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# Ambulance Billing Guide



## Railroad Medicare



**Palmetto GBA**

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## Disclaimer

This publication contains the Railroad Medicare Part B Guidelines regarding billing for ambulance services provided to Railroad Medicare beneficiaries. The publication is deemed to be no more or less than a guide to filing claims for ambulance services with this office, and does not provide instructions on how claims will be processed by Railroad Medicare. Railroad Medicare has produced this publication as an informational reference source for providers/suppliers furnishing services/supplies to Railroad Medicare beneficiaries. This material is intended to complement and not replace Medicare program requirements as set forth in statute, regulations and manual instructions.

These guidelines may be updated due to regulatory and other changes that may occur from time to time. If you have an earlier version of this guide, please be aware that some regulations have changed that impact ambulance service providers. You should review this guide to make sure you fully understand the impact of these changes on your billing operation. When there is a conflict or discrepancy between this publication and the policy as published in the Internet Only Manual (IOM), Publication 100-2 Chapter 10, the policy set forth in the IOM shall prevail. Railroad Medicare makes efforts to ensure the information contained in this publication is accurate and current. However, because the Medicare program is constantly changing, it is the responsibility of each provider/supplier to remain abreast of the Medicare program requirements.

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# Vehicle and Crew Requirements

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## Basic Life Support

A basic life support (BLS) ambulance is one that provides transportation, plus the equipment and staff needed for such basic services as bleeding, splinting of fractures, treatment for shock, delivery of babies, and cardio-pulmonary resuscitation (CPR). A basic life support ambulance is not limited to the above services.

The ambulance supplier must be certified. Certification includes **all** of the following requirements, in addition to any state regulations:

- o Any vehicle used as an ambulance must be designed and equipped to respond to medical emergencies and, in non-emergency 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. At a minimum, the ambulance must contain a stretcher, linens, emergency medical supplies, oxygen equipment, and other lifesaving emergency medical equipment and be equipped with emergency warning lights, sirens, and telecommunications equipment as required by state or local law. This should include, at a minimum, one two-way voice radio or wireless telephone. It must also have all other safety and life-saving equipment required by state and local authorities.

**Note:** Items considered a part of the general ambulance service that is itemized separately will be denied. EOMB reason statement - *“payment is included in the allowance for the basic service, i.e., included in the charge for the trip. Under the Medicare assignment agreement, the beneficiary is not liable for these charges.”*

- o Basic Life Support ambulances must be staffed by at least two people, at least one of whom must be certified as an emergency medical technician (EMT) by the state or local authority where the services are being furnished and be legally authorized to operate all lifesaving and life-sustaining equipment on board the vehicle.

## Advanced Life Support

The Advanced Life Support (ALS) vehicle must have specialized life sustaining equipment and, ordinarily, equipment for radiotelephone contact with a physician or hospital. Typical of this type of ambulance are mobile coronary care units and other ambulance vehicles that are appropriately equipped and staffed by personnel trained and authorized to administer intravenous therapy (IVs), provide anti-shock trousers, establish and maintain a patient's airway, defibrillate the heart, stabilize pneumothorax conditions, and perform other advanced life support procedures or services such as cardiac monitoring. The aforementioned services, with the exception of cardiac monitoring services, are considered to be an integral part of the ALS service and will not be reimbursed when reported separately.

ALS vehicles must be staffed by two people with one of the two staff members certified as a EMT paramedic or an EMT Intermediate who is trained and certified, by the State or local authority where the services are being furnished, to perform one or more ALS service.

ALS services are not eligible for reimbursement if the patient is not transported. Ambulance companies may not bill Railroad Medicare for ALS services which do not include a transportation component.

**Note:** The ALS vehicle must be the transporting vehicle.

## Ambulance Licensure

Railroad Medicare requires ambulance providers to, **upon request**, submit a statement accompanied by documentary evidence that the ambulance(s) has the equipment required by the state and local authorities.

**Note: Ambulance providers are required to furnish their local Medicare Part B with current license/certification information in order to maintain billing privileges with Medicare.**

In determining whether the vehicles and personnel of each supplier meet all of the above requirements carriers may accept the supplier's statement (absent information to the contrary) that its vehicles and personnel meet all of the requirements if:

- o The statement describes the first aid, safety, and other patient care items with which the vehicles are equipped;
- o The statement shows the extent of first aid training acquired by the personnel assigned to those vehicles;
- o The statement contains the supplier's agreement to notify the carrier of any change in operation which could affect the coverage of ambulance services; and
- o The information provided indicates that the requirements are met.

# Emergency/Non-Emergency

CMS has categorized ambulance transports as either *Emergency* or *Non-Emergency*.

## Definition of “Emergency Response”

An “emergency response” is one that, 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. The absence of immediate medical attention could reasonably be expected to:

- o Place the patient’s health in serious jeopardy;
- o Result in serious impairment of bodily functions; or
- o Result in serious dysfunction of any bodily organ or part.

## Definition of “Non-Emergency Transports”

The term “non-emergency” refers to all scheduled transportation, regardless of origin and destination, which does not meet the criteria for “emergency” transport. By definition, hospital discharge trips, trips to and from ESRD facilities for maintenance dialysis, trips to and from other outpatient facilities for chemotherapy, radiation therapy or other diagnostic or therapeutic service are scheduled runs and, therefore, considered non-emergency services.

Examples of conditions that could establish medical necessity for non-emergency ambulance transportation:

- o Patient had to remain immobile because of a fracture that had not been set or the possibility of a fracture (i.e., hip fracture);
- o Patient is markedly disoriented or must be restrained (**Note:** documentation of dementia not sufficient for this case);
- o Patient is in a body cast;
- o Patient is bed confined (patient must meet the definition of bed confined);
- o Patient has signs and symptoms of severe pain or distress or a medical condition or conditions that would be exacerbated by transport other than ambulance;
- o Patient must remain in a supine position; or
- o Patient must be moved by stretcher because of a specific physical condition or limitation.

## Specialty Care Transport (SCT)

Specialty care transport (SCT) is hospital-to-hospital 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.

The EMT-Paramedic level of care is set by each State. Care above the level that is medically necessary and that is furnished at a level of service above the EMT-Paramedic level of care is considered SCT. That is to say, if EMT-Paramedics-without specialty care certification or qualification-are permitted to furnish a given service in a State, then that service does **not** qualify for SCT. The phrase "EMT-Paramedic with additional training" recognizes that a State may permit a person who is not only certified as an EMT-Paramedic, but who also has successfully completed additional education as determined by the State in furnishing higher level medical services required by critically ill or critically injured patients, to furnish a level of service that otherwise would require a health professional in an appropriate specialty care area (for example, a nurse) to provide. "Additional training" means the specific additional training that a State requires a paramedic to complete in order to qualify to furnish specialty care to a critically ill or injured patient during an SCT.

