FAQ

Q: What services are covered by Medicare and Medicaid?

A: When the patient's condition is such that the use of any other method of transportation would endanger the patient's health. There are three criteria:

1) The patient was suffering from an illness or injury that contraindicated transportation by other means.
2) Destination requirements are met.
3) Transport was medically necessary and reasonable?

Q: What is "*medically necessary* and *reasonable*"?

A: *Medically necessary* is established when patient's clinical condition is such that the use of any other method of transportation, such as taxi, private car, or wheelchair van would be contraindicated (i.e., endanger the patient's health). *Reasonable* is based on whether the patient actually needed to go from point of Origin to point of Destination. (Example: Patient may have IV, Drugs, and Oxygen but if the current hospital or a closer hospital can manage the patient, insurance will not pay to go to a different or more distance hospital.) It is not based on actual availability of another mode of transport. If the ambulance service is not both necessary and reasonable for the illness or injury involved, the service is not covered, even if a Doctor orders the transport.

Q: What about "bedbound"?

A: Defined as being unable, because of medical illness or injury, to get out of bed unassisted, unable to ambulate, AND the inability to sit in a chair or wheelchair. **NOTE: ALL THREE MUST APPLY.** The terms "bedbound" or "non-ambulatory" will not suffice.

Q: When may the patient be expected to sign ABN?

A: When a service could be provided at the origin of the transport (home, Nursing Home, or Hospital), or a transport is to a physician's office, for the convenience of a physician, a patient's choice, or transported beyond the nearest appropriate facility, the patient may be asked to sign an Advance Beneficiary Notice confirming we told you or your family before transport that your insurance would not cover the transport.

Q: How do we help you?

A: We offer 24 hour support for Hospitals and Nursing Homes to help complete forms, advise if services are covered by your insurance, or help to determine if the transport meets medical necessity. No one can predict how a carrier will respond to a claim but our staff knows how to handle appeals when a claim has been wrongly denied.

OUR COMMITTMENT

With over 60 combined years in health care, both hands-on or in the billing office, the office staff of NorthStar EMS brings an honest and knowledgeable approach to EMS. NORTHSTAR EMS staff currently sits on committees with Alabama Medicaid Agency, Alabama Medicare, and the American Ambulance Association. We actively work to bring about positive changes in the EMS industry. We teach classes to hospitals and nursing homes and offer Continuing Education Credits to participants.

We offer rapid response and trained, qualified personnel for 911 or emergency calls. We never ask about insurance coverage or ability to pay. Without hesitation, our professional crews respond, provide care, and transport to the emergency department of the hospital. We never base emergency transports on the patient's ability to pay.

Prior to transporting a non-emergent patient, we may request additional information to determine the correct payor source. Our goal is to make sure the proper payor source is billed. If we recognize a problem, we feel it is our responsibility to advise the patient or the facility of any financial responsibility on their part. We call that *responsible billing*. We ensure that we get necessary forms and information up front to offer the best outcome possible. All runs are not payable but we work hard to see that all payable runs are paid by the insurance carrier.

To help ensure the best outcome, we ask questions about the intended care and payor sources. Obtaining this information at the onset of the transport is optimum. Our goal is to see that every medically necessary trip is covered by the appropriate payor source.

Here at NORTHSTAR EMS, we believe that problems should be resolved before the call is made rather than after the claim is denied.

"Dedicated to providing personalized and professional care to our community"

NorthStar Emergency Medical Services

THERE IS A DIFFERENCE

There is a difference when it comes to ambulance transports. Sure, the units look the same and the crews go through the same training.
So, what could be the difference?

At NORTHSTAR EMS, we think the difference is the continuum of care from the time of the first contact all the way through until the claim is adjudicated.

We would like to tell you about the difference we make.

Support Brochure-July 2009

WHY YOUR CLAIM MAY BE DENIED AND WHAT CAN YOU DO

Insurance carriers often deny claims. A lot of the time, it is due to an error. The error may be their error, it may be the ambulance provider's error, or it may be your error. Here are some things to look for.

- ✓ Check to make sure the insurance carrier is actually your carrier and that all numbers are correct. Send any corrected information back to your ambulance provider and ask them to refile.
  - o Medicare HMO's are billed differently than traditional Medicare. Make sure all providers know who your current Medicare carrier.
  - o Nor all BCBS claims are filed to Alabama BCBS. Make sure NORTHSTAR EMS knows where claims should be mailed.
  - o Medicare, BCBS or other health insurance payors may not be the primary payor on this claim*.
- ✓ Examine your summary notice from your insurance to determine if a partial payment was made and why. Deductible? Co-pay?
- ✓ Call the provider and ask for an explanation or call the insurance carrier and ask for help.
- ✓ If under a company insurance policy, contact the Human Resource Department and ask about coverage limitations.
- ✓ If you are under Medicare, check with your MEDICARE AND YOU Handbook. It explains about how and for what your Medicare pays. Most common reasons your insurance claim is denied are:
  - o Wrong beneficiary name or insurance number.
  - o Wrong insurance carrier on file. If you change insurances, even from traditional Medicare to an HMO, notify all medical agencies involved about the date of the change and the new contract numbers.
  - o Your transport did not meet the criteria of a covered service.
  - o Hospice still has you listed as a Hospice patient.
  - o There was a third party payor* responsible for payment of your ambulance bill.

