



WPS Medicare Ambulance Guide

MEDICARE AMBULANCE GUIDELINES

AMBULANCE DOCUMENTATION



**PRESENTED BY
MEDICARE PROVIDER EDUCATION
WISCONSIN PHYSICIANS SERVICE**

A CMS contractor serving
WISCONSIN, ILLINOIS, MICHIGAN, MINNESOTA,
IOWA, KANSAS, NEBRASKA, MISSOURI
UNITED STATES AND THE U.S. VIRGIN ISLANDS



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Disclaimer

The information contained in this guidebook has been designed as guidance only. The information contained on the Centers for Medicare & Medicaid Services (CMS) Website, publications, and other sources overrides any information that may be different in the guidebook.

This guide is a tool to assist providers. Every reasonable effort was made to ensure the accuracy of the information. However, the provider has the ultimate responsibility for correct submission of claims. WPS Medicare bears no liability for results or consequences of any misuse of the information.

WHAT MEDICARE COVERS

The Centers for Medicare and Medicaid Services (CMS) Medicare Benefit Policy Internet-Only Manual (IOM) Pub. 100-02, Chapter 10, Sections 10.1, 10.2, and 10.3 (Section 10.4 for air ambulance only) define when Medicare covers ambulance trips when certain conditions are met. The IOM is available at <http://www.cms.hhs.gov/manuals/Downloads/bp102c10.pdf> on the CMS Website.

1. The ambulance meets Medicare rules for the vehicle, crew, and supplies. (See Vehicle and Crew Requirements)
2. The patient is picked up from and taken to certain places. In most cases, Medicare covers only transport to a hospital or a skilled nursing facility. (See Distance and Destination)
3. The ambulance trip is medically necessary because it is the only way to safely move a patient. (See Medical Necessity)

COVERAGE EXCLUSIONS

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

- Medi-Car, Medi-Van, or wheelchair ambulance services.
- Trips to a funeral home.
- Trips made for services such as drawing blood and catheterization which could have been provided at the patient's location.
- Transportation of a beneficiary pronounced dead before the ambulance was called. (See Ambulance Services for a Deceased Beneficiary)
- Ambulance service to a physician's office unless;
 - a) the trip was to a hospital but stopped at a physician's office due to an urgent need for medical attention, or
 - b) an otherwise covered round trip is made from a skilled nursing facility to a physician's office for diagnostic or therapeutic services not available at the skilled nursing facility. However, the cost must be less than bringing the service to the patient.
- Inpatient round trips - when a patient is taken from a hospital to another facility and returned to the same hospital on the same day without a discharge. The hospital will bill Medicare Part A.
- Non transport (See Ambulance Services for a Deceased Beneficiary). The Medicare ambulance benefit is a transportation benefit. If no transport of a Medicare patient occurs, then there is no Medicare-covered service. This applies to situations where the beneficiary refuses to be transported, even if medical services are provided prior to loading the beneficiary on the ambulance.

If a supplier has provided one of the above listed coverage exclusions, a claim does not have to be submitted to Medicare unless the patient requests it. If the

service is submitted to Medicare, include modifier GY for statutorily excluded service. However, the supplier can bill the patient for the non-covered services.

An Advance Beneficiary Notice of Non-Coverage (ABN form CMS-R-131) is **optional in this situation** to assist suppliers in informing beneficiaries that the services they are receiving are excluded from Medicare benefits. The ABN can be accessed at <http://www.cms.hhs.gov/BNI>.

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DOCUMENTATION REQUIREMENTS FOR AMBULANCE PROVIDERS

Medical record documentation is the key for reimbursement of all ambulance services. It serves as interaction to other healthcare professionals involved in the patient's care. It also is required to record pertinent facts, findings and observations of the patient. The healthcare environment we are living in has put greater pressure on providers to document at a more specific and more consistent level. Ambulance providers are no exception to this higher expectation. The foundation of excellence in patient care is partly dependent on legible documentation.

Medicare and other payers have certain documentation requirements. Payers have contractual agreements to enrollees that mandate reasonable documentation be present to allow coverage of the services provided. They may need to request information that validates site of service, medical necessity of the service provided, and verifies if services have been accurately reported.

Medicare strongly encourages a detailed documentation policy be placed within ambulance compliance programs. The compliance program would also serve as an educational component for those who receive and track documentation for various payers.

One of the most important elements of medical record documentation is that the medical record should always be complete and legible. Various national healthcare organizations state that they believe that the fundamental reason for maintaining an adequate medical record is its contribution to the high quality of medical care. It is the transfer of care from one provider to another that is linked by documentation resulting in continuity for the patient.

Ambulance providers work with three core data elements when documenting. They provide **clinical** information that documents the patient's condition and care and services that were provided. They provide

operational information that captures the patient's demographics, how the call for service was received, and its response type. The **reimbursement** category includes all information regarding the payment source for services rendered.

Clinical documentation includes:

- * patient presentation,
- * patient complaint,
- * history of present illness,
- * past history,
- * family history,
- * medications,
- * allergies,
- * relevant social history,
- * physical assessment,
- * clinical impression,
- * treatments,
- * method of transfer,
- * changes in patient status, and
- * transfer of care.

Operational documentation includes:

- * address where patient was found,
- * city, county, state,
- * name of person who initiated call,
- * call source,
- * type of location where incident occurred,
- * date of incident,
- * chief complaint,
- * nature of call with related response,
- * time of the event,
- * response mode,
- * service type,
- * incident number,
- * response number,
- * patient record number,
- * agency and unit number,
- * vehicle type,
- * crew members,
- * transport mode,
- * destination type,
- * mileage, and
- * patient disposition.

Reimbursement documentation includes:

- * demographic information,

- ★ insurance information,
- ★ prior authorization, (not applicable for Medicare)
- ★ Physician Certification Statement,
- ★ patient signatures,
- ★ responsible party,
- ★ service levels, and
- ★ medical necessity.

It is very important, when documenting ambulance services, that each individual encounter note is a stand-alone entry. It must clearly document the medical necessity of all the services provided on that particular billing date. It is well known that ambulance services are defined differently by different insurers. Therefore, there is no clear universal medical necessity standard. Medicare does say in the Internet Only Manual 100-02 Chapter 10 Section 10.2.1 that “Medical necessity is established when the patient's condition is such that use of any other method of transportation is contraindicated.”

Approaching ambulance documentation in an organized manner allows the record to appear complete, accurate, objective, readable, and capture any exceptions. With these entries, the Patient Care Report (PCR) is used to determine appropriate continuous care.

The basis of a narrative piece of ambulance documentation is the chief complaint. When this is documented, the ongoing narrative flows in an organized manner to sequence issues that transpired with the patient from time of pick up to the time of turn over.

With all that in mind, the ambulance staff member that is documenting the service needs to be aware that this is also a legal document. This is why complete documentation is so important. It reduces liability. One also needs to be aware that every documented element for the service provided is confidential. Medical records must be treated with the highest degree of confidentiality. Ongoing quality improvement in all aspects of an ambulance service operation is imperative. Training and reminding crewmembers of the importance of documentation will only increase the level of service provided to your patients and will assist your company in receiving correct and accurate reimbursement. A critical look at current documentation levels can only assist providers in knowing where training would be most effective.

A great way to check your own documentation is to ask yourself several questions. Is my documentation legible? Did I document in proper sequence? Did I complete all necessary paperwork? Did I sign my entry? Are my abbreviations understandable?

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DOCUMENTATION REQUIREMENTS

All ambulance trips must be documented. Consider a trip to one location followed by a return trip to the original location as two separate ambulance trips and maintain separate documentation. If the pick-up ZIP codes are different, then submit the trips on separate claims. Details of the patient's condition, services rendered and times and mileage for all trips must be documented.

Reminders:

- Use only current modifiers
- Include the National Provider Identifier of the referring/ordering physician in the documentation for scheduled non-emergency transport (typically on the Physician Certification Statement (PCS))
- Documentation may be requested to support medical necessity in the following situations (not an all inclusive list):
 - More than two trips on the same day (same provider or different providers)
 - Two trips with the same or like origin/destination (same provider or different providers)
 - Two transfers on the same day
- Documentation that may be requested (not an all inclusive list):
 - Run sheets for each trip, including times and mileage.
 - Hospital records.
 - Patient's condition at first encounter: i.e.: unconscious, bed-confined before and after trip, severe hemorrhaging, etc.
 - How patient was found: i.e.: lying on floor, walking, etc.
 - Physician written order for transport (if non-emergency physician ordered)
 - Trip record to include:
 - Detailed statement of the condition necessitating the ambulance
 - Point of origin (identify place and complete address)
 - Detailed documentation of condition during transfer
 - Point of destination (name of facility, complete address)
 - Number of loaded miles/cost per mile/mileage charge
 - Minimal or base charge and charge for special items or services with an explanation
 - Statement if patient was admitted as an inpatient

- Certification and rationale of necessity for non-emergent transfers
- Certification of bed confinement if applicable
- Any further documentation that supports medical necessity of air and/or ground ambulance transport (i.e. emergency room report)

Different states and Emergency Medical Services (EMS) Boards use different forms to record information. Medicare does not require any particular form as long as it documents the patient's condition and the services provided.

VEHICLE AND CREW REQUIREMENTS

CMS IOM 100-02 Chapter 10 Section 10.1 specifies the Medicare ambulance vehicle and crew requirements. The IOM is available at <http://www.cms.hhs.gov/manuals/Downloads/bp102c10.pdf> on the CMS Website.

Vehicle

CMS states:

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

- Must have customary patient care equipment including:
 - Stretcher
 - Clean linens
 - Emergency medical supplies
 - Oxygen equipment
 - Other safety and lifesaving equipment
- Vehicle must be equipped with:
 - Warning lights
 - Sirens
 - Telecommunications equipment required by state or local law

Crew

The ambulance crew must consist of at least two crewmembers.

At least one crewmember must have first aid training minimally equivalent to that provided by the standard and advanced Red Cross first aid courses.

Basic Life Support (BLS)

- Must be staffed by at least two people.
- At least one person must be an Emergency Medical Technician (EMT).
- EMT must be certified by the state.
- EMT must be legally able to operate all lifesaving and life-sustaining equipment.

Advanced Life Support (ALS)

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

Certification

- Contractors can accept the supplier's statement concerning compliance.
- Provider Enrollment forms will capture all needed information.
- Contractors will keep all information on file.
- Re-inspection and certification documentation must be submitted to the contractor.
- Contractors can perform on-site inspection if necessary.