# Fee Schedule Payment

Under the fee schedule, payment is made according to the 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 fee schedule is made only for the level of service furnished, and then only when the service is medically necessary.

During the ambulance fee schedule transition period, Medicare allows the ALS-level payment for the reasonable charge portion of the blended rate for emergency and non-emergency transports when an ALS vehicle is used but no ALS service is furnished, if no BLS vehicle was available at the time.

## **A – ALS Vehicle Used, Emergency Transport, No ALS Service Furnished**

During the ambulance fee schedule transition period, if an ALS vehicle is used for an emergency transport, but no ALS level service is furnished, the fee schedule portion of the blended payment is based on the emergency BLS level.

## **B – ALS Vehicle Used, Non-Emergency Transport, No ALS Service Furnished**

During the ambulance fee schedule transition period, if an ALS vehicle is used for a non-emergency transport, but no ALS level service is furnished, the fee schedule portion of the blended payment is based on the non-emergency Basic Life Support (BLS) level.

## **C – Transport for Specialized Services**

An ambulance transport is covered to the nearest treatment facility to obtain necessary diagnostic and/or therapeutic services (such as a CT scan or cobalt therapy) as well as the return transport. In addition to all other coverage requirements, this transport situation is covered only to the extent of the payment that would be made for bringing the service to the patient.

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# Necessity and Reasonableness

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

Note: The presence or absence of a physician's order for transport by ambulance does not necessarily prove or disprove whether the transport was medically necessary.

The transport must be to obtain a Medicare covered service or to return from such a service.

Payment is made according to the medically necessary services actually furnished. Payment is based on the level of service furnished (provided the service was medically necessary), not on the vehicle used.

Note: Even if a local government requires an ALS response for all calls, payment under the fee schedule is made only for the level of service furnished, and then only when the service is medically necessary.

If other modes of transportation (such as automobile, taxi, wheelchair van, invalid coach or bus) could have been used without endangering the patient's health, benefits will not be paid for ambulance services.

Medicare will not pay for ambulance service when an ambulance was used simply for convenience or because other means of transportation were not available.

Prior to payment determination, medical necessity provided on the claim will be reviewed.

Medicare's payment of ambulance services is determined by the medical condition of the beneficiary **at the time of transport**. Coverage is limited to emergency situations and to beneficiaries who are severely ill or disabled by injury or disease. This program is **not** meant to provide a mode of transportation for the general Medicare population who are able to safely travel by other means, whether or not such other means is actually available or affordable.

## Bed Confined

Non-emergency transportation by ambulance is appropriate if either: the beneficiary is bed-confined, and it is documented that the beneficiary's condition is such that other methods of transportation are contraindicated; or, if his or her medical condition, regardless of bed confinement, is such that transportation by ambulance is medically required.

Thus, bed confinement is not the sole criterion in determining the medical necessity of ambulance transportation. It is one factor that is considered in medical necessity determinations.

For a beneficiary to be considered bed-confined, the following criteria must be met:

- (i) The beneficiary is unable to get up from bed without assistance.
- (ii) The beneficiary is unable to ambulate.
- (iii) The beneficiary is unable to sit in a chair or wheelchair.

Submitted documentation must indicate the patient was bed-confined "before" *and* "after" the ambulance trip. It would not include a person who became ill and was placed on bed rest by their physician or a person who has gone to bed due to feeling unwell. Also, the definition, of 'bed-confined' does not mean that the patient needs "assistance into the ambulance" or "stays in bed *most* of the time."

A patient may only be considered "bedridden" or "bed confined" when they meet the three conditions noted above. "Bed bound" is not considered synonymous with bed confined.

**Note:** Using "bed confined" on a claim as a medical reason for coverage when the beneficiary is **not** bed confined is considered falsification and could result in exclusion from the Medicare program and/or referral to the Office of the Inspector General for investigation. Criminal and/or Civil prosecution may also result.

# Physician's Certification Statement of Medical Necessity for Non-Emergency Ambulance Transport

Effective for services provided on or after September 9, 1999, Medicare requires ambulance providers to obtain a physician's certification statement of medical necessity for ambulance transport. This physician medical necessity certification must be obtained/retained for all non-emergency ambulance transports, scheduled or unscheduled, for those patients who are bed confined or are considered to be unable to be transported by other than ambulance. Exception: No certification is required for those beneficiaries living at home or in a facility where they do not receive direct physician care.

For services furnished **on or after January 31, 2000**, ambulance suppliers must follow the procedures described below:

Before submitting a claim for non-emergency transport, ambulance suppliers must obtain a signed certification statement from the attending physician. The ambulance supplier must obtain the certification statement of medical necessity for the non-emergency transport from the attending physician within 60 days prior to a scheduled transport or within 48 hours of a nonscheduled transport. If the ambulance supplier is unable to obtain a signed certification statement from the attending physician, a signed certification statement must be obtained from either the physician assistant, clinical nurse specialist, nurse specialist, nurse practitioner, registered nurse or discharge planner who is employed by the hospital or facility where the beneficiary is being treated, **with** knowledge of the beneficiary's condition at the time the transport was ordered or the service was rendered.

OR

If the supplier is unable to obtain the required physician certification statement within 21 calendar days following the date of service, the ambulance supplier must document its attempt(s) to obtain the requested physician certification statement in the same manner as described above and may then submit the claim.

In all cases, the appropriate documentation must be kept on file, and upon request, presented to the carrier. It is important to note that **neither the presence nor absence of the signed physician certification statement necessarily proves or disproves whether the transport was medically necessary.** *The ambulance service must meet all other coverage criteria in order for payment to be made.*

## Scheduled Transports

A **scheduled transport** is a service requested 24 or more hours in advance of the required transportation.

The physician's certification must be dated no more than 60 days prior to the date that the service is provided.

## Non-scheduled Transports

A **non-scheduled transport** is a service requested less than 24 hours in advance of required transportation.

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 verbal orders from the physician. The RN's signature is acceptable in instances where non-emergency, 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 the medically necessary transport is required.

The physician must later countersign the certification. The ambulance supplier is responsible for obtaining the certification with the appropriate signatures in an expeditious manner.

In cases where a beneficiary requires a non-emergency, unscheduled transport, the physician's certification can be obtained 48 hours after the ambulance transportation has been provided.

The 48-hour time frame is the standard required by the regulation to obtain a physician's signature. However, there may be instances when meeting this requirement may not be possible. In those instances where an ambulance supplier is unable to obtain the physician's medical necessity certification within the 48-hour time period, it must be obtained before bill is submitted for the service (see above for details on obtaining certification).

