

Billing Requirements For LDT's Only

Definitions:

- A. **Medically Necessary** – This means that the service given is in the best interest of the patient’s health. For ambulance transports, this means that transportation could not reasonably be done another way. This is important since Medicare and other insurance coverage is often based on medical necessity. For most insurance companies, emergencies that have occurred suddenly and appear to need prompt medical treatment in order to avoid serious medical consequences are not usually questioned. Non-emergencies, to be medically necessary, usually require that the patient be bed-confined and unable to be moved by any means other than a stretcher. A doctor's order, without supporting documentation, rarely justifies medical necessity.
- B. **Emergency Transport** – Transport of a patient for the sudden onset of acute symptoms for an unforeseen medical condition which could reasonably be expected to place the patient’s health in serious jeopardy and which requires unscheduled medical attention in an *emergency room*.
- C. **Non-Emergency Transport** – A “medical transfer” is a transport for a patient who has an appointment to be seen for an on-going medical problem. A non-emergency medical transport can also occur when a patient requires transport back to his/her residence at the end of a hospitalization.
- D. **Covered Service** – Each insurance company decides what service it is going to pay for (or “cover”) in its policies. To determine which services are covered by your particular policy, you may need to contact your insurance company.
- E. **Specialized Service** – Medicare requires ambulance providers to report whether “specialized service” was given or not. “Specialized” service includes the giving of any treatment or medication such as EKG or starting an I.V.

Medicare Coverage Guidelines

- A. In order for an ambulance transport to qualify for Medicare payment, it must meet two criteria:
 1. It must be medically necessary
 2. It must be a covered service. Definitions of “medically necessary” and “covered service” can be found in the Definitions section above.
- B. The below chart was developed to provide a quick reference to determine Medicare coverage for medically necessary ambulance transports. Medicare determines coverage by the origin (the place where the patient is picked up by the ambulance) and the destination (the place where the patient is taken by the ambulance). Medicare will determine whether the transport was medically necessary before deciding coverage. If the transport was not medically necessary, Medicare will refuse to pay. If Medicare determines the transport was medically necessary, the following determines coverage:

This chart is intended to provide a *general* understanding of Medicare coverage. Should you have questions on a particular case, please take a moment to review the detailed notes for the type of transfers being considered or contact our billing department (903-832-8531).

Origin	Destination	Medicare Covers
Hospital	Home or Nursing Home	Yes
Hospital	Hospital	Only if medical services not available at 1 st can be provided at 2 nd No for patient/physician convenience

When requesting non-emergency ambulance service we will need to know:

- A. Where the patient is located.
- B. The name of the caller and his/her telephone number (including extension).
- C. The date and time of service being requested.
- D. Patient's destination (including address, floor, apartment number). The date and time of the patient's appointment.
- E. Patient's name.
- F. Age and sex of the patient.
- G. Patient's diagnosis.
- H. Patient's physician.
- I. Any unique requirements for the patient (i.e. oxygen; suction; I.V.)
- J. Is the patient bed-confined? If so, what makes him/her bed-confined?

Medicare / Medicaid Requirements for Reimbursement

- A. Emergency from any location to hospital
 1. If medical necessity requirements are met, Medicare will pay 80% of their allowed charge after annual deductible has been met.
 2. Medicaid will pay the state rate for emergency transportation if Medicaid is the patient's only insurance. If Medicaid is supplemental to Medicare and Medicare denies the claim for lack of medical necessity, Medicaid will deny also.
 3. Insurance will cover according to the provisions in the patient's insurance contract. (Policies that are supplements to Medicare generally will not pay unless Medicare approves the transport).
- B. Non-emergency hospital discharge to private residence or nursing home
 1. For Medicare, medical necessity must be established. If medical necessity requirements are met, Medicare will pay 80% of their allowed charge after the annual deductible has been met. If medical necessity is not established, Medicare will likely deny payment as "not deemed medically necessary". To establish medical necessity, the patient must be bed confined or unable to sit in a wheelchair unrestrained.
 2. Medicaid may pay the state rate for non-emergency transportation if Medicaid is the patient's only insurance. If Medicaid is supplemental to Medicare and Medicare denies the claim for lack of medical necessity, Medicaid generally denies also. However, all non-emergency Texas Medicaid transports require prior-authorization. Please reference the Texas Medicaid section of this handbook.
 3. Insurance will cover according to the provisions in the patient's contract (policies that are supplements to Medicare generally will not pay if Medicare denies).
 4. HMO's generally require prior-authorization for non-emergency transports. Please call your physician or HMO for this prior-authorization.
 5. As long as medically necessary, Medicare will pay only to return a patient to his/her place of residence prior to hospital admission. If the patient was at home before admission, but is now going to a nursing home, Medicare will not pay. Medicaid will pay if medically necessary (i.e. bed confined, can only be moved by stretcher, requires restraints, etc).
- C. Non-emergency transfer from home/nursing home to hospital
 1. For Medicare, medical necessity must be established. If medical necessity requirements are met, Medicare will pay 80% of their allowed charge after the annual deductible has been met. If medical necessity is not established, Medicare will likely deny payment as "not deemed