MEDICAL NECESSITY REQUIREMENTS

CMS IOM 100-02 Chapter 10 Section 10.2 covers Medical Necessity. The IOM is available at <http://www.cms.hhs.gov/manuals/Downloads/bp102c10.pdf> on the CMS Website.

Medical necessity for payment of an ambulance trip is established when the patient's condition is such that the use of any other method of transportation is contraindicated. This is interpreted as:

- The patient's condition would be jeopardized if he/she was not transported by ambulance,
- The patient must lie flat or otherwise be immobilized or is incapable of sitting up unassisted, or
- The patient requires a service (e.g. intravenous drugs) that is available in the ambulance but not in a vehicle such as a private automobile, taxi, or Medi-car.

Chest or abdominal pain, headache, dizziness, loss of consciousness or a nosebleed **could** be symptomatic of a more serious condition and would fit into the first category.

Many fractures fit the second category and require immobilization by a professional to prevent complications.

However, when a patient is released from the hospital, most return trips are not medically necessary. The patient's condition must necessitate an ambulance.

Wheelchair bound does not, alone, demonstrate medical necessity. A wheelchair bound patient who can sit up unassisted would not fall into any category and medical necessity would not be met.

Reasons such as “there was no other way to get there” or “the physician ordered it” do not make an ambulance trip payable.

One or more of the following conditions establishes medical necessity:

- The patient was transported in an emergency situation as a result of an accident, injury, or an acute illness.
- The patient was unconscious or in a state of shock.
- The patient suffered a heart attack or stroke.
- The patient was severely hemorrhaging.
- The patient required oxygen or other emergency treatment while being transported. (Oxygen use needs to show medical necessity and alone does not establish medical necessity for the transport.)
- The patient was completely bed-confined before and after the ambulance trip or could be moved only by stretcher. (Documentation should indicate why.)
- The patient's condition required the use of restraints.
- The patient had to remain immobile due to an unset fracture or the possibility of a fracture.

Terms such as bedridden, bed-confined, stretcher patient or required restraints do not, by themselves, support medical necessity. The determining factor is the condition of the patient. If the patient's condition does not contraindicate other means of transportation, then medical necessity is not met. This is not a Limitation of Liability denial. This is a coverage issue.

NOTE:

“Bed confined” as defined by CMS states that the beneficiary is:

“Unable to get up from bed without assistance; unable to ambulate; and is unable to sit in a chair or wheelchair.”

The term “bed confined: is not synonymous with “bed rest” or “nonambulatory.” In addition, “bed confined” is not meant to be the sole criterion to be used in determining medical necessity. It is one factor to be considered when making medical necessity determinations.

Situations that may be considered “bed confined” are:

- Contractures creating non-ambulatory status in a patient who cannot sit,
- Severe generalized weakness,

- Immobility of lower extremities (patient in spic cast, fixed hip joints, or lower extremity paralysis) in a patient who is unable to be moved by wheelchair.

Non-Emergency Transport

According to 42CFR Chapter IV, section 410.40 non-emergency transportation by an ambulance is appropriate when the following are met:

- *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 an ambulance is medically required.*

Reasonableness of Ambulance Trip

Payment for ambulance services is made according to the level of services provided to the beneficiary (provided they were medically necessary) and not based on the vehicle used.

Transport for Special Services

Ambulance services are covered when the beneficiary is transported to the nearest medical facility to obtain necessary diagnostic and/or therapeutic services (ex. CT scan or Cobalt therapy) as well as the return transport. In addition, to the all other requirements, this transport situation is covered only to the extent that would be necessary to bring the services to the patient. (*Pub 100-2, Chap. 10, Section 10.3*).

NON-COVERED AMBULANCE SERVICES

Statutorily excluded ambulance transports such as those listed on page 4 do not have to be submitted to Medicare unless the patient requests it. All other services should be submitted to Medicare.

Services where the patient's condition or the circumstances do not warrant Medicare payment for ambulance transport should be billed as "request for denial only" with a short description and Modifier **GY**.

Modifier **GY** indicates "item or service statutorily excluded or does not meet the definition of any Medicare benefit". The services are specifically excluded based on rules and regulations set forth by a Medicare governing body. Modifier **GY** will cause the claim to deny with the patient liable for the charges. These denials can be appealed by either the provider/supplier or beneficiary. If Medicare determines that the services are payable during the appeals process, the **GY** modifier is irrelevant. The provider cannot collect amounts above the co-insurance and deductible or the Limiting Charge amount.

DIAGNOSIS CODING

CMS Medicare Claims Processing IOM 100-04 Chapter 15 Section 40 covers the medical condition code list. The IOM is available at <http://www.cms.hhs.gov/manuals/downloads/clm104c15.pdf> on the CMS Website.

Iowa, Kansas, Missouri, and Nebraska Part B WPS Medicare Diagnosis and Medical condition code list article:
http://www.wpsmedicare.com/j5macpartb/training/resources/provider_types/medicodesamb.shtml

Illinois, Michigan, Minnesota, and Wisconsin Part B WPS Medicare Diagnosis and Medical condition code list article:

- Ambulance suppliers are not required to submit diagnosis codes on the CMS 1500 form.
- Diagnosis Codes generally do not trigger a payment or a denial of a claim.
- Emergency medical technicians cannot diagnose, but they can code what they observed such as respiratory distress (786.09).

The medical conditions list is an educational guideline. It is intended to assist in communicating a patient's condition to the Medicare contractor. Use of the medical condition list does not guarantee payment of the claim or level of service. It is the responsibility of the ambulance service to maintain adequate documentation of dispatch instructions, patient condition, other scene information and details of the transport. Documentation may be used by the contractor or other oversight authority for medical review and determination of medical necessity.

If you choose to use a diagnosis code, follow the guidance provided below.

Coding Basics

The designated diagnosis coding system of WPS is the International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM), Fourth Edition, Volumes 1 and 2 as published by Practice Management Information Corporation (PMIC).

The ICD-9-CM system is composed of codes with three, four or five digits. Three-digit codes are used as stand alone codes or as the heading of a category of codes that are further subdivided by the use of fourth or fifth digits that provide greater specificity.

ICD-9-CM Coding Guidelines

First, reference the ICD-9-CM alphabetical index, (Volume 2) that is arranged by condition. After you locate the code in the index, go to Volume 1 to be certain that the code “fits.” The ICD-9-CM code must be appropriate for the patient’s gender and age.

Up to four ICD-9-CM codes can be entered on your Medicare B claim:

- Report first the diagnosis, condition, symptom or problem shown in the medical record to be chiefly responsible for the services provided that day.
- Report additional codes that describe any current co-existing conditions being treated.

To link a diagnosis code to the procedure code, list the reference number in the appropriate claim field. Link to one diagnosis only!

For paper submitters, the reference number from Item 21 (1 or 2 or 3 or 4) is then indicated in Item 24e; the diagnosis code should be listed in Item 21 only.

For electronic billers using ANSI 837 version 4010A1, the reference number should be located in the Loop 2300 and Data Element Principle Diagnosis Code, Diagnosis Code.

Truncated Codes

Truncated codes are ICD-9-CM codes submitted without the appropriate fourth or fifth digit. For example, code 428, *Heart failure*, should not be used when the patient’s condition is more correctly described by 428.0, *Congestive heart failure*.

- Assigned claims submitted with truncated diagnosis codes are denied as unprocessable.

To avoid the use of truncated codes, use the code at its highest level of specificity (as shown in the current ICD-9 coding manual):

- Assign three-digit codes only if there are no four-digit codes within that code category,
- Assign four-digit codes only if there are no fifth-digit sub classifications for that category, and
- Assign the five-digit sub classification code for those categories only where it exists.

DISTANCE AND DESTINATION REQUIREMENTS

CMS IOM 100-02 Chapter 10 Section 10.3 covers appropriate destination information for ambulance transports. The IOM is available at <http://www.cms.hhs.gov/manuals/Downloads/bp102c10.pdf> on the CMS Website.

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. Local refers to transportation within the surrounding area or the institution from which individuals are expected to come for hospital or skilled nursing care.

When the beneficiary is taken beyond the local area, full payment is made only if the evidence clearly establishes the beneficiary was taken to the nearest appropriate facility.

The term nearest appropriate facility means that the institution is generally equipped to provide the needed care. A physician or physician specialist who can provide the care required for the patient's condition must be available.

Ambulance transportation to a more distant hospital, solely to obtain the services of a specific physician, does not determine the more distant hospital to be the closest appropriate facility and nor does a more distant hospital that is better equipped (qualitative or quantitative) warrant that a closer institution does not have "appropriate facilities".

An institution must have a bed available to be considered the nearest appropriate facility. The contractor assumes that beds are available unless evidence is provided to the contrary.

Ambulance transportation from hospital discharge to hospital admission or skilled nursing facility (SNF) discharge to SNF admission may be covered if:

- The discharging institution does not have appropriate facilities.
- The admitting institution is the nearest and the most appropriate facility.
- The transportation is medically necessary.

Ambulance service from a hospital or SNF to the beneficiary's home may be covered if:

- The home is within the local transportation area.
- The discharging institution is the closest appropriate facility.
- The trip is medically necessary

When submitting a claim for a payable ambulance transport to a facility that is not the nearest facility, please include the following information:

- Name of facility that was bypassed because services were not available there (electronically: this should be given following the reason for transport.)
- The specific service (s) or physician specialty that was not available at the nearest facility and what the patient needed (electronically: this should be entered in the reason for the transport).
- The name, complete address, and type of facility where the transport started and ended.
- The mileage of the trip.

ORIGIN AND DESTINATION MODIFIERS

The CMS IOM 100-04 Chapter 15 Section 30A covers the use of origin and destination modifiers. The IOM is available at <http://www.cms.hhs.gov/manuals/downloads/clm104c15.pdf> on the CMS Website.

Ambulance claims must include origin and destination modifiers. The origin modifier should be placed in the first modifier position (A0428**RH**) and the destination modifier in the second position. A list of these modifiers and their descriptions follow:

Modifier	Description
D	Diagnostic or therapeutic site other than P or H when these are used as origin codes
E	Residential, domiciliary, custodial facility (other than 1819 facility)
G	Hospital based ESRD facility
H	Hospital
I	Site of transfer (e.g. airport or helicopter pad) between modes of ambulance transport
J	Freestanding ESRD facility
N	Skilled nursing facility
P	Physician's office
R	Residence
S	Scene of accident or acute event
X	Intermediate stop at physician's office on way to hospital (destination code only)

For Part A:

Institutional based providers must also report one of the following modifiers with every HCPCS code to describe whether the service was provided under the arrangement or directly:

- QM: provided under arrangement by a provider of services
- QV: furnished directly by a provider of services

The combinations of these items may duplicate other HCPCS modifiers, when billed with an ambulance transportation code. The reported modifiers can only indicate origin/destination.