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## Example

# Physician's Medical Necessity Certification

Complete for non-emergency ambulance transportation – scheduled or unscheduled

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In order for ambulance services to be covered, they must be medically necessary and reasonable. This form provides the information needed to make medical necessity determinations for **non-emergency** ambulance transportation.

Beneficiary's Name: \_\_\_\_\_

Beneficiary's HIC #: \_\_\_\_\_

Date of Trip/Origin: \_\_\_\_\_

Destination: \_\_\_\_\_

Ambulance transportation (is) \_\_\_\_\_ (is not) \_\_\_\_\_ medically necessary.

Ambulance transportation is medically necessary for the following reasons. (Select one)

- \_\_\_\_\_ 1. **Bed Confined** - The patient is: (all three conditions must apply)
- unable to get up from bed without assistance; **and**
  - unable to ambulate; **and**
  - unable to sit in a chair or wheelchair
- \_\_\_\_\_ 2. Other means of transportation are contraindicated because it would be harmful to the patient's condition. Even if no other means of transportation are available, ambulance trips must be medically necessary and not for convenience. Significant medical documentation must accompany these claims.

List condition(s) (not diagnosis) which necessitates the transport:

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

**I CERTIFY THAT THE INFORMATION CONTAINED HEREIN IS, TO THE BEST OF MY KNOWLEDGE, COMPLETE AND ACCURATE AND SUPPORTED IN THE MEDICAL RECORD OF THE PATIENT. THE INFORMATION BEING UTILIZED ON THIS FORM IS BEING GATHERED TO ASSIST IN SEEKING REIMBURSEMENT FROM THE MEDICARE PROGRAM. I UNDERSTAND THAT ANY INTENTIONAL MISREPRESENTATION OR FALSIFICATION OF ESSENTIAL INFORMATION, WHICH LEADS TO INAPPROPRIATE PAYMENTS, MAY BE SUBJECT TO INVESTIGATIONS UNDER APPLICABLE FEDERAL AND/OR STATE LAWS.**

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Physician's Signature of Attestation  
(Stamp Facsimile Unacceptable)

Date

**Physician Certification is good 60 days from date of physician's signature**

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# Destination

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Medicare covers ambulance transports (that meet all other program requirements for coverage) only to the following destinations:

- Hospital;
- Critical Access Hospital (CAH);
- Skilled Nursing Facility (SNF);
- Beneficiary's home; or
- Dialysis facility for ESRD patient who requires dialysis; or
- A physician's office is not a covered destination. However, under special circumstances an ambulance transport may temporarily stop at a physician's office with out affecting the coverage status of the transport.

As a general rule, only local transportation by ambulance is covered, and therefore, only mileage to the nearest appropriate facility equipped to treat the patient is covered. However, if two or more facilities that meet the destination requirements can treat the patient appropriately and the locality of each facility encompasses the place where the ambulance transportation of the patient began, then the full mileage to any one of the facilities to which the beneficiary is taken is covered. Because all duly licensed hospitals and SNFs are presumed to be appropriate sources of health care, only in exceptional situations where the ambulance transportation originates beyond the locality of the institution to which the beneficiary was transported, may full payment of mileage be considered. And then, only if the evidence clearly establishes that the destination institution was the nearest one with appropriate facilities under the particular circumstance.

## **Institution to Beneficiary's Home**

Ambulance service from an institution to the beneficiary's home is covered when the home is within the locality of such institution or when the beneficiary's home is outside of the locality of such institution but the institution, in relation to the home, is the nearest one with the appropriate facilities.

## Institution to Institution

Occasionally, the institution to which the patient is initially taken is found to have inadequate or unavailable facilities to provide the required care, and the patient is then transported to a second institution, which has the appropriate facilities. In such cases, transportation by ambulance to both institutions would be covered; to the extent of the mileage to be the **nearest** institution with appropriate facilities. Responsibility for payment would follow the rules in the CMS Manual System, Pub. 100-02 Medicare Benefit Policy, Chapter 10, Section 10.3.3.

In these cases, transportation from such second institution to the patient's home could be covered if the home is within the locality served by that institution, or the locality served by the first institution to which the patient was taken.

## Part B and SNF Transports

When the SNF Prospective Payment System (PPS) was introduced in 1998, it changed not only the way SNFs are paid but also the SNFs must work with suppliers, physicians, and other practitioners. Consolidated Billing (CB) assigns the SNF itself the Medicare billing responsibility for virtually all of the services that the SNF's residents receive during the course of a covered Part A stay. Payment for this full range of services is included in the SNF PPS global per diem rate.

The only exceptions are those services that are specifically excluded from this provision, which remain separately billable to Medicare Part B by the entity that actually furnished the service.

Ambulance services have not been identified as a type of service that is categorically excluded from the CB provisions. However, certain types of ambulance transportation have been identified, as being separately billable in specific situations, i.e., based on the reason the ambulance service is needed.

Similarly, an ambulance trip that conveys a beneficiary from the SNF at the end of a stay is not subject to CB when it occurs in connection with one of the events specified in regulations at 42 CFR 411.15(p)(3)(i)-(iv) as ending the beneficiary's SNF "resident" status. The events are as follows:

- o A trip for an inpatient admission to a Medicare-participating hospital or critical access hospital (CAH) See discussion below regarding an ambulance trip made for the purpose of transferring a beneficiary from the discharging SNF to an inpatient admission at another SNF.);
- o A trip to the beneficiary's home to receive services from a Medicare-participating home health agency under a plan of care;

- o A trip to a Medicare-participating hospital or CAH for the specific purpose of receiving emergency services or certain other intensive outpatient services \* that are not included in the SNF's comprehensive care plan (see further explanation below); or
- o A formal discharge (or other departure) from the SNF that is not followed by readmission to that or another SNF by midnight of that same day.

## Ambulance Trips Receiving Excluded Outpatient Hospital Services

The regulations specify the receipt of certain exceptionally intensive or emergency services furnished during an outpatient visit to a hospital as one circumstance that ends a beneficiary's status as a SNF resident for CB purposes. Such outpatient hospital services are, themselves excluded from the CB requirement, on the basis that they are well beyond the typical scope of the SNF care plan. Currently, only those categories of outpatient hospital services that are specifically identified in Program Memorandum (PM) No. A-98-37, November 1998 (Reissued as PM No. A-00-01, January 2000) are excluded from CB on this basis. These services are the following:

- o Cardiac catheterizations;
- o Computerized Axial Tomography Imaging (CT) scans;
- o Magnetic Resonance Imaging (MRI) services;
- o Ambulatory surgery involving the use of an operating room (the ambulatory surgical exclusion included the insertion of percutaneous esophageal gastrostomy (PEG) tubes in a gastrointestinal or endoscopy suite);
- o Emergency room services;
- o Radiation therapy;
- o Angiography; and
- o Lymphatic and venous procedures.

