnormality, NEC). No comments were given on the ECS claim.

Comment:

The above diagnosis codes are significant to indicate the chronic condition of the patient; however, without comments in the narrative field to clarify the situation (the specific services rendered, patient status en route, etc.), medical necessity has not been shown. After receiving all significant information at the Medicare Hearing level, this claim was found to meet Medicare guidelines and payment was made. Additional information included that the patient required adjustment of Oxygen to keep pulse oximeter greater than 85 percent.

Significant Questions to Ask Prior to Claim Submission:

- Vital signs taken? If yes, what are there abnormal findings?
- Was Oxygen flow adjusted en route? If yes, what is the medical need for Oxygen adjustment?
- What is the patient's level of consciousness; what behaviors require monitoring?

Example:

Diagnosis Code(s): 487.0 (influenza with pneumonia). No comments were given on the ECS claim.

Comment:

The diagnosis code 487.0 indicates the reason for admission to the hospital, not the patient condition at discharge to a SNF. Based upon the information received at the claim level, medical necessity was not indicated. After receiving the Patient Care Report at the claim review level, this ambulance transport was deemed medically necessary due to the patient's condition. Per the trip report, "the patient required monitoring of abnormal vitals, including a respiratory rate of 28, a decreased mental status, and patient required wound care due to bleeding moderately from site of IV" (This statement would have been able to be placed in the ECS comment field). According to the information received at the review level, transportation by other means was

contraindicated; thus, meeting Medicare guidelines for coverage.

Significant Questions to Ask Prior to Claim Submission:

- What specific services were rendered to the patient during transport?
- Vitals taken? If yes, what are the aberrant findings?
- Was Oxygen administered en route? If yes, list the medical justification for the oxygen use.
- What is the patient's mental status, is it sufficiently deteriorated to require monitoring?

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Appeals

If after receiving your Medicare Remittance Advice, you disagree with the decision, you have the right to a Medicare appeal process. The appeal process consists of the following steps:

Claims Review Request

If you are dissatisfied by the initial claim determination, you may request a review. A request for review should be in writing and filed with the carrier, National Heritage Insurance Company at the following address:

Medicare Claims Review
Chico, CA 95976

When requesting a review, be sure to include all pertinent documentation (the Patient Care Report, letter from doctor, etc.) which supports the need for transport by ambulance. In order to qualify for a review, you must request the review within 6 months after the date of the initial determination as indicated on your Remittance Advice.

Hearing Request

A Medicare Hearing gives you an opportunity to present reasons for your dissatisfaction with a claim decision and to receive a new determination on your claim from an impartial hearing officer. When you, the physician or supplier, request a Hearing, the hearing officer reviews the facts of the case and bases his or her determination upon the Medicare laws, guidelines and regulations. Section B3 12017 of the Medicare Carriers Manual states that when preparing for a hearing, the hearing officer is not to develop for more information when the claimant is a provider of service. Therefore, when you provide the hearing officer with incomplete information, the hearing officer may not ask or develop for more documentation, and the hearing determination will be based solely upon the evidence available. When requesting a Hearing be sure to submit to Medicare all related information as this will assist in guaranteeing that a sound determination is made.

Send your requests for a hearing with all documentation to the following address:

Medicare Hearings Department
P.O. Box 2807

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[\[1\]](#) Final Rule, Federal Register, January 25, 1999 (pages 3637-3650)