(D) Diagnostic or therapeutic site

A building or portion of a building equipped for the sole purpose of providing diagnostic or therapeutic services.

(E) Residential, domiciliary, custodial facility

The facility providing room, board, and other personal assistance services on a long-term basis and does not include a medical component.

(G) Hospital based ESRD facility

A dialysis unit contained within a hospital, or located adjacent to a hospital.

(H) Hospital

A building or portion of a building used to treat patients that are sick or injured. The building must contain medically equipped care rooms for overnight stays.

(I) Site of transfer

Ground ambulance suppliers who transport patients to or from I (site of transfer) need to supply the following information:

- Patient's condition
- Reason for air involvement
- Circumstances, i.e., hospital to hospital transfer, scene of accident to landing area
- Hospital records of transfer if applicable
- Transfer form
- Information on all legs of the trip

(J) Freestanding ESRD Facility

A dialysis facility not located within or adjacent to a hospital.

(N) Skilled Facility Defined

The facility provides skilled nursing care and related services to inpatients that require medical or nursing care, or rehabilitation services for the rehabilitation of injured, disabled or sick persons. Communicate with the facility for determination.

(P) Physician's Office Defined

Physician offices, free standing diagnostic or therapeutic sites, clinics and urgent care center. If in doubt, ask the facility how they classify the patient's status. For ambulance billing, Urgent Care Facilities, Ambulatory Surgical Centers, and other similar types of organizations are considered a physician's office. The appropriate origin and destination modifier is "P".

The physical building of a hospital could include several different types of facilities: nursing home beds, skilled facility beds, observation care beds, outpatient, emergency room, inpatient and clinic. A supplier should verify how the facility classifies the patient to determine the appropriate origin and destination modifiers.

A trip to a physician's office is not covered unless:

- The trip was to a hospital but stopped at a physician's office due to an urgent need for medical attention, (O/D Modifier X) or
- An otherwise covered round trip is made from a skilled nursing facility to a physician's office for diagnostic or therapeutic services not available at the skilled nursing facility. However, the cost must be less than bringing the service to the patient. (O/D Modifier D)

(S) Scene of accident or acute event

(X) Intermediate stop at physician's office on way to hospital (destination code only)

A physician office used to treat a patient in an emergency setting. This is an interim stop only used when the patient is in such distress that stopping at a physician's office on the way to the hospital is in the best interest of the patient.

(R) Residence

This is the place where the patient makes his/her home and dwells permanently.

ZIP CODE/ POINT OF PICKUP

The ZIP Code/ Point of Pickup (POP) requirements are located CMS IOM 100-04 Chapter 15 Section 20.1.5. To view the ZIP code requirements visit <http://www.cms.hhs.gov/manuals/downloads/clm104c15.pdf> on the CMS Website.

All claims for services after January 1, 2001 must include the zip code for the point of pickup. Only one zip code can be reported on each claim. Zip codes

must be valid and accurate. Invalid zip codes will cause the claim to be returned as unprocessable.

For Part A use the CMS 1450/UB-04 form, add the ZIP code in the Value Code field in Form Locators 39-41.

For Part B use Box 23 of the CMS 1500 form or ANSI version X-12N837 (4010) loop 2310D in field N403.

The POP determines the basis for payment under the FS (fee schedule), and the POP is reported by its 5-digit ZIP code. Thus, the ZIP code of the POP determines both the applicable Geographical Price Cost Index (GPCI) and whether a rural adjustment applies. If the ambulance transport required a second or subsequent leg, then the ZIP code of the POP of the second or subsequent leg determines both the applicable GPCI for such leg and whether a rural adjustment applies to such leg. Accordingly, the ZIP code of the POP must be reported on every claim to determine both the correct GPCI and, if applicable, any rural adjustment. Part B Contractors must report the POP ZIP code, at the line item level, to CWF when they report all other ambulance claim information. CWF must report the POP ZIP code to the national claims history file, along with the rest of the ambulance claims record.

The zip codes public use files are on the CMS Website located at <http://www.cms.hhs.gov/AmbulanceFeeSchedule> under Downloads. The correct file is the National Breakout of the Geographical Area Definitions by ZIP Code.

For point of pickup outside the United States or in United States territorial waters, suppliers should report the point of pickup zip codes according to the following:

- For ground or air transport outside of the United States to a drop off outside of the United States (in Canada or Mexico), use the closest United States zip code to the actual point of pickup.
- For water transport from the territorial waters of the United States to the United States, use the zip code for the point of entry.
- For ground transport from Canada to Mexico to the United States, use the zip code at the United States border at the point of entry into the United States.
- For air transport from areas outside the United States to the United States, use the zip code at the border at the point of crossing into the United States.

It is the supplier's responsibility to determine the accurate zip code to use for the point of pickup. Some areas do not have a zip code assigned. Suppliers should verify with the United States Post Office or other authoritative source that no zip code exists. If that is the case, then the nearest zip code to the point of pickup

should be used. Suppliers should annotate the claim "Surrogate zip code: POP in No-Zip".

All new zip codes are considered urban until otherwise designated by the Center for Medicare and Medicaid Services (CMS). CMS provides the contractor with two separate ambulance files:

1. National ZIP Code file located at <http://www.cms.hhs.gov/center/ambulance.asp> under Coding / Billing / Payment entitled ZIP code to Carrier Locality File
2. National Ambulance Fee Schedule file at http://www.cms.hhs.gov/AmbulanceFeeSchedule/01_overview.asp#TopOfPage under downloads and entitled National Breakout of the Geographical Area Definitions by ZIP Code.

MANDATORY ASSIGNMENT

CMS IOM 100-02 Chapter 10 Section 20.1 located at <http://www.cms.hhs.gov/manuals/Downloads/bp102c10.pdf> states:

When an ambulance provider/supplier, or a third party under contract with the provider/supplier, furnishes a Medicare-covered ambulance service to a Medicare beneficiary and the service is not statutorily excluded under the particular circumstances, the provider/supplier must submit a claim to Medicare and accept assignment of the beneficiary's right to payment from Medicare.

CMS IOM 100-04 Chapter 1 Section 30.3.1 located at <http://www.cms.hhs.gov/manuals/downloads/clm104c01.pdf> states:

The following practitioners who provide services under the Medicare program are required to accept assignment for all Medicare claims for their services. This means that they must accept the Medicare allowed amount as payment in full for their practitioner services. The beneficiary's liability is limited to any applicable deductible plus the 20 percent coinsurance.

Ambulance suppliers are listed in the section mandating assignment the follows the above statement.

The assignment agreement is binding. If the deductible or co-insurance amounts are not known, it is advisable to wait for the Remittance Notice before collecting from the patient.

PATIENT SIGNATURE

CMS IOM 100-02 Chapter 10 Section 20.1.2 is located at <http://www.cms.hhs.gov/manuals/Downloads/bp102c10.pdf> and explains the patient signature requirements and states:

Medicare requires the signature of the beneficiary, or that of his or her representative, for both the purpose of accepting assignment and submitting a claim to Medicare.

The section further defines who is able to sign if the beneficiary is unable to sign:

- 1) *The beneficiary's legal guardian.*
- 2) *A relative or other person who receives social security or other governmental benefits on behalf of the beneficiary.*
- 3) *A relative or other person who arranges for the beneficiary's treatment or exercises other responsibility for his or her affairs.*
- 4) *A representative of an agency or institution that did not furnish the services for which payment is claimed, but furnished other care, services, or assistance to the beneficiary.*
- 5) *A representative of the provider or of the nonparticipating hospital claiming payment for services it has furnished, if the provider or nonparticipating hospital is unable to have the claim signed in accordance with 42 CFR 424.36(b) (1 – 4).*
- 6) *A representative of the ambulance provider or supplier who is present during an emergency and/or nonemergency transport, provided that the ambulance provider or supplier maintains certain documentation in its records for at least 4 years from the date of service. A provider/supplier (or his/her employee) cannot request payment for services furnished except under circumstances fully documented to show that the beneficiary is unable to sign and that there is no other person who could sign.*

The IOM allows for signature to be obtained after the transport, but prior to submitting to the claim.

Other recommendations:

- 1) If a beneficiary refuses to sign a permission form to submit medical information to Medicare Part B for payment, the provider may refuse services or document the beneficiary's refusal to sign and hold the beneficiary responsible for the cost of the service.
- 2) This Signature on File requirement applies to providers submitting claims either electronically or on paper CMS-1500 forms.
- 3) If Medicare Part B should request further documentation from a provider in order to process or review a claim, the original signature on file card does give permission for additional transmission of information.

- 4) Providers who have been using a blank 1500 claim form signed by the beneficiary as permission to send all future claims to Medicare must replace this with a valid form that follows the instructions in the Medicare Contractors Manual.

If the patient is unable to sign, the signature documentation must contain the representative's name, address, and relationship to the patient and the reason the patient cannot sign. When a person signs by a mark, a witness must include his/her name and address.

This also applies to crewmembers if no one else is available. The claims should indicate:

- No one else is available
- Reason the patient is unable to sign
- Name, address and company

For services furnished to inpatients of a hospital, or SNF, the request is effective for the period of confinement. For services furnished by an HHA under a plan of treatment, the request is effective for the plan of treatment. For other services, the request is effective until revoked. If a patient objects to part of the request for payment, the provider should annotate the statement accordingly. Providers should refer to CMS IOM 100-04, Chapter 1, and Section 50.1.2 for patient signature information required for all providers.

JURISDICTION

The contractor that should process a claim is currently based on where one or multiple vehicles are garaged or housed. Jurisdiction is located in IOM 100-04 Chapter 15 Section 20.1.2 located at <http://www.cms.hhs.gov/manuals/downloads/clm104c15.pdf> on the CMS Website.

One Vehicle – Claims jurisdiction for suppliers is considered to be where the ambulance vehicle is garaged or hangared. Claims jurisdiction for institutional based providers is based on the primary location of the institution.

MILEAGE

IOM 100-04 Chapter 15 Section 20.2 located at <http://www.cms.hhs.gov/manuals/downloads/clm104c15.pdf> on the Website indicates only loaded mileage (patient is on board) can be covered.

IOM 100-02 Chapter 10 Section 10.3 located at <http://www.cms.hhs.gov/manuals/Downloads/bp102c10.pdf> indicates

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.

Patients should be transported to the closest appropriate facility. Closest appropriate facility means a facility capable of treating the patient's condition.