Since the receipt of one of these excluded types of outpatient hospital services is considered to end a beneficiary's status as an SNF resident for CB purposes, any associated ambulance trips are, themselves, excluded from CB as well; thus, an ambulance trip furnished in connection with the receipt of such services should be billed separately to Part B by the outside supplier.

## When Not to Bill Medicare Part B for SNF Transports

Ambulance transports of beneficiaries in Part A SNF stays are considered to be paid as part of the SNF prospective payment system (PPS) rate, and may not be billed as Part B services to the carrier, except in specific instances. Effective October 1, 2004, your carrier has been instructed to deny your Part B claims for ambulance transports of our Medicare Part A residents to or from a diagnostic or therapeutic site other than a hospital (e.g., a non-hospital setting, such as an independent diagnostic testing facility (IDTF), or a freestanding cancer center, radiation therapy center, or wound care center).

## Transportation for Dialysis Services

A beneficiary receiving maintenance dialysis on an outpatient basis is not ordinarily ill enough to require ambulance transportation for dialysis treatment, whether the outpatient facility is an independent enterprise, or part of a hospital. If a claim for ambulance services furnished to a maintenance dialysis patient does not show that the patient's condition requires ambulance services; contractors must disallow it. However, if the documentation submitted with the claim shows that ambulance services are required, the contractor will determine whether the facility meets the destination requirements under the ambulance service benefit.

## Transport for Specialized Services

An ambulance transport is covered to the nearest treatment facility to obtain necessary diagnostic and/or therapeutic services (such as a CT scan or cobolt therapy) as well as the return transport. In addition to all other coverage requirements, this transport situation is covered only to the extent of the payment that would be made for bringing the service to the patient.

## Locality

The term "locality" with respect to ambulance service means the service area surrounding the institution to which individuals normally travel to receive hospital or skilled nursing services.

### EXAMPLE

Mr. A becomes ill at home and requires ambulance service to the hospital. The small community in which he lives has a 35-bed hospital. Two large metropolitan hospitals are located some distance from Mr. A's community and both regularly provide hospital services to the community's residents. The community is within the "locality" of both metropolitan hospitals and direct ambulance service to either of these (as well as to the local community hospital) is covered.

## Appropriate Facilities

The term “appropriate facilities” means that the institution is generally equipped to provide the necessary hospital or skilled nursing care for the illness or injury involved. In the case of a hospital, it also means that a physician or a physician specialist is available to provide the care required to treat the patient’s condition.

### Notes:

- o The fact that a particular physician does or does not have staff privileges in a hospital is not a consideration in determining whether the hospital has appropriate facilities.
- o Ambulance transport to a more distant hospital solely to avail a patient of the service of a specific physician or physician specialist does not make the hospital in which the physician has staff privileges the nearest hospital with appropriate facilities.
- o The fact that a more distant institution is better equipped to care for the patient does not warrant a finding that a closer institution does not have “appropriate facilities.” Such a finding is warranted, however, if the beneficiary’s condition requires a higher level of trauma care or other specialized service available only at the more distant hospital. In addition, a legal impediment barring a patient’s admission would permit a finding that the institution did not have “appropriate facilities.” For example, the nearest tuberculosis hospital may be in another State and that State’s law precludes admission of nonresidents.
- o An institution is also not considered an appropriate facility if there is no bed available.
- o Coverage is not available for transport from a hospital capable of treating the patient because the patient and/or his or her family prefer a specific hospital or physician.

## Air Ambulance Services

Medically appropriate air ambulance transportation is a covered service regardless of the State or region in which it is rendered. However, contractors approve claims only if the beneficiary's medical condition is such that transportation by either basic or advanced life support ground ambulance is not appropriate.

## Coverage Requirements

Air ambulance transportation services, either by means of a helicopter or fixed wing aircraft, may be determined to be covered only if:

- o The vehicle and crew requirements are met;
- o The beneficiary's medical condition required immediate and rapid ambulance transportation that could not have been provided by ground ambulance; and either
  1. The point of pickup is inaccessible by ground vehicle (this condition could be met in Hawaii, Alaska, and in other remote or sparsely populated areas of the continental United States), or
  2. Great distances or other obstacles are involved in getting the patient to the nearest hospital with appropriate facilities.

Additionally, Medicare allows payment for an air ambulance service when the air ambulance takes off to pick up a Medicare beneficiary, but the beneficiary is pronounced dead before being loaded onto the ambulance for transport (either before or after the ambulance arrives on the scene). This is provided the air ambulance service would otherwise have been medically necessary. In such a circumstance, the allowed amount is the appropriate air base rate, i.e., fixed wing or rotary wing. However, no amount shall be allowed for mileage or for a rural adjustment that would have been allowed had the transport of a living beneficiary or of a beneficiary not yet pronounced dead been completed.

For the purpose of this policy, a pronouncement of death is effective only when made by an individual authorized under State law to make such pronouncements.

This policy also states no amount shall be allowed if the dispatcher received pronouncement of death and had a reasonable opportunity to notify the pilot to abort the flight. Further, no amount shall be allowed if the aircraft has merely taxied but not taken off or, at a controlled airport, has been cleared to take off but not actually taken off.

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# Non-Covered Services

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The following are some commonly billed non-covered services:

1. Transport to or from a doctor's office (regardless of the location of the office).
2. Transport to be treated by a preferred physician or in preferred hospital.
3. Transport to be closer to home/family.
4. Transport to a hospital just to receive VA benefits.
5. Transport to a funeral home.
6. Separate charges for "night" runs, holiday or "after hours" runs unless there is documented **unusual circumstances and extra expense associated with the time of the run.**
7. Transport in a wheelchair van.
8. Refusal to be transported.

## Electronic Claims

### **ADMINISTRATIVE SIMPLIFICATION COMPLIANCE ACT (ASCA) ENFORCEMENT OF MANDATORY ELECTRONIC SUBMISSION OF MEDICARE CLAIMS**

The ASCA amendment to section 1862(a) of the Act prescribes that “no payment may be made under Part A or Part B of the Medicare Program for any expenses incurred for items or services” for which a claim is received in a non-electronic form. Consequently, absent an applicable exception, paper claims received by Medicare will not be paid. Entities determined to be in violation of the statute or this rule may be subject to claim denials, overpayment recoveries, and applicable interest on overpayments.

The Mandatory Electronic Submission of Medicare Claims became effective on July 1, 2005, and implemented for all Medicare carriers on July 5, 2005 (refer to the CMS Manual System, Pub. 100-04 Medicare Claims Processing, Transmittal 450, Change Request (CR)# 3440). As required by ASCA, with few exceptions, claims must be submitted to Medicare electronically.