*If a third party payor has the liability for payment of a claim, your health insurance (public or private) becomes the secondary payor. Auto coverage, home owners, Workers' Compensation, an injury caused by a business, or any claim where an attorney has become involved are all classified as third party liability (TPL) payors. Health insurance carriers become a third party to such claims. The TPL payor must make payment or *prove* they are not liable before your health insurance becomes responsible for payment. It is your responsibility to see that your health carrier is notified about such third party payors. Often, attorneys and auto insurance carriers are unaware of the new rulings from CMS (Center for Medicare and Medicaid Services).

Both you and your attorney or insurance agent are responsible for notifying Medicare and Medicaid of any Third Party Liability (TPL) payor. See 42 U.S.C. 1395y(b) (7) & (8) or go to www.cms.hhs.gov/MandatoryInsRep

THINGS YOUR INSURANCE DOES NOT COVER

MEDICARE (Primary)

- ✓ Does not cover a routine doctor's office visit. Regardless of a physician's letter and regardless of your physical condition. A routine office visit follow up on your progress, to change your medications, or consult with your physician about surgery or advanced care.
- ✓ Medicare does not cover convenience transports. Convenience transports may be from one nursing home to another or one hospital to another to be closer to family, because your physician does not admit to the first hospital, or because you are dissatisfied with the first facility.
- ✓ Does not remain primary if a third party liability payor is involved. This is auto insurance, attorney's, Workers' Compensation, or other third party payors. In such a situation, Medicare becomes secondary.

BLUE CROSS-BLUE SHIELD (Primary)

- ✓ Often does not cover non-emergency transports. A non-emergency transport such as travel from hospital or nursing home to residence or for transport not going to an emergency department of a hospital is frequently denied.
- ✓ Does not cover a routine doctor's office visit*. BCBS is based on the policy paid for by your employer or your privately paid contract. Carefully read your policy to see what it does and does not cover.
- ✓ Does not pay 100% of the billed amount. You are responsible for deductibles and co-pays based on the policy you are covered under. Again, read your policy carefully. Only hospitals and certain physicians are under any agreement to accept Blue Cross paid amount as payment in full.
- ✓ Does not remain primary if a third party liability (TPL) payor in involved*. This is Auto Insurance, Attorney's, and other third party payors. In this event, BCBS becomes secondary.

BLUE CROSS-BLUE SHIELD (Secondary)

- ✓ Will not automatically cover you if your primary insurance does not pay.* There are rare BCBS policies that will pay if the primary does not cover. (B. F. Goodrich, Federal BCBS are examples.) Know your policy's limitations.

MEDICAID is not an insurance, it is an entitlement program and works very differently from insurance carriers. For information on MEDICAID, please speak with one of our office personnel at 1-888-828-0911.

WORKING TOGETHER

1) NORTHSTAR EMS works as a team with nurses, discharge planners, case managers, physicians, hospitals, nursing homes, family members, and transport coordinators with your best interest as the primary objective.
2) Ambulance services are an interactive medical provider with trained health care providers (most over 2000 hours) who continue patient care during transport.
3) Medical information from the hospital or nursing home is just as important for our insurance filing as it is for other providers. Insurance numbers, addresses, dates of birth, admissions information, discharge summaries, and H & P's offer support information when filing initial claims, reviews and hearings with insurance carriers. Make sure all other agencies or facilities have your permission to work with us to quickly resolve problems.
4) If you receive a letter from NORTHSTAR EMS requesting a signature or additional information, respond quickly. All insurance carriers have time frames for filing claims.
5) Remember, as a patient advocate, NORTHSTAR EMS works aggressively to see that all claims that meet both a) medical necessity and 2) meet the covered services requirements are paid correctly by your insurance.
6) **If you are left with a co-pay or deductible or if you are un-insured, we will work with you to set up payment plans.**

Most insurance carriers require a signature from the patient, the Power of Attorney or from the sending or receiving facility.
If we do not have a signature at time of service, the claim becomes your responsibility until a signature is received. If you receive a Signature Form, please check all information, correct information, sign, and return the form promptly to our office.