IOM 100-04 Chapter 15 Section 30.1.2 located at <http://www.cms.hhs.gov/manuals/downloads/clm104c15.pdf> indicates miles should be submitted in whole numbers. Always round up. One line of services can contain up to 999 miles.

WPS Medicare believes that odometer readings provide the most accurate documentation for mileage charges. If you are unable to provide beginning and ending miles, then electronic mapping software or trip odometers can be used as an alternate source of mileage. If you are using an alternate source of mileage, it is a best practice to provide an explanation as to why you are doing so.

Code A0425 should be used for all ground and water miles. There is no separation for BLS and ALS. Air ambulance should report statute miles with procedure codes A0435 (Fixed Wing) or A0436 (Rotary Wing).

Transports past the closest appropriate facility should be billed with A0888 (Noncovered ambulance mileage). This could be for a patient or physician preference. This code is non-covered and is a patient liability.

CATEGORIES OF AMBULANCE SERVICES

IOM 100-04 Chapter 15, Section 30B located at <http://www.cms.hhs.gov/manuals/downloads/clm104c15.pdf> defines the HCPCS codes billable for Medicare ambulance services. The full definitions are from the HCPCS procedure codebook. CMS provides definitions for service type in IOM 100-02 Chapter 10 Section 30.1 located at <http://www.cms.hhs.gov/manuals/Downloads/bp102c10.pdf>

Ground Ambulance Services

There are seven categories of ground ambulance services and two categories of air ambulance services under the fee schedule. ("Ground" refers to both land and water transportation.) The level of service is determined based on the patient condition, not the vehicle used.

A0428 - Ambulance service, basic life support, non-emergency transport (BLS)

Basic Life Support (BLS) is transportation by ground ambulance vehicle and of medically necessary supplies and services, plus the provision of BLS ambulance services. The ambulance must be staffed by an individual who is qualified in accordance with State and local laws as an emergency medical technician-basic (EMT-Basic). These laws may vary from State to State. For example, only in some states in an EMT-Basic permitted to operate limited equipment on board the vehicle, assist more qualified personnel in performing assessments and interventions and establish a peripheral intravenous (IV) line.

A0429 - Ambulance service, basic life support, emergency transport (BLS emergency)

The Basic Life Support – When medically necessary, the provision of BLS services, as specified above, in the context of an 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.

A0426 - Ambulance service, advanced life support, non-emergency transport, level 1 (ALS1)

Advanced life support, level 1 (ALS1) is the transportation by ground ambulance vehicle and the provision of medically necessary supplies and services including the provision of an ALS assessment or at least one ALS intervention.

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

An advanced life support (ALS) intervention is a procedure that is in accordance with State and local laws, required to be done by an emergency medical technician-intermediate (EMT-Intermediate) or EMT-Paramedic. An ALS intervention must be medically necessary to qualify as an intervention for payment for an ALS level of service. An ALS intervention applies only to ground transports.

Advanced life support personnel means an individual trained to the level of the emergency medical technician – intermediate (EMT-Intermediate) or paramedic. The EMT-Intermediate is defined as an individual who is qualified, in accordance with State and local laws, as an EMT-Basic and who is also qualified in accordance with State and local laws to perform essential advanced techniques and to administer a limited number of medications.

The EMT-Paramedic is defined as possessing the qualifications of the EMTIntermediate and also, in accordance with State and local laws, as having enhanced skills that includes being able to administer additional interventions and medications.

A0427 -Ambulance service, advanced life support, emergency transport, level 1 (ALS1- emergency)

The Advanced Life Support, Level 1 - Emergency response category is defined as the provision of ALS1 services as specified above, in the context of an emergency response.

Emergency response means responding immediately at the BLS or ALS1 level of service to a 911 call or the equivalent in areas without a 911 call system. An immediate response is one in which the ambulance supplier begins as quickly as possible to take the steps necessary to respond to the call.

A0432 - Paramedic Intercept (PI)

Paramedic Intercept services are ALS services provided by an entity that does not provide the ambulance transport. This type of service is most often provided for an emergency ambulance transport in which a local volunteer ambulance that can provide only basic life support (BLS) level of service is dispatched to transport a patient. If the patient needs ALS services such as EKG monitoring, chest decompression, or I.V. therapy, another entity dispatches a paramedic to meet the BLS ambulance at the scene or once the ambulance is on the way to the hospital. The ALS paramedics then provide services to the patient.

A0433 - Advanced Life Support, Level 2 (ALS2)

The Advanced Life Support, Level 2 category is:

- 1) Three or more different administrations of medications by intravenous push/bolus or by continuous infusion excluding crystalloid, hypotonic, isotonic, and hypertonic solutions (Dextrose, Normal Saline, Ringer's Lactate), or transportation, medically necessary supplies and services.
- 2) The provision of at least one of the following ALS procedures:
 - Manual defibrillation/cardioversion
 - Endotracheal intubation (The monitoring and maintenance of an endotracheal tube that was previously inserted prior to the transport also qualifies as an ALS2 procedure.)
 - Central venous line
 - Cardiac pacing
 - Chest decompression
 - Surgical airway

- Intraosseous line

A0434 - Specialty Care Transport (SCT)

SCT is an inter-facility 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 provided 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.)

Note:

A0425 - Ground Mileage, per statute mile

AIR AMBULANCE SERVICES

The CMS IOM 100-02 Chapter 10 Section 10.4 addresses air ambulance transport. The IOM is located at <http://www.cms.hhs.gov/manuals/Downloads/bp102c10.pdf> on the CMS Website.

For additional information on air ambulance visit CMS IOM 100-04 Chapter 15 Section 20.3. The IOM is located at <http://www.cms.hhs.gov/manuals/downloads/clm104c15.pdf> on the CMS Website.

Medical reasonableness is only established when the beneficiary's condition is such that the time needed to transport a beneficiary by ground, or the instability of transportation by ground, poses a threat to the beneficiary's survival or seriously endangers the beneficiary's health. Following is an advisory list of examples of cases for which air ambulance could be justified. The list is not inclusive of all situations that justify air transportation, nor is it intended to justify air transportation in all locales in the circumstances listed.

- a) Intracranial bleeding - requiring neurosurgical intervention.
- b) Cardiogenic shock.
- c) Burns requiring treatment in a Burn Center.
- d) Conditions requiring treatment in a Hyperbaric Oxygen Unit.
- e) Multiple severe injuries.
- f) Life threatening trauma.

Differing Statewide Emergency Medical Services (EMS) systems determine the amount and level of basic and advanced life support ground transportation available. However, there are very limited emergency cases where ground

transportation is available but the time required to transport the patient by ground as opposed to air endangers the beneficiary's life or health. As a general guideline, when it would take a ground ambulance 30-60 minutes or more to transport a beneficiary whose medical condition at the time of pick-up required immediate and rapid transport due to the nature and/or severity of the beneficiary's illness/injury, contractors should consider air transportation to be appropriate.

If a determination is made that transport by air ambulance was necessary, but ground ambulance service would have sufficed, payment for the air ambulance service is based on the amount payable for ground transport, if less costly.

If the air transport was medically appropriate (that is, ground transportation was contraindicated, and the beneficiary required air transport to a hospital), but the beneficiary could have been treated at a nearer hospital than the one to which they were transported, the air transport payment is limited to the rate for the distance from the point of pickup to that nearer hospital.

For air ambulance services, the mileage would include ramp to taxiway, taxiway to runway, takeoff run, air miles, roll out upon landing and taxing after landing. Additional air miles may be allowed in situations where additional mileage is incurred, due to circumstances beyond the pilot's control. These circumstances include but are not limited to, the follow:

- a) Military base and other restricted zones, air-defense zones and similar FAA restrictions and prohibitions.
- b) Hazardous weather
- c) Variances in departure patterns and clearance routes required by an air traffic controller.

Per IOM 100-02 Chapter 10 Section 10.4, there are two categories of air ambulance services: fixed wing (airplane) and rotary wing (helicopter) aircraft. The higher operational costs of the two types of aircraft are recognized with two distinct payment amounts for air ambulance mileage. The air ambulance mileage rate is calculated per actual loaded (patient onboard) miles flown and is expressed in statute miles (not nautical miles).

A0430 - Ambulance service, conventional air services, transport, one way (Fixed Wing Air Ambulance FW)

Fixed wing air ambulance is furnished when the beneficiary's medical condition is such that transport by ground ambulance, in whole or in part, is not appropriate. Generally, transport by fixed wing air ambulance may be necessary because the beneficiary's condition requires rapid transport to a treatment facility, and either great distances or other obstacles, e.g., heavy traffic, preclude such rapid delivery to the nearest appropriate facility. Transport by fixed wing air ambulance

may also be necessary because the beneficiary is inaccessible by a land or water ambulance vehicle.

A0431 - Ambulance service, conventional air service, transport, one way (Rotary Wing Air Ambulance RW)

Rotary wing air ambulance is furnished when the beneficiary's medical condition is such that transport by ground ambulance, in whole or in part, is not appropriate. Generally, transport by rotary wing air ambulance may be necessary because the beneficiary's condition requires rapid transport to a treatment facility, and either great distances or other obstacles, e.g., heavy traffic, preclude such rapid delivery to the nearest appropriate facility. Transport by rotary wing air ambulance may also be necessary because the beneficiary is inaccessible by a land or water ambulance vehicle.

Note:

A0435 - Fixed wing air mileage, per statute mile

A0436 - Rotary wing air mileage, per statute mile

EMERGENCY VS NON-EMERGENCY

CMS IOM 100-02 Chapter 10 Section 30.1.1 defines an emergency response as *"...a BLS or ALS1 level of service that has been provided in immediate response to a 911 call or the equivalent. 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 IOM is located at <http://www.cms.hhs.gov/manuals/Downloads/bp102c10.pdf> on the CMS Website.

Emergency response is a BLS or ALS1 level of service that has been provided in immediate response to a 911 call or the equivalent. 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.

According to 42CFR Chapter IV, section 410.40 non-emergency transportation by an ambulance is appropriate when the following are met:

- 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 an ambulance is medically required.

REIMBURSEMENT

The CMS IOM 100-04 Chapter 15 Section 20 covers reimbursement of Medicare covered ambulance service. IOM 100-04 is available at

<http://www.cms.hhs.gov/manuals/downloads/clm104c15.pdf> on the CMS Website.

See section 20.1.1 for Medicare covered ambulance services that are paid under the ambulance fee schedule. Payment under the ambulance fee schedule includes:

- Includes a base rate payment plus a separate payment for mileage;
- Covers both the transport of the beneficiary to the nearest appropriate facility and all items and services associated with such transport; and
- **Does not include** a separate payment for items and services furnished under the ambulance benefit.