You can learn more about the instructions issued to your carrier/intermediary regarding ASCA Enforcement of Mandatory Electronic Submission of Medicare Claims at: [http://www.cms.hhs.gov/manuals/transmittals/comm\\_date\\_dsc.asp](http://www.cms.hhs.gov/manuals/transmittals/comm_date_dsc.asp)

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### **Information to Send Claims Electronically**

An option that may be available to you with electronic claims submission is through an automated billing system. If you currently use a computer billing system that submits claims to other Medicare Carriers and insurers, chances are that it is also capable of submitting your Railroad Medicare claims. Please check with your software vendor to see if electronic billing is available. Vendor software can enable you to bill your claims electronically and can provide other office accounting functions, such as Electronic Remittance Notices. Electronic Remittances save time by posting

automatically to your patients' accounts. When choosing a system, it is important to consider whether you plan on using the computer for billing only or if you intend to use the computer for both billing and office accounting functions.

To send claims electronically from your PC, you will need to use billing software. Palmetto GBA offers free Windows based software called PC-Ace Pro32. If you would like to receive our free billing software or if you have any questions pertaining to electronic billing, please contact us at (866) 749-4301 or visit our Web site at [www.PalmettoGBA.com](http://www.PalmettoGBA.com).

## Electronic Claim Submission Guidelines

Ambulance providers who file electronically know that this is a fast and efficient way to get claims processed. The following items contain suggestions to minimize repeated filings and denial for additional information:

1. Use complete health insurance claim numbers. This number can be found on the beneficiary's red, white and blue Medicare card.
2. When using modifiers, key the proper sequence of the transport; e.g., R (Residence) to H (Hospital) should be billed with RH following the correct code.
3. Always round mileage to whole numbers. Do not key halves, such as 2-1/2 as 205. This appears as two hundred five miles.
4. Clearly identify if transport is for "non-emergency" outpatient services, such as labs, x-rays, scans, etc. This information can be documented in the "Purpose of Round Trip" or "Purpose of Stretcher" fields on the electronic claim.
5. To eliminate delays, include the following information when submitting hospital-to-hospital transports.
  - a. Reason for the transport; e.g., cardiologist not available at the first hospital; VA benefits available at the second hospital; or, location closer to home or family.
  - b. Indicate if the patient was admitted.
  - c. Indicate if the patient was transported because the second hospital was the closest facility to provide the required care.
  - d. Indicate names and locations of sending/receiving hospitals in the origin and destination fields.
6. When transporting to a dialysis facility, the name of the facility must be indicated.
7. Purpose of stretcher – address the mobility of the patient, ability to follow commands, capability to sit in a wheelchair, etc.

# Common Billing Errors

Avoiding these common errors will help prevent future denials:

1. Insufficient or no documentation to show that any other method of transportation will endanger the patient's health.
2. Always indicate whether this is the closest facility that can handle the patient's condition at the time.
3. When a patient is transported from hospital to hospital, remember to include why they are being transferred. Always indicate what services were unavailable at the first hospital. Indicate if the patient was discharged from the first hospital and admitted to the second hospital. If the patient was admitted to the first hospital but not discharged, the transport is a Medicare Part A expense. Always indicate **full** names of sending/receiving hospitals and their addresses.
4. If a patient is being transported to a Rehabilitation facility, indicate the type rehabilitation services needed. When billing electronically, use the documentation text field. Medical necessity criteria must be met.
5. If a patient is an outpatient, indicate "outpatient." Do not check admission and discharge on the same day if the patient is really transported to the outpatient department. This does not constitute admission. Also, list the reason for transport to the outpatient department.
6. If a patient was "bed confined before and after" the transport, include this information on your claim. If the patient is bed confined for a few days during recovery, do not use "bed confined before and after." This is not the same thing as long-term bed confinement. Always indicate the specific reason for long-term bed confinement (not diagnosis). (refer to subsection "Bed Confined")
7. If an ambulance was dispatched but there was no patient transport, explain why.

As examples, the following reasons, or combinations thereof, are **not sufficient** to justify ambulance transport. However, with additional supporting documentation it will be considered: (Some of these reasons were taken from actual claims for transports from the hospital to a nursing facility or residence.)

1. Debilitating weakness due to old age
2. Altered level of consciousness
3. Reactive confusion
4. Contractures (no location or severity shown)
5. Decubitus ulcer
6. Senile dementia
7. Organic brain syndrome
8. Alzheimer's disease

## Documentation Requirements

It is incumbent upon all Medicare providers to remain abreast of Medicare rules, policies and payment guidelines, and make an independent determination if the service is medically necessary, and have available supporting medical documentation. The issue of medical necessity extends to the provider ordering the service, as well as to the provider performing and/or billing the service. Medical necessity must be demonstrated at all levels of care.

Ambulance suppliers are required to retain documentation on file supporting ambulance services billed to Medicare. The purpose of documentation is to provide a permanent record of each patient's medical condition (at the time of transport) and the reason for transport. This information must meet ambulance transport medical necessity criteria. The ambulance trip sheet for each leg of the trip should be maintained in the ambulance company's records and we recommend the following information:

- o Beneficiary name, address, phone number and health insurance claim (HIC) number;
- o Date and time of transport;
- o Indication of emergency or non-emergency situation;
- o Name of person who ordered the transport;(if available);
- o Patient's signature or representative's signature;
- o Patient's height and weight (**report only when extra attendant is required**);
- o Reason for transport /patient's complaint/ current condition;
- o Patient assessment (by ambulance personnel); which should include the chronological narrative of care/service rendered by ambulance personnel;

- “Indicate” the patient’s past medical history;
- Name and address of origin and destination;
- Odometer reading at point of pick up and destination;
- Number of loaded miles;
- Itemization of specialized services and/or supplies;
- Name of treating doctor or receiving physician;
- Names, titles and signatures of ambulance personnel;
- Name and address of the entity rendering ALS services, if not the transporting company;
- Provider’s vehicle number and license plate number; and
- Type of equipped vehicle used for transport (BLS or ALS).

**Note:** In the event of a round trip, documentation should be completed for each leg of the transport. Separate trip sheets are recommended for documenting each leg. Evidence supporting the ambulance company’s billing of the patient’s 20 % co-insurance and the collection of these payments must be provided upon carrier request.

During a carrier review, it may be necessary to verify information indicated on a completed physician’s medical necessity certification. If it is determined medical necessity/contraindication was not met, a refund of Medicare monies paid in error will be requested.