medically necessary". To establish medical necessity, the patient must be bed confined or unable to sit in a wheelchair unrestrained.

2. Medicaid may pay the state rate for the non-emergency transportation if Medicaid is the patient's only insurance. If Medicaid is supplemental to Medicare and Medicare denies the claim for lack of medical necessity, Medicaid generally denies also. However, all non-emergency Texas Medicaid transports require prior-authorization. Please reference the Texas Medicaid section of this handbook.
 3. Insurance will cover according to the provisions in the patient's contract. (Policies that are supplements to Medicare generally will not pay if Medicare denies).
 4. HMO's require prior-authorization on non-emergency transports. Please call your physician or HMO for this prior-authorization.
- D. Non-emergency out of town transfer (non-emergency)
1. Medicare will pay for the nearest appropriate facility to care for the patient.
 2. Medicaid will pay for the nearest appropriate facility to care for the patient. However, all non-emergency Texas Medicaid transports require prior-authorization. Please reference the Texas Medicaid section of this handbook.
 3. Insurance will pay if there are provisions for such in the patient's insurance contract.
 4. HMO's generally require prior-authorization for non-emergency transports. Please call your physician, or HMO to obtain this prior-authorization. If the patient wishes, LifeNet will be happy to discuss coverage with the patient's insurance carrier in advance of the transport.
 5. Without a guarantee of payment from the patient's insurance carrier, LifeNet requires payment of estimated charges in advance.
- E. For Medicare and Medicaid coverage:
1. If the patient is to be returned to the hospital after the procedure/treatment; and was never discharged from the original facility, then the first hospital will include the transport charge in their bill to be covered under Medicare Part A.
 2. If the patient was discharged from the original facility because he/she was to be admitted to second facility for services not available at the first:
 3. If medical necessity requirements are met, Medicare will pay 80% of their allowed charge after the annual deductible has been met. Medicaid may pay the state for non-emergency transports if Medicaid is the patient's only insurance. If Medicaid is supplemental to Medicare and Medicare denies the claim for lack of medical necessity, Medicaid generally denies also.
 4. Insurance will pay according to the provisions in the patient's contract.
 5. HMO's generally require prior-authorization for non-emergency transports. Please call your physician or HMO to obtain this prior-authorization.

Texas medicaid prior-authorization

- A. Effective January 1, 1998, Texas Medicaid requires that all non-emergency ambulance transports must be pre-authorized. This was published in the Texas Medicaid Bulletin #128. A non-emergency transport for Texas Medicaid is defined as:
1. A client that meets the severely disabled criteria transported to a scheduled appointment. A client is considered severely disabled when the client's physical condition limits mobility and requires the client to be bed confined at all times, unable to sit unassisted at all times or requires life-support systems to be monitored.

- B. NHIC, the insurance carrier for the Texas Medicaid program, will respond to prior-authorization requests within 48 hours of receipt of the requests.
- C. Documentation of the client's condition that meets the severely disabled definition must be provided at the time of the request.
- D. It is the responsibility of the sending facility to obtain the prior authorization number. This must be provided to LifeNet at the time of transfer. Information and documentation must be sent with the request before the need for transport to the initial or next medical appointment.
- E. Examples of supporting documentation for prior-authorization requests are:
 - 1. Admit and discharge records with prognosis
 - 2. A history and physical from the primary care physician or the care plan with daily activity sheet from the nursing home
 - 3. A history and physical that has been performed within one year or a letter from the primary care physician on his letterhead
- F. If a letter is sent requesting prior authorization, it must be on the physician's letterhead and signed by the physician. The letter must include a detailed description of the client's physical disability or other information documenting that the client meets the severely disabled criteria.
- G. In hospital to hospital or hospital to outpatient medical facility transfers and other situations where documentation is not immediately available, the ambulance unit of NHIC will consider information over the telephone.

This Fax Form can be found on page 24 of the Texas Medicaid Bulletin #128.
If you have any questions, please contact NHIC or LifeNet's Business Office.