The supplier of service cannot bill the beneficiary for items or services, as Medicare does not allow for a separate reimbursement.

Medicare's payment amount will depend on the ambulance fee schedule and mileage billed. Medicare will always pay the lower of the billed amount and the Medicare allowed amount. Medicare cannot allow more than was billed.

The CMS IOM 100-04 Chapter 15 Section 30 covers reimbursement of Medicare covered ambulance service for the Multi-Carrier System and Fiscal Intermediary Shared System Guidelines. IOM 100-04 is available at <http://www.cms.hhs.gov/manuals/downloads/clm104c15.pdf> on the CMS Website.

Institution based ambulance providers may bill on CMS-1450 Form or the ANSI X12N 837P data set. These claims are processed using the FISS system.

THE AMBULANCE FEE SCHEDULE

The ambulance fee schedule is addressed in the IOM 100-04 Chapter 15 Section 20.1.4 at <http://www.cms.hhs.gov/manuals/downloads/clm104c15.pdf>.

The payment amount under the fee schedule is determined as follows:

For ground and water ambulance services, the fee schedule amount includes:

- 1) A money amount that serves as a nationally uniform base rate, called a "conversion factor" (CF), for all ground ambulance services. The CF will be updated annually.
- 2) A relative value unit (RVU) assigned to each type of ground ambulance service.
- 3) A geographic adjustment factor (GAF) for each ambulance fee schedule area ((geographic practice cost index (GPCI)). The location where the beneficiary was put into the ambulance (point of pickup) establishes which

Geographic Practice Cost Index (GPCI) applies. The GAF for the Fee Schedule uses the facility practice expense of the GPCI of the Medicare physician fee schedule to adjust payment to account for regional differences. The applicable GPCI is multiplied by 70% of the base rate. For multiple vehicle transports, each leg of the transport is separately evaluated for the applicable GPCI. The GPCI is not applied to the mileage factor.

- 4) A nationally uniform loaded mileage rate.
- 5) An additional amount for certain mileage for a rural point-of-pickup is reimbursed. For ground ambulance services, the rural adjustment is an increase in the mileage rate of 50% per loaded statute mile for the first 17 miles. For service from 7/1/04 – 12/31/08 Miles past 50 are reimbursed at the urban rate. The point of pickup, as identified by the zip code, establishes whether a rural adjustment applies to a particular service.

For services dated December 31, 2008 and after, the rural adjustment will only apply to miles 1 through 17.

For air ambulance services, the fee schedule amount comprises:

- 1) A nationally uniform base rate for fixed wing and a nationally uniform base rate for rotary wing. There is no conversion factor (CF) applicable to air ambulance services. Also, air ambulance services have no RVUs.
- 2) A geographic adjustment factor (GAF) for each ambulance fee schedule area (GPCI). The GAF, as described above for ground ambulance services, is applied in the same manner to air ambulance services. However, for air ambulance services, the applicable GPCI is applied to 50% of each of the base rates (fixed and rotary wing.)
- 3) A nationally uniform loaded mileage rate for each type of air service.
- 4) A rural adjustment to the base rate and mileage for services furnished in a rural area. For air ambulance services, the rural adjustment is an increase of 50% to the unadjusted fee schedule amount, i.e. the applicable air service base rate multiplied by the GAF plus the mileage amount. The point of pickup ZIP code determines if there is a rural adjustment.

COVERED UNDER THE AMBULANCE FEE SCHEDULE

The IOM 100-04 Chapter 15 Section 20.1 located at <http://www.cms.hhs.gov/manuals/downloads/clm104c15.pdf> indicates Medicare includes payment for all disposable supplies in the Ambulance Fee Schedule base rate allowed amount. Payment for items or services that are considered part of the base rate should not be submitted for separate payment. Suppliers may not notify patients that these items or services are not covered by Medicare and may not bill the patient for bundled items or services.

Payment for any drug or biological covered under Part B for ambulance suppliers by Medicare is included in the ambulance fee schedule. Therefore, no separate reimbursement is made for drugs or biological, and the patient can not be billed separately.

HOSPITAL TO HOSPITAL AIR AMBULANCE SERVICE

The IOM 100-02 Chapter 10 Section 10.4.4 located at <http://www.cms.hhs.gov/manuals/Downloads/bp102c10.pdf> indicates Medicare covers medically necessary ambulance transports for a hospital to hospital trip when certain requirements are met:

Two Trips on the Same Day

An ambulance that transports an inpatient to another facility and returns on the same day should submit the charges to the hospital for inclusion on the Part A claim. An Intra-Facility transport within the certified campus of a facility is not within the scope of the Medicare ambulance benefit because it fails to meet the origin/destination requirements (CFR 413.65(a)(2) has the definition of "certified campus".) Medicare payment to a facility includes an allowance for patient transportation. Billing the beneficiary or another insurer for such included services would be improper.

- 1) An outpatient transported from the emergency room to another hospital for a diagnostic test can be payable by Medicare Part B if medical necessity is met.
- 2) The return transport is generally not covered since the second facility should be able to treat the patient.

Transfer

Patient, family and/or physician preference is not a payable circumstance for transporting the patient from one hospital to another. Medicare Part B pays to transport the patient by ambulance from one hospital for admission to a second hospital under certain circumstances:

- There is no bed available at the first facility.
- The 'services needed were not available at the first hospital' and the patient must be moved to a larger, better equipped hospital, or a higher level facility.
- A burn unit is needed for treatment.
- The patient was moved from a psychiatric to a general hospital.
- The patient must be moved to a psychiatric ward.
- Special diagnostic studies are needed.

PARAMEDIC INTERCEPT

The CMS IOM 100-02 Chapter 10 Section 30.1.1 defines paramedic intercepts. The IOM is located at <http://www.cms.hhs.gov/manuals/Downloads/bp102c10.pdf> on the CMS Website.

Paramedic Intercept services are ALS services provided by an entity that does not provide the ambulance transport. This type of service is most often provided for an emergency ambulance transport in which a local volunteer ambulance that can provide only basic life support (BLS) level of service is dispatched to transport a patient. If the patient needs ALS services such as EKG monitoring, chest decompression, or I.V. therapy, another entity dispatches a paramedic to meet the BLS ambulance at the scene or once the ambulance is on the way to the hospital. The ALS paramedics then provide services to the patient.

The same area of the IOM continues to say:

Paramedic intercept services furnished on or after March 1, 1999, may be payable separate from the ambulance transport, subject to the requirements specified below.

The intercept service(s) is:

- *Furnished in a rural area;*
- *Furnished under a contract with one or more volunteer ambulance services; and,*
- *Medically necessary based on the condition of the beneficiary receiving the ambulance service.*

In addition, the volunteer ambulance service involved must:

- *Meet the program's certification requirements for furnishing ambulance services;*
- *Furnish services only at the BLS level at the time of the intercept; and*
- *Be prohibited by State law from billing anyone for any service.*

Finally, the entity furnishing the ALS paramedic intercept service must:

- *Meet the program's certification requirements for furnishing ALS services, and,*
- *Bill all recipients who receive ALS paramedic intercept services from the entity, regardless of whether or not those recipients are Medicare beneficiaries.*

For purposes of the paramedic intercept benefit, a rural area is an area that is designated as rural by a State law or regulation or any area outside of a Metropolitan Statistical Area or in New England, outside a New England County Metropolitan Area as defined by the Office of Management and

*Budget. The current list of these areas is periodically published in the **Federal Register**.*

See the Medicare Claims Processing Manual, Chapter 15, "Ambulance," §20.1.4 for payment of paramedic intercept services.

IOM 100-04 Chapter 15, Section 20.1.4 located at <http://www.cms.hhs.gov/manuals/downloads/clm104c15.pdf> on the CMS Website states:

For Paramedic Intercept, an area is a rural area if:

- It is designated as a rural area by any law or regulation of a State;*
- It is located outside of an MSA (Metropolitan Statistical Area) or NECMA (New England County Metropolitan Area); or*
- It is located in a rural census tract of an MSA as determined under the most recent Goldsmith modification.*

See IOM Pub. 100-02, Medicare Benefit Policy Manual, chapter 10 – Ambulance Services, section 30.1.1 – Ground Ambulance Services for coverage requirements for the Paramedic Intercept benefit. Presently, only the State of New York meets these requirements.

The definition for intercept services is in 100-02 Chapter 10 Section 30.1.1 states: *Paramedic intercept services furnished on or after March 1, 1999, may be payable separate from the ambulance transport, subject to the requirements specified below.*

The intercept service(s) is:

Furnished in a rural area;

Furnished under a contract with one or more volunteer ambulance services; and,

Medically necessary based on the condition of the beneficiary receiving the ambulance service.

In addition, the volunteer ambulance service involved must:

Meet the program's certification requirements for furnishing ambulance services;

Furnish services only at the BLS level at the time of the intercept; and,

Be prohibited by State law from billing anyone for any service.

Finally, the entity furnishing the ALS paramedic intercept service must:

Meet the program's certification requirements for furnishing ALS services, and,

Bill all recipients who receive ALS paramedic intercept services from the entity, regardless of whether or not those recipients are Medicare beneficiaries.

*For purposes of the paramedic intercept benefit, a rural area is an area that is designated as rural by a State law or regulation or any area outside of a Metropolitan Statistical Area or in New England, outside a New England County Metropolitan Area as defined by the Office of Management and Budget. The current list of these areas is periodically published in the **Federal Register**.*

The following documentation must be submitted:

- Name of both companies
- "Joint response" should be indicated on the claim form. (List the information Item 19 (CMS-1500) or narrative record for electronic claims
- Reason for the intercept
- Treatment given
- Patient's condition

MULTIPLE PATIENTS

The CMS IOM 100-02 Chapter 10 Section 10.3.10 addresses multiple patient transports. The IOM is located at <http://www.cms.hhs.gov/manuals/Downloads/bp102c10.pdf> on the CMS Website.

When more than one patient is transported in an ambulance, the Medicare allowed charge for each beneficiary is a percentage of the allowed charge for a single beneficiary transport. The applicable percentage is based on the total number of patients transported, including both Medicare and non-Medicare patients. The policy applies to both ground and air transports. Suppliers should report this situation using the GM Modifier.

If two patients are transported at the same time in one ambulance to the same destination, then Medicare will allow 75 percent of the single-patient allowed amount for the level of service furnished to a beneficiary, plus 50 percent of the total mileage payment allowance for the entire trip.