As a Medicare carrier, it is our responsibility to ensure that claims submitted for Medicare reimbursement are appropriately billed. All Medicare providers are subject to review of their claim submissions. Altering or creating records in response to a carrier request for documentation is unacceptable and can result in criminal and civil penalties. The purpose of record documentation is to provide an accurate, comprehensive permanent record of each patient’s condition and the treatment rendered on the date(s) of service billed. Only when the documentation of services is described in a clear, accurate and legible manner can the reviewer:

- validate that services billed have been rendered;
- were appropriate for the patient’s medical condition;
- met reasonable standards for medical care; and
- were billed and reimbursed under the most appropriate procedure code(s).

It should be noted that these four elements are basic to any type of review by any reviewing entity.

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# Procedure Code Modifiers

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The following modifiers should be used, in the proper chronological order (i.e., “origin” modifier first, followed by “destination” modifier) on all claims.

You will be notified of any changes in modifiers by Special Bulletins from your local Medicare Carrier

- D -- Diagnostic or therapeutic site other than “P” or “H”
- E -- Residential, domiciliary, custodial facility (other than a SNF facility)
- G -- Hospital-based Dialysis Facility (Hospital or Hospital-related)
- H -- Hospital
- I -- Site of transfer between modes of ambulance transport (Example-airport or helicopter pad)
- J -- Non-hospital based Dialysis Facility
- N -- Skilled Nursing Facility (SNF)
- P -- Physician’s office (includes HMO Non-Hospital facility, clinic, etc.)
- R -- Residence
- S -- Scene of accident or acute event
- X -- Intermediate stop at physician’s office enroute to the hospital (includes HMO Non-Hospital facility, clinic, etc.) Note: Modifier X can only be used as a designation code in the second position of a modifier.

**Note:** Modifiers are required on the base code and the mileage code.

# Commonly Used Abbreviations

<b>2o</b>	Secondary To, Related To, Due To	<b>BGL</b>	Blood Glucose Level	<b>CO</b>	Complains of
<b>AAMC</b>	Anderson Area Medical Center	<b>BILAT</b>	Bilateral	<b>Coffee Grounds</b>	Indicates slow bleeding in the stomach/Vomiting blood
<b>A&amp;O</b>	Alert and Orientated	<b>BK</b>	Back	<b>COMB</b>	Combativeness
<b>ABC</b>	Airway, Breathing, Circulation	<b>BKA</b>	Below the Knee Amputee	<b>COPD</b>	Chronic Obstructive Pulmonary Disease
<b>ABD</b>	Abdomen	<b>BOW OB</b>	Bowel Obstruction	<b>CP</b>	Chest Pains
<b>AC</b>	Acute	<b>BP</b>	Blood Pressure	<b>CPR</b>	Cardiopulmonary Resuscitation
<b>ACC</b>	Accident	<b>BS</b>	Blood Sugar/Bowel Sounds	<b>CRB HMG</b>	Cerebral Hemorrhage
<b>ACLF</b>	Adult Congregate Living Facility	<b>BSA</b>	Body Surface Area	<b>CVA</b>	Cerebral Vascular Accident/Stroke
<b>ADM</b>	Admit	<b>CA</b>	Cancer	<b>CX</b>	Chest
<b>ADMIN</b>	Administration	<b>CABG</b>	Coronary Artery Bypass Graft	<b>CYAN</b>	Cyanotic
<b>AFIB</b>	Atrial Fibrillation	<b>CAD</b>	Coronary Artery Disease	<b>DCD</b>	Discounted or Discharged
<b>AFT</b>	After	<b>CAO</b>	Conscious, Alert, Orientated	<b>DCH</b>	Discharge
<b>AKA</b>	Above the Knee Amputee	<b>CARD</b>	Cardiac	<b>DEH</b>	Dehydration
<b>ALOC</b>	Altered Level of Consciousness	<b>CBC</b>	Complete Blood Count	<b>DEST</b>	Destination
<b>AMB</b>	Ambulatory	<b>CC</b>	Chief Complaint	<b>DIA</b>	Diaphoretic
<b>AMI</b>	Acute Myocardial Infarction	<b>CHEMO</b>	Chemotherapy	<b>DIAL TR</b>	Dialysis Treatment
<b>AMS</b>	Altered Mental Status	<b>CHF</b>	Congestive Heart Failure	<b>DIFF</b>	Difficulty
<b>ASHD</b>	Arteriosclerotic Heart Disease	<b>CHI</b>	Closed Head Injury	<b>DJD</b>	Degenerate Joint Disease
<b>ASP</b>	Aspiration	<b>CHNG</b>	Change	<b>DLOC</b>	Decreased Level of Consciousness
<b>AOSTF</b>	Arrival on Scene to Find	<b>CIRC</b>	Circumflex Coronary Artery	<b>DO</b>	Doctor's Office
<b>BBS</b>	Bilateral Breath Sounds	<b>CLN</b>	Clinic	<b>DOM PT</b>	Domiciliary Patient

<b>BDB</b>	Bed Bound	<b>CLST</b>	Closet	<b>DP</b>	Dorsalis Pedis
<b>BEF</b>	Best Equipped Facility	<b>CMN</b>	Certificate of Medical Necessity	<b>DT's</b>	Delirium Tremors
<b>D/T</b>	Due To	<b>HOH</b>	Hard of Hearing	<b>N/V</b>	Nausea & Vomiting
<b>DVT</b>	Deep Vain Thrombosis	<b>HTN</b>	Hypertension	<b>NAD</b>	No Apparent Distress
<b>DX</b>	Diagnosis	<b>HX</b>	History	<b>NC</b>	Nasal Cannula/Providing oxygen through a small tube
<b>EBL</b>	Estimated Blood Loss	<b>ICF PT</b>	Intermediate Care Patient	<b>NEC</b>	Not Elsewhere Classified
<b>ECF</b>	Extended Care Facility	<b>ICP</b>	Intracranial Pressure	<b>NEF</b>	Nearest Equipped Facility
<b>EMG</b>	Emergency	<b>IDDM</b>	Diabetes Mellitus	<b>NEURO</b>	Neurology
<b>EPI</b>	Episode	<b>IM</b>	Intramuscular	<b>NH</b>	Nursing Home
<b>ER</b>	Emergency Room	<b>INF</b>	Infection	<b>NKA</b>	No Known Allergies
<b>ESRD</b>	End Stage Renal Disease	<b>INJ</b>	Injury or Injection	<b>NKDA</b>	No Known Drug Allergies
<b>ET</b>	Endotrachial	<b>IP</b>	Inpatient	<b>NOS</b>	No Other Symptoms
<b>EXTREM</b>	Extremities	<b>I &amp; O</b>	Intake and Output	<b>NRM</b>	Non Rebreathing Mask
<b>FACIL</b>	Facility	<b>IVP</b>	Intravenous Push	<b>NRS/NSG</b>	Nurse/Nursing
<b>FAM</b>	Family	<b>KCI</b>	Potassium Chloride	<b>NSR</b>	Normal Sinus Rhythm
<b>FB</b>	Foreign Body	<b>KVO</b>	Keep Vein Open	<b>NT</b>	Non-tender (doesn't hurt)
<b>FRM</b>	From	<b>LAC</b>	Laceration	<b>NTG</b>	Nitroglycerin
<b>FUO</b>	Fever of Unknown Origin	<b>LAD</b>	Left Anterior Descending	<b>O2</b>	Oxygen
<b>FX</b>	Fracture	<b>LLOC</b>	Low Level of Consciousness	<b>OD</b>	Right Eye
<b>GBW</b>	Gross Body Weight	<b>LLQ</b>	Lower Left Quadrant	<b>OP</b>	Out Patient
<b>GFT</b>	Graft	<b>LOC</b>	Level/Loss of Consciousness	<b>ORIG</b>	Origin
<b>GI</b>	Gastrointestinal	<b>LPM</b>	Liters Per Minute	<b>ORTHO</b>	Orthopedic
<b>GLU</b>	Glucose (blood sugar measure)	<b>LRQ</b>	Lower Right Quadrant	<b>OS</b>	Left Eye
<b>GSW</b>	Gunshot Wound	<b>LUQ</b>	Left Upper Quadrant	<b>OTP</b>	Outpatient
<b>HA</b>	Headache	<b>MAEW</b>	Moves All Extremities Well	<b>OU</b>	Both Eyes
<b>HEENT</b>	Head, Ear, Eyes, Nose, Throat	<b>MCR</b>	Medicare	<b>PAC</b>	Premature Atrial Contractions
<b>HEM</b>	Hemorrhage	<b>MI</b>	Myocardial Infarction/Heart Attack	<b>PCS</b>	Physician Certification Statement

<b>HEPTIC COMA</b>	Due to liver	<b>MISC</b>	Miscellaneous	<b>PE</b>	Physical Exam
<b>HLOC</b>	Higher Level of Care	<b>MRSA</b>	Methicillin Resistant Staph Aureus	<b>PED</b>	Pediatric
<b>HLTH</b>	Health	<b>MS</b>	Multiple Sclerosis	<b>PERL</b>	Pupils Equal & Reactive to Light
<b>HN</b>	Home	<b>MVA</b>	Motor Vehicle Accident	<b>PM</b>	Program Memorandum
<b>PMH</b>	Past Medical History	<b>RLQ</b>	Right Lower Quadrant	<b>SZ</b>	Seizure
<b>PN</b>	Pain	<b>RO</b>	Rule Out	<b>TACH</b>	Tachycardia
<b>POSS</b>	Possible	<b>ROM</b>	Range of Motion	<b>TIA</b>	Transient Ischemic Attack
<b>POSTOP</b>	Post Operation	<b>RX</b>	Prescribed for	<b>△ Triangle</b>	Change
<b>PRN</b>	As Needed	<b>S/P or SP</b>	Status Post (past history of or happened in the past)	<b>TX</b>	Treatment
<b>PRONE</b>	Lying Flat on Abdomen	<b>S/S</b>	Signs & Symptoms	<b>UA or U/A</b>	Upon Arrival or Urinalysis
<b>PSTV</b>	Paroxysmal Supraventricular Tachycardia	<b>SAT</b>	Oxygen Saturation	<b>UKN</b>	Unknown
<b>PSYCH</b>	Psychiatric	<b>SEMI-SITTING</b>	Not lying flat, not sitting straight up (lying down but propped at a 45 degree angle)	<b>UNC/UNR</b>	Unconscious/Unresponsive
<b>PT</b>	Patient	<b>SEP</b>	Sepsis	<b>UOA</b>	Upon Our Arrival
<b>PTCA</b>	Percutaneous Translumina Angioplasty	<b>SHK</b>	Shock	<b>URI</b>	Upper Respiratory Infection
<b>PT-COT-SQUAD</b>	Put Patient on Cot in Ambulance	<b>SNF</b>	Skilled Nursing Facility	<b>UTI</b>	Urinary Tract Infection
<b>PVC</b>	Premature Ventricular Contractions	<b>SNF PT</b>	Skilled Nursing Facility Patient	<b>VFIB</b>	Ventricular Fibrillation
<b>PVD</b>	Peripheral Vascular Disease	<b>SOB</b>	Shortness of Breath	<b>VO</b>	Verbal Order
<b>PWD</b>	Pink, Warm, Dry (normal skin)	<b>S/P</b>	Status/Post	<b>VS</b>	Vital Signs
<b>RAD TX</b>	Radiation Treatment	<b>SPO2</b>	Oxygen Saturation	<b>VT</b>	Ventricular Tachycardia
<b>RCA</b>	Right Coronary Artery	<b>SQ</b>	Subcutaneous	<b>XP</b>	Transport
<b>RES</b>	Residence	<b>STB</b>	Stretcher Bound	<b>W/C or WC</b>	Wheelchair
<b>RESP</b>	Respiration	<b>SUPINE</b>	Laying Flat on Back	<b>W/D or WD</b>	Warm, Dry (normal skin)
<b>RL</b>	Ringers Lactate	<b>SYNC</b>	Syncope	<b>WNL</b>	Within Normal Limits

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# Redeterminations

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## Reason Codes and Review Requests

Claims are rejected, or denied, for a variety of reasons. The reason codes listed below relate to ambulance claims. These codes explain the circumstances for the denial or identify the data needed to determine the necessity of the ambulance transport (i.e., letter from the attending/ordering physician).

**Note:** We have also included the messages, which appear on the beneficiary's EOMB.

The information contained in this packet should help support the appropriateness of the denial (i.e., ambulance trip to doctor's office).