If three or more patients are transported at the same time in one ambulance to the same destination, then Medicare will allow 60 percent of the single-patient allowed amount for the level of service furnished that beneficiary. In addition, the total mileage allowed amount would be divided by the number of all patients onboard.

When submitting the claims, suppliers must:

- 1) Use modifier "GM" to identify a multiple transport.
- 2) Submit documentation to specify the particulars of a multiple transport.
The documentation must include the total number of patients transported in the vehicle at the same time and the health insurance claim numbers for each Medicare beneficiary.
- 3) Submit the charge applicable to the appropriate service rendered to each beneficiary and the total mileage for the trip.
- 4) Submit all associated Medicare claims for that multiple transport within a reasonable number of days of submitting the first claim.

HOSPICE

In the IOM 100-02 Chapter 9 Section 40.1.9 is states:

Any other item or service which is included in the plan of care and for which payment may otherwise be made under Medicare, in accordance with title XVIII of the Social Security Act, is a covered service under the Medicare hospice benefit. The hospice is responsible for providing any and all services indicated in the plan of care as necessary for the palliation and management of the terminal illness and related conditions.

EXAMPLE:

A hospice determines that a patient's condition has worsened and has become medically unstable. An inpatient stay will be necessary for proper palliation and management of the condition. The hospice adds this inpatient stay to the plan of care and decides that, due to the patient's fragile condition, the patient will need to be transported to the hospital by ambulance. In this case, the ambulance service becomes a covered hospice service.

Ambulance services that are not related to Hospice care can be covered by Medicare Part B. Services related to or caused by the terminal illness should be submitted to the hospice. Documentation is required to verify the reason for the ambulance trip is not related to the terminal illness or is prior to the start of hospice. Modifiers GV and YB are not applicable to ambulance suppliers.

AMBULANCE SERVICES FOR A DECEASED BENEFICIARY

The CMS IOM 100-02 Chapter 10 Section 10.2.6 addresses transport for a deceased beneficiary. The IOM is located at <http://www.cms.hhs.gov/manuals/Downloads/bp102c10.pdf> on the CMS Website.

The following information states Medicare policy related to the death of a beneficiary and the payment for ambulance services. The death of a patient is recognized when the pronouncement of death is made by an individual legally

authorized to do so by the State where the pronouncement is made. The following three situations apply when furnishing services to a deceased patient.

- 1) The patient is pronounced dead after the ambulance is called but before transport. Ground providers can bill a BLS service along with the QL modifier *Patient pronounced dead after ambulance called*. Air providers can use the appropriate code with the QL modifier. There will be no rural allowance or mileage billed.
- 2) The patient is pronounced dead after being loaded into the ambulance. Pronouncement is made enroute or upon arrival. Payment is made following the usual rules.
- 3) No payment will be made if the patient was pronounced dead prior to the ambulance being called.

Air ambulance suppliers should submit documentation to show that:

- 1) The air ambulance was dispatched to pick up a Medicare beneficiary.
- 2) The aircraft actually took off to make the pickup.
- 3) The beneficiary to whom the dispatch relates was pronounced dead before being loaded onto the ambulance for transport.
- 4) An individual authorized by the State made the pronouncement of death.
- 5) The dispatcher did not receive notice of such pronouncement in sufficient time to permit the flight to be aborted before take off.

The pronouncement of death is only recognized when an individual authorized under State Law makes it.

DIALYSIS SERVICES

The CMS IOM 100-04 Chapter 15 various section addresses transport for dialysis services. The IOM is located at <http://www.cms.hhs.gov/manuals/downloads/clm104c15.pdf> on the CMS Website.

Section 10.4 states, "Beginning February 24, 1999, ambulance transports to or from a non-hospital-based dialysis facility, origin and destination modifier "J," satisfy the program's origin and destination requirements for coverage."

Section 30.2.2 states, "The following ambulance transportation and related ambulance services for residents in Part A stays are not included in the PPS rate. They may be billed as Part B services by the supplier only in the following situations: ... The ambulance trip is to a hospital based or non-hospital based ESRD facility (either one of any HCPCS code ambulance modifier codes is G (Hospital based dialysis facility) or J (Non-hospital based dialysis facility)."

The general rules for billing "Separately Payable Ambulance Transport Under Part B versus Patient Transportation that is Covered Under a Packaged Hospital

Service” are located in IOM 100-02 Chapter 10 Section 10.3.3 located at <http://www.cms.hhs.gov/manuals/Downloads/bp102c10.pdf> on the CMS Website. The information defines when a service is not billable to the inpatient facility.

Our guidance on when Ambulance transport for maintenance dialysis may be a covered service is as follows:

- 1) Ambulance transport is medically necessary.
- 2) The facility is approved as a destination.
 - G- hospital based facility includes
 - Hospital administered/hospital located
 - Non- hospital administered/hospital located
 - J – non-hospital based facility includes
 - Hospital administered/non-hospital located
 - Non-hospital administered/non-hospital located
 - Located or adjacent to a hospital
 - Furnishes service to patients of the hospital
 - There is a professional relationship between facilities.
- 3) Provider must meet the Physician Certification Statement (PCS) requirement.
- 4) The claim must indicate the full name and address of the origin and destination.

PHYSICIAN CERTIFICATION OF AMBULANCE SERVICES (PCS)

The CMS IOM 100-01 Chapter 4 addresses Physician Certification and Recertification of services. The IOM is located at <http://www.cms.hhs.gov/manuals/downloads/ge101c04.pdf> on the CMS Website and 42 CFR 410.40(d)(2) and 410.40(d)(30).

A PCS is required for the following ambulance services:

- 1) Non-emergency, scheduled, repetitive ambulance services; and
- 2) Unscheduled, non-emergency ambulance services or non-emergency ambulance services scheduled on a non-repetitive basis for a resident of a facility who is under the care of a physician.

A PCS that is in connection with ambulance services furnished by a participating hospital is required. When an ambulance service transports a patient from the scene of an accident and no physician is involved until the patient reaches a hospital, any physician in the hospital who examines the patient or has knowledge about the case may certify the ambulance transport services.

Note: For non-emergency, scheduled, repetitive ambulance services, the physician's order must be dated no earlier than 60 days before the date that the service is furnished. A repetitive ambulance service is defined as medically necessary ambulance transportation that is furnished three or more times during a 10-day period or at least once per week for at least three weeks. Dialysis and respiratory therapy are types of treatments for which repetitive ambulance services are often necessary.

A PCS is not required for the following ambulance services:

- 1) Emergency; and
- 2) Non-emergency, unscheduled ambulance services for a beneficiary who at the time of the transport, was residing either at home or in a facility and who was not under the direct care of a physician.

If unable to obtain the physician's signature, it is acceptable to obtain a signed certification statement from the physician assistant, nurse practitioner, registered nurse, clinical nurse specialist, or discharge planner, who has personal knowledge of the beneficiary's condition at the time the ambulance transport is ordered or the service is furnished. This individual must be employed by the beneficiary's attending physician or by the hospital or facility where the beneficiary is being treated and from which the beneficiary is transported.

For non-emergency services that are either unscheduled or that are scheduled on a non-repetitive basis, the PCS must be obtained within 48 hours of providing the service.

If unable to obtain the written order within the 48-hour limit, the supplier may attempt to obtain the order from one of the alternatives listed above. If after 21 days the supplier is unable to get the PCS, then a certified letter with a return receipt requested or other proof of mailing can be used to document the attempt. Suppliers may use the U.S. Postal Service Certificate of Mailing, form 3817 as an acceptable alternative to certified mail. The claim can be submitted to Medicare at this point.

This requirement also applies in a situation where the supplier responds to a non-emergency call and upon arrival the condition of the beneficiary requires emergency care. The claim for this type of service would not qualify for "emergency transport."

All non-emergency, scheduled and non-scheduled, transports must have a physician's certification statement on file certifying the need for ambulance transport.

The presence or absence of the form will not affect the medical necessity decision.

Exception

- Transports for patients not under the care of a physician do not require the PCS.
- A good faith response to an emergency subsequently down coded to a nonemergency.

There is no specific form required for physician certification as long as the certification requirement is met. In accordance with CMS IOM, Benefit Policy Manual, Chapter 10, Section 10.2.4, the presence or absence of a signed physician order for ambulance transport neither proves or disproves medical necessity of transport. The ambulance service must meet all program coverage criteria in order for payment to be rendered.

LIMITATION OF LIABILITY

The IOM 100-04 Chapter 30, Section 20 located at <http://www.cms.hhs.gov/manuals/downloads/clm104c30.pdf> on the CMS Website discusses limitation of liability.

This provision waives the patient's responsibility for payment when the provider should have known the service would be non-covered. The patient must accept liability if:

- The patient has received a previous denial on similar services
- The provider notifies the patient in advance in writing that the service will be denied.

Limitation of Liability only applies to assigned ambulance claims. Limitation of Liability could apply for ambulance services when:

The patient is transported to a hospital for services that could have been more economically brought to the patient.

A SNF patient is transported to a facility when services could have been more economically brought to the patient.

The patient is transported by air ambulance when the transporting entity believes the transport could have been done by ground transportation.

A level of care downgrade, e.g., from ALS-2 to ALS-1 or from ALS to BLS when the transport at the lower level of care is a covered transport.

ADVANCE NOTICE OF NON-COVERAGE

The advance notice must be in writing and must inform the beneficiary of the likelihood that Medicare will deny payment for the item or service to be furnished. The statement must be more than a routine notice of the possibility that payment for the item or service will be denied. In order to make an informed decision on accepting liability for payment, the beneficiary needs to be apprised of a definite reason for the likelihood of the Medicare denial.

The language of the advance notice indicating Medicare may deny payment for a particular service is important, and the beneficiary's signed, and dated agreement to pay for the service is required. Effective 1/1/03 the ABN must be on a CMS approved form. The Form is the CMS-R-131. The GA modifier should be included on the claim when the ABN has been given to the patient.

An ABN is rarely used for ambulance services, and may only be issued for nonemergency transports. An ABN may not be used when the patient is under great duress. A beneficiary is considered to be under great duress when his/her medical condition requires emergency care.

The CMS website section for Advance Notice of Non-coverage is located at <http://www.cms.hhs.gov/bni/> and will guide you through the new form.

SCENARIOS

Patient is an inpatient at a SNF and is transported to a doctor's office.