<b>Code</b>	<b>Message</b>
<b>C016</b>	<p>Claim/service lacks information that is needed for adjudication - <b>No Appeal Rights</b> (Incomplete/invalid street, city, state and/or zip code for the point of pickup) (Medicare does not pay for this service because the name and address of the hospital or other destination was not shown on the claim.)</p> <p><b>Note:</b> There are several reasons a claim may be rejected, a few examples listed above. All rejections <b>must</b> be resubmitted.</p>
<b>C057</b>	<p>Claim/service denied/reduced because the payer deems information submitted does not support this level of service, this many services, this length of service, or this dosage. (The information we have in your case does not support the need for extra help in the ambulance.) (The information we have in your case does not support the need for ambulance waiting time.) (The information we have in your case does not support the need for an air ambulance.)</p>
<b>C097</b>	<p>Payment is included in the allowance for the basic service/procedure. (This service is included in the total allowance for advanced life support transportation.)</p>
<b>C0112</b>	<p>Claim/service denied/reduced as not furnished directly to the patient and/or not documented. (Medicare coverage for ambulance transfers does not include payment for mileage when you're not in the ambulance.)</p>
<b>C0B15</b>	<p>Claim/service denied/reduced because this procedure/service is not paid separately.</p>

## Reason Codes and Review Requests (continued)

Code	Message
<b>PR46</b>	<p>This (these) service(s) is (are) not covered.</p> <p>(Medicare does not pay for ambulance service to or from a doctor’s office.)</p> <p>(Medicare does not pay for transportation in a wheelchair van.)</p> <p>(Medicare does not pay for transportation to any facility to be closer to home or family.)</p>
<b>PR50</b>	<p>These are non-covered services because this is not deemed a “medical necessity” by the payer.</p> <p>(The information we have in your case does not support the need for ambulance service.)</p> <p>(The information we have in your case does not support the need for this transportation.)</p>
<b>PR112</b>	<p>Claim/service denied/reduced as not furnished directly to the patient and/or not documented.</p>
<b>PR117</b>	<p>Claim/service denied/reduced because transportation is only covered to the closest facility that can provide the necessary care.</p> <p>(Medicare pays for transportation to the closest hospital or skilled nursing facility that can provide the necessary care.)</p>
<b>PRB6</b>	<p>This service/procedure is denied/reduced when performed/billed by this type of provider, by this type of provider in this type of facility, or by a provider of this specialty.</p> <p>(Medicare does not pay for this type of service by this ambulance supplier.)</p>
<b>PRB7</b>	<p>This provider was not certified for this procedure/service on this date of service.</p> <p>(Medicare does not pay for this because the ambulance is not approved by Medicare.)</p>
<b>PRB8</b>	<p>Claim/service not covered/reduced because alternative services were available and should have been utilized.</p> <p>(Medicare does not pay for this because you could have traveled another way.)</p>

## Important Notes Concerning Reason Codes

1. You may only bill the beneficiary for reason codes beginning with PR. This indicates “Patient Responsibility.” You **cannot** bill the beneficiary for other “reason” codes.
2. Any requests for redetermination should include the pertinent data necessary to make a payment determination.

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# Post-payment Audits/Trip Sheet Criteria

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Copies of trip sheets are occasionally requested, especially in the event of post-payment reviews. The documentation must substantiate the services billed to Medicare, including:

**Personal Information** Date, name, age/date of birth, patient location, chief complaint, brief past medical history.

**Origin and Destination** Full name of the facilities, such as hospital, emergency room, outpatient, lab, etc. Do not use abbreviations. Should additional information be needed, the appropriate facility must be easily identifiable.

**Medical Information** Mental and physical status **at the time** of ambulance arrival at the scene and during the transport.

**Special Procedures** EKG monitoring, oxygen, immobilization, intravenous, advanced life support, CPR, medications administered, etc.

**Note:** Any special procedure or service must be warranted by the patient's condition, symptom or complaint.

**Mileage** Beginning and ending odometer readings.

**Personnel** Names of attendants involved in the transport.

**Note:** Failure to provide requested documentation, or grant access to medical records, may result in the suspension of all Medicare payments and/or suspension from the Medicare Program.

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# Documentation Suggestions

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The following suggestions will help your claims to be processed in a more accurate and timely manner.

1. Indicate SNF, ICF or NH on every claim where a nursing home is indicated.
2. Clearly separate the patient's history and the reason they are being transported on that particular date. Only show the history that could affect payment of the transport. For example, do not include a history of diabetes, but do include a history of quadriplegia.
3. Indicate the dates, if known, of fractures (state if the fracture is stable or unstable), CVAs, MIs, etc.
4. For specialized repetitive non-emergency transports services such as dialysis, radiation therapy, CAT scans, physical therapy, chemotherapy, etc., please include all relevant information. Indicate why the patient had to travel by ambulance. Include completed copy of the "Certificate of Medical Necessity" with the claim for faster payment.
5. On EMC claims, use ICD-9 codes and the documentation field, whenever possible.

To avoid delay an/or denial, it is highly recommended, though not required, that a run sheet accompany all ambulance claims, especially those filed on CMS-1500 forms (CMS-1500 forms require sufficient information to determine that coverage criteria are met.)

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# Ambulance Claim Checklist

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Prior to sending your ambulance claims to Railroad Medicare, please review the checklist below to ensure proper documentation is submitted and to reduce claim denials.

The following documentation must be provided in order to be considered for payment:

1. Origin/destination: Must give the full name of all facilities (hospital, nursing home, etc.). Do not use abbreviations.
2. Identify if the patient was admitted, received emergency room care, was an outpatient, or discharged.
3. If the diagnosis is “possible” or “questionable,” give symptoms and/or complaints.
4. Indicate the reason why the patient was transported by ambulance.
5. Identify all tests and/or equipment needed.
6. If mileage is involved, indicate whether or not the facility was the closest available for the patient’s condition.
7. Use proper modifiers.
8. Identify why the patient was transferred. Identify the specialist, equipment and/or treatment that were not available at the original facility, as well as the admitting diagnosis (hospital to hospital transport).
9. Provide both the admitting diagnosis and the discharge diagnosis for the return trip when billing round-trip transports.
10. **All** information on or attached to the claim, including the “trip” or “run” sheet **must be legible.**
11. Please explain any non-standard abbreviations that may be used in your documentation (refer to the “Commonly Used Abbreviations” section in this guide, pages 24-26).

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# Coinsurance/Deductible

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## **EFFECT OF WAIVER OF COINSURANCE OR DEDUCTIBLE ON CARRIER DETERMINATIONS OF ACTUAL CHARGES AND CUSTOMARY CHARGES**

In determining the reasonable charge for an item or service, the following are considered:

- o The prevailing charge,
- o The customary charge of the supplier,
- o The actual charge made in a given case, and
- o The amount the supplier actually expects to receive from the patient and/or third party payer. (In this regard, a billed amount that is not reasonably related to an expectation of payment is not considered the “actual” charge for the purpose of processing a current claim or for the purpose of determining customary charges.)

Some billing practices may constitute a violation of the law pertaining to false claims and kickbacks. For example:

A supplier who **routinely and consistently** waives the collection of coinsurance and/or deductible amounts from, or on behalf of, Medicare beneficiaries may be subject to a reduction of their actual charges.

Failure to collect coinsurance and/or deductible amounts, **after a reasonable collection effort**, does not subject a supplier to a reduction in their charges.

**Note:** To be considered a reasonable collection effort, the effort to collect Medicare coinsurance/deductible amounts must be similar to the effort made to collect comparable amounts from non-Medicare patients. It must also involve the issuance of a bill to the beneficiary or to the party responsible for the patient’s personal financial obligations.