Questions:

- 1) What is the purpose of the visit?
- 2) Is it for a diagnostic or therapeutic service not available at the SNF? If so, identify the service.
- 3) If the transport is for a service not available at the SNF, what is the patient's condition?
- 4) The supplier will need to secure a PCS prior to submitting the charge to Medicare.
- 5) Is the transport for a physician visit? If so, the transport is not a covered service.
- 6) An ABN should be given to the patient prior to transport.
- 7) If the purpose of the transport is a visit, the patient's condition does not make the service payable.
- 8) Is the patient is a covered Part A Stay?
- 9) Is the transport for a professional service?

Patient is transported from one hospital to another.

Questions:

- 1) Why is the patient being moved?
- 2) Is the patient an inpatient or outpatient?

- 3) Was the patient returned to the first hospital on the same day?
- 4) Is the patient being moved for a medical or personal reason?
- 5) What is patient's condition?
- 6) Is the receiving hospital the closest appropriate facility?
- 7) Is the service an emergency?
- 8) Is the patient's condition critical?
- 9) Is there an extra attendant on board?
- 10) What additional training does the paramedic have?

BLS transports patient from a Nursing Home to the emergency room. The ambulance is intercepted by ALS enroute.

- 1) What is patient's condition?
- 2) Is the service an emergency?
- 3) What condition necessitated the intercept?
- 4) Do ALS personnel board the BLS?
- 5) Is the patient transferred to the ALS ambulance?
- 6) Which ambulance is billing?
- 7) Is the BLS billing as ALS?

Ambulance responds to a 911 call. Service billed as ALS2.

Questions

- 1) What is the patient's condition?
- 2) Is the patient transported?
- 3) Is the patient going to the closest appropriate facility?
- 4) Is the patient in an emergency situation?
- 5) Are there any medications administered?
- 6) What are the medications?
- 7) What are the ALS interventions being provided?

CONSOLIDATED BILLING

For service and supplies furnished to a SNF resident covered under the Part A benefit, SNFs will no longer be able to unbundle services to an outside provider of services or supplies that can then submit a separate bill directly to the Medicare contractor. Instead, the SNF must furnish the services or supplies either directly or under an arrangement with an outside provider. The SNF, rather than the provider bills Medicare. Medicare does not pay amounts that are due a provider of the services or supplies to any other entity under assignment, power of attorney, or any other direct payment arrangement. As a result, the outside provider of the service or supplies must look to the SNF, rather than to the beneficiary or the Medicare contractor, for payment. Most covered services and supplies billed by the SNF, including those furnished under arrangement with an

outside provider, for a resident of a SNF in a covered Part A stay are included in the SNFs bill to the Fiscal Intermediary (FI).

Except for specific exclusions, consolidated billing includes those medically necessary ambulance trips that are furnished during the course of a covered Part A stay. CMS states the following under **excluded services** on the SNF Consolidated Billing Website:

An ambulance trip that conveys a beneficiary to the SNF for the initial admission, or from the SNF following a final discharge.

To locate information on SNF Consolidated billing, visit:

http://www.cms.hhs.gov/SNFPPS/05_ConsolidatedBilling.asp

Listed below are a number of specific circumstances under which a beneficiary may receive ambulance services that are covered by Medicare, but excluded from consolidated billing.

- A medically necessary trip to a Medicare participating hospital or CAH for the specific purpose of receiving emergency or other excluded outpatient hospital services.
- Medically necessary ambulance trips after a formal discharge or other departure from the SNF, **unless** the beneficiary is readmitted or returns to that or another SNF before midnight of the same day.
- An ambulance trip to receive dialysis -related services.
- A trip for an inpatient admission to a Medicare participating hospital or CAH.
- After a discharge from the SNF, a medically necessary trip to the beneficiary's home where the beneficiary will receive services from a Medicare participating home health agency under a plan of care.

A beneficiary's transfer from one SNF to another before midnight of the same day is not excluded from consolidated billing. The first SNF is responsible for billing the services to the FI.

NOTE: This only applies to Medicare fee-for-services beneficiaries.

COVERAGE FOR FOREIGN AMBULANCE SERVICES

The CMS IOM 100-02 Chapter 10 Section 20 addresses coverage for foreign ambulance services. The IOM is located at <http://www.cms.hhs.gov/manuals/Downloads/bp102c10.pdf> on the CMS Website.

Payment can be made for medically necessary ambulance services furnished in connection with a covered foreign hospitalization. The Ambulance service can be covered if:

- The foreign hospitalization has been determined to be covered; and
- The ambulance service meets the coverage requirements set forth in §§10-10.3. If the foreign hospitalization has been determined to be covered on the basis of emergency services (See the Medicare Claims Processing Manual, Chapter 1, “General Billing Requirements,” §10.1.3), the necessity requirement (§10.2) and the destination requirement (§10.3) are considered met.

Only the beneficiary can file a non-assigned claim for a foreign ambulance supplier.

AMBULANCE CERTIFICATION

Ambulance suppliers must complete a CMS Form 855B to become certified with Medicare. The 855B is located at <http://www.cms.hhs.gov/CMSforms/downloads/cms855b.pdf> and contains attachment 1 that ambulance suppliers must complete.

Ambulance suppliers must provide the following information to establish certification requirements:

- A description of the vehicle(s), including safety and other patient care items onboard.
- Evidence that each crewmember has training in the standard and advanced Red Cross first aid courses or the equivalent. (e.g., copies of certification)
- Copies of all pertinent state and local licenses or permits related to the vehicle(s), crew, equipment and operation.

Ambulance suppliers can download the 855B form at the link above. For help completing the 855B, contact our provider enrollment department. The telephone number and address is at the back of the book.

Provider Enrollment information located on the WPS Medicare Website.
IL, MI, MN, WI:

http://www.wpsmedicare.com/part_b/business/enrollment.shtml

IA, KA, MO, NE:

Part A:

<http://www.wpsmedicare.com/i5macparta/departments/enrollment/>

Part B:

<http://www.wpsmedicare.com/i5macpartb/departments/enrollment/>

STATE LICENSURE

An ambulance company cannot be approved as a Medicare provider until it has satisfied state inspection and licensure requirements. Inquiries concerning licensing or other state requirements should be directed to:

Wisconsin

DPH/EMS and IP
Box 2659
Madison, WI 53701-2659
(608) 266-1568

Minnesota

Emergency Medical Services Regulatory Board
2829 University Avenue South East, Suite # 310
Minneapolis, Minnesota 55414-3222
(612) 201-2804

Illinois

Department of Public Health
EMS and Highway Safety
525 West Jefferson Street
Springfield, Illinois 62761
(217) 782-4977

Michigan

Department of Community Health
EMS & Trauma Systems Section
Capitol View Building, 6th Floor
201 Townsend Street
Lansing, Michigan 48913
Telephone: (517) 241-3025

Iowa

Kirk E. Schmitt, Bureau Chief
Lucas State Office Bldg
321 E. 12th Street
Des Moines, IA 50319
(800) 728-3367

Nebraska

Nebraska Department of HHS
Public Health Assurance
P.O. Box 95026
Lincoln, NE 68509-5007
(402) 471-3578

Kansas

Kansas Board of Emergency Medical Services
Landon State Office Building
900 SW Jackson Street, Suite 1031
Topeka, Kansas 66612-1228
(785)-296-7296

Missouri

Bureau of Emergency Medical Services
Missouri Department of Health and Senior Services
PO Box 570
Jefferson City, MO 65102-0570
573-751-6356

Ambulance providers must complete a CMS 855B application form to be eligible to bill Medicare. A provider number allows the provider to receive payment from Medicare.

Ambulance suppliers must submit the state re-certification when received from the state. Suppliers should update the contractor with crewmember changes as those changes occur.

New providers, providers changing tax numbers and providers who are moving must complete the 855B form. To request the form call the Provider Enrollment Department.

CMS requires that all providers notify contractors of any change in a mailing address **within 30 days of the effective date of the change.**

Do Not Forward Initiative – effective 7/1/00

All contractors use 'Return Service Requested' envelopes for all checks mailed to providers. Medicare cannot automatically change the address of the provider or re-mail the check to the provider. The provider must complete and file a CMS 855B to change enrollment information. Once the address is updated Medicare will release the checks to the correct address.

MANDATORY CLAIMS SUBMISSION/TIMELY FILING

Suppliers are required to submit all covered services to Medicare. Claims must be filed by the end of the calendar year following the year services were provided. Claims 10/1/07 and after can be filed through December 31, 2008.

Claims filed after the file limit will be denied. The patient may only be charged 20% of the amount that Medicare would have approved.

Never-covered or statutorily denied claims do not have to be submitted to Medicare unless the patient requests it.

PATIENT ELIGIBILITY

An individual entitled to Medicare will receive a Medicare card with their health insurance claim number (HICN), name, sex, and effective dates of entitlement. The HICN must be submitted on all claims and correspondence.

If possible, providers should make a copy of the Medicare card and recheck it at least once a year. The alphanumeric suffixes (Beneficiary Identification Codes or BICs) following the HICN indicates the beneficiary's classification. The most common suffixes are:

SUFFIX	DESCRIPTION
A	Male or female wage earner
B	Wife – 65 and over
D	Widow – 65 and over
M	Uninsured for Medicare A, insured for Medicare B
T	Entitled to Medicare A and Medicare B but not entitled to Social Security Benefits

Some other valid suffixes are B1 through B9, C1 through C9, D1 through D8, E, E1 through E3, E7, F1, through F8, J1 through J4, K1 through K4, M1, T1 through T9, W, W1 through W7.

If the beneficiary's HICN begins with a letter, the beneficiary is covered under Railroad Retirement. Example: W123-45-6789. Other prefixes that may appear as the HICN prefix identifying a Railroad Retirement beneficiary include A, CA, JA, MA, PA, WA, H, MH, PH, WH, PD, WCS, WCD, and WD.

MISUSE OF BENEFICIARY'S HICN

Medicare has seen an increase in patients misusing the HICN. When Medicare sees this situation, we will recoup the payment from the entity that received payment.

The following information should be verified:

- Ask to see the Medicare card
- Ask for a picture ID
- Ask for telephone number

BENEFICIARY'S RESPONSIBILITY FOR MEDICAL SERVICES

The patient is responsible for first approved charges each year to satisfy the deductible. The deductible increases each year, so be sure you are checking it.

The patient is responsible for the 20% coinsurance on assigned claims. The patient is responsible for the billed amount for nonassigned ambulance claims.

MEDICARE FRAUD AND ABUSE

Fraud and Abuse costs the Medicare program over 20 Billion dollars a year. The Program Safeguard Contractor (PSC) is responsible for identifying and investigating cases of fraud and abuse for possible referral to other government agencies.

Abuse - Refers to incidents or practices of providers that, while not usually considered fraudulent, are not consistent with accepted sound medical, business or fiscal practices.

Fraud – Intentional deception or misrepresentation an individual makes which could result in some unauthorized benefit.

MEDICARE PROVIDERS AND THE PRIVACY ACT

The Medicare contractor cannot disclose any information to a provider without a valid HICN of the patient. Until a provider submits a claim for processing, the contractor cannot reveal any specific information. Providers should be careful not to reveal information concerning their patients inappropriately.

MEDICAL REVIEW PROGRESSIVE CORRECTIVE ACTION (PCA)

This is a program that includes pre-payment and post-payment claim reviews. PCA assists contractors in detecting potentially abusive or fraudulent practices. The

PCA principles are:

- 1) Analyze data
- 2) Test hypotheses
- 3) Prioritize and target workload
- 4) Collect money when errors are identified
- 5) Provide focused provider feedback and education
- 6) Make Fraud referrals when needed

UNPROCESSABLE GUIDELINES FOR PART B PROVIDERS

A paper or electronic claim that contains incomplete or invalid information may be “returned as unprocessable.” An “initial determination” will not be made. Providers must correct the error and resubmit the claim.

Medicare can return a claim in one of three ways:

- 1) The claim may be returned either by paper or electronically before entry into our computer system.
- 2) A claim may be accepted but require development.
- 3) The claim is returned through the Remittance Notice.

Medicare will supply you with the following (as long as it appears on the claim):

- Name
- HICN
- Date of Service
- Patient Account Number
- Explanation of Error

MEDICARE SECONDARY PAYER

By Federal law, Medicare is secondary to a variety of government and private insurance plans. The separate types are:

- 1) Automobile Medical or No-fault – If the services are related to an auto accident, the auto policy should be billed first.
- 2) Black Lung – Services related to Black Lung should be submitted to the Department of Labor.
- 3) Disability – The patient, spouse or family member has coverage through current employment and the employer has at least 100 employees.
- 4) End Stage Renal Disease (ESRD) – The patient or spouse has coverage through past or present employment regardless of the number of employees. Medicare is secondary for a 30-month coordination period.
- 5) Liability Insurance – Services provided after an injury or accident where someone is found liable. After a 120 “promptly pay” period, the provider must choose whether to pursue the liability or to bill Medicare. If the provider chooses to pursue the liability, they cannot collect from the patient until the liability settlement has been completed and then only up to the proceeds of the settlement. If the provider chooses to bill Medicare, the provider must drop any liens against the liability settlement.
- 6) Veteran’s Administration – The patient can choose to bill VA or Medicare.

- 7) Worker's Compensation – Services provided for a work-related illness or injury should be submitted to the employer insurance. Medicare can make a conditional payment.
- 8) Working Aged – The patient has insurance coverage through the current employment of themselves or the spouse. The employer must have at least 20 employees.

Providers must ask questions to determine who is primary and bill the charge accordingly.

The development process to determine whether Medicare should be primary is now handled by a separate company known as the Coordination of Benefits Contractor (COBC). The COBC can be contacted at (800)999-1118.

OVERPAYMENTS

The contractor will send a letter requesting payment when an overpayment is discovered. Providers are requested to return the payment within 30 days. If the payment is not received, a follow-up letter is sent assessing interest for 2 months. If payment is not received in 40 days, we will begin offset procedures.

A provider has appeal rights. However, the appeal does not stop the overpayment time frames.

VOLUNTARY REFUNDS

Providers who identify an incorrect payment are required to return the payment to the contractor. Providers should submit complete information such as:

- Beneficiary Name HICN
- Date of Service
- Procedure
- Reason for returned payment.

Providers who are subject to a Corporate Integrity Agreement should indicate this in the correspondence.

The Part B voluntary refund form is located at:

Part B Illinois, Michigan, Minnesota, and Wisconsin
http://www.wpsmedicare.com/part_b/business/vol_refund_new.pdf

Part B Iowa, Kansas, Missouri, and Nebraska
http://www.wpsmedicare.com/j5macpartb/forms/ files/b_refundform.pdf

APPEALS

Providers and Beneficiaries have the right to appeal claim determinations. Part B providers have 120 days to file a request for redetermination. Redeterminations must be submitted in writing. Medicare does not accept “implied” requests for redeterminations. Providers use CMS Form 20027 Medicare Redetermination Request Form when filing redetermination. Ambulance providers should include a run sheet as minimum documentation.

The Part B form is located at:

<http://www.cms.hhs.gov/cmsforms/downloads/cms20027.pdf> and can be mailed to:

Illinois	Michigan
WPS - Illinois Appeals P.O. Box 4433 Marion, IL 62959	WPS - Michigan Appeals P.O. Box 5533 Marion, IL 62959
Minnesota	Wisconsin
WPS- Minnesota Appeals 8120 Penn Ave South, Suite 200 Bloomington, MN 55431-1394	WPS- Wisconsin Appeals P.O. Box 1268 Madison, WI 53701
Iowa	Kansas
WPS Medicare Part B Appeals Department P.O. Box 8550 Madison, WI 53708	WPS Medicare Part B Appeals Department P.O. Box 7238 Madison, WI 53707
Missouri	Nebraska
WPS Medicare Part B Appeals Department P.O. Box 7128 Madison, WI 53707	WPS Medicare Part B Appeals Department P.O. Box 8667 Madison, WI 53708

The Part A form is located at:

<http://www.wpsmedicare.com/j5macparta/forms/>

MEDIGAP AND CROSSOVER

The Medigap program is designed for participating providers. This allows providers to indicate the Medigap information on the claim. Medicare will forward a copy of the payment records to the Medigap insurer for further processing.

Crossover is a program for the supplemental insurance companies.

These companies send an eligibility tape to be matched to our eligibility information. When a match is found, the file is flagged. An electronic payment record is forwarded to the supplemental insurance.

MEDICARE INFORMATION ON THE INTERNET

In an effort to expand our Customer Service level, WPS will help you find specific Medicare information on the Internet. Our intention is to make the Medicare Program more accessible and understandable.

1. **CMS-1500 Claim form and Filing Instructions**— Please note WPS does not accept new claims on black and white copies of the CMS-1500 CMS claims filing instructions are located at IOM 100-04 Ch. 26 Section 10.4. The location is <http://www.cms.hhs.gov/manuals/downloads/clm104c26.pdf> on the CMS Website.
2. **CMS-1450 Claim form and Filing Instructions**— Please note WPS does not accept new claims on black and white copies of the CMS-1450 CMS claims filing instructions are located at IOM 100-04 Ch. 25, Section 75. The location is: <http://www.cms.hhs.gov/manuals/downloads/clm104c25.pdf> on the CMS Website.
3. **CMS Ambulance Services Center**—
<http://www.cms.hhs.gov/center/ambulance.asp>
4. **COB Website and Contractor information**—
<http://www.cms.hhs.gov/COBGeneralInformation/>
5. **Computer-based training**—National Provider Education and Training program. Free Medicare training courses that will help you strengthen your understanding of a variety of Medicare topics including Medicare benefits, coverage and billing procedures—
http://cms.meridianksi.com/kc/main/kc_frame.asp?kc_ident=kc0001&loc=1
6. **Education**—Information on free educational opportunities provided through satellite broadcasts, computer based training session and publications—
<http://www.cms.hhs.gov/home/outreacheducation.asp>
7. **Electronic Data Interchange**—
<http://www.cms.hhs.gov/ElectronicBillingEDITrans/>
8. **HIPAA Information**— <http://www.cms.hhs.gov/HIPAAGenInfo/>
9. **Medicare Program Memos and Transmittals**

- α. *Program Memos and Transmittals* are official agency transmittals used for communicating reminder items, request for action or information of a onetime only, nonrecurring nature—
<http://www.cms.hhs.gov/Transmittals/>
- b. *CMS Regulations and Notices* are forwarded to the Office of the Federal Register (OFR) for publication and are announced on this web site as a service to the public—
<http://www.cms.hhs.gov/home/regsguidance.asp>
- c. The *Federal Register* is the official daily publication for Rules, Proposed Rules, and Notices of Federal agencies and organizations, as well as Executive Orders and other Presidential Documents— <http://www.gpoaccess.gov/fr/Index.html>

10. **Official U.S. Government Site for Medicare Beneficiary information—**
Medicare publications, covered Medicare services, HealthCare choices, Medicare health plans and supplemental coverage, rights, protections, costs and payment, national participating physician directory —
<http://www.medicare.gov/>

11. **Provider Enrollment Information—**
<http://www.cms.hhs.gov/MedicareProviderSupEnroll/>

12. **Provider Information—** <http://www.cms.hhs.gov/>

13. **NPI Directory -** <https://nppes.cms.hhs.gov/NPPES/NPIRegistryHome.do>

WPS Medicare Part B Information

WPS Medicare Ambulance Center

IA, KS, NE, MO – Part B

http://www.wpsmedicare.com/j5macpartb/training/resources/provider_types/ambulance.shtml

WI, MI, MN, IL – Part B

http://www.wpsmedicare.com/part_b/education/specialty.shtml#amb

Copies of newsletters, contractor instructions, EDI instructions, medical policies, etc. can be found at the following website address at:

<http://www.wpsmedicare.com/> and select the section you wish to visit.

Please select the appropriate section for your state and provider type.

Disclosure of Information

Provisions of the Social Security Act, the Privacy Act, the Freedom of Information Act and the Department of Health and Human Services Public Information Regulation govern the disclosure of information about Medicare beneficiaries. Federal agencies, such as the Centers for Medicare and Medicaid and its Medicare contractors, must comply with these provisions. It is for this reason that providers calling our customer service department are asked for their Medicare Provider Transaction Number (PTAN). This allows our customer service staff to determine whether the provider is authorized to obtain the information being requested.

Providers calling on non-assigned claims can only receive the following information:

- Claim has/has not been received
- Claim has/ has not been processed
- Beneficiary can expect an EOMB/MSN by a certain date

Date of eligibility and personal information (sex, date of birth, etc.) are not releasable.

HOW TO CONTACT WPS

A complete list of contact information is located at the link provided.

Part B

Illinois, Michigan, Minnesota, Wisconsin:

http://www.wpsmedicare.com/part_b/selfservice/contactinformation.shtml

Iowa, Kansas, Missouri, Nebraska:

http://www.wpsmedicare.com/j5macpartb/selfservice/contact_us/

Part A

Iowa, Kansas, Missouri, Nebraska:

http://www.wpsmedicare.com/j5macparta/selfservice/contact_us/

United States and U.S. Virgin Islands:

http://www.wpsmedicare.com/part_a/selfservice/contactinformation.shtml