DEFINITIONS

BEDBOUND – Must meet all three (3) criteria. Cannot get out of bed, unable to ambulate, cannot sit (chair, wheelchair or car).

Physician Certification Statement (PCS) – Any form that proves other modes of transport (car, wheelchair, etc.) are contraindicated and a stretcher is required. Statements like "weak", "needs supervision", and "bedbound" without any qualifiers or explanation are too vague and carriers will not accept these as valid reasons.

Prior Authorization – When required prior to transport, we will ask the questions that the carrier will ask of us and submit those answers in order to get the authorization. Without authorization, the carrier will not pay even with a great PCS. We never ask for information the carrier does not require.

Contracted Supplier – Some carriers have contracted ambulance providers that should be used for non-emergency transports. If the hospital or nursing home chooses another provider, the contracted carrier will not pay regardless of medical necessity.

HMO's and Ambulance Transports – Some HMO's (i.e. Viva, Healthspring, Seniors First, etc.) leave the patient with high co-pay with some over as $150.00. This can be for emergency and non-emergency transports.

HIPAA – It was never the intent of the HIPAA regulation to restrict the flow of information between the ambulance company and the patient's sending or receiving facility. Direct treatment relationships have regulatory permission for such uses and disclosures. (CFR Vol 67, No. 157, 8/14/02).

ABN – Advance Beneficiary Notices can be required on ambulance transports. The ambulance provider has the same responsibility as other health care entities to advise the patient that a service may be denied.

Medically Necessary – Medical necessity is established when patient's clinical condition is such that the use of any other method of transport could endanger the patient's health.

NorthStar, Your EMS Provider

Just like hospitals, nursing homes, DME suppliers, medical laboratories, home health agencies, and hospice providers; our goad is to provide cost effective, appropriate service for beneficiaries. Just as case managers seek options and solutions when discharging patients, the transportation industry seek these same options and solutions when accepting non-emergency patients. The medical needs of the patient, proper payer sources; appropriate receiving facilities; required signatures, compliance forms; meeting city, state, and federal regulations; and proper crews are just some of the considerations we prepare for. Sometimes it seems that some of these responsibilities put our agency at odds with other health care providers but it certainly should not.

The primary objective of all providers should be to see that the patient is transported by the appropriate means; to the appropriate place; at the most economical cost; and with minimal health or medical risk. If an insurance carrier is responsible for payment, the objective should also include seeing that all information is gathered to ensure the insurance carrier pays. This is prudent for the patient and for all providers involved in the continuum of care.

There are times that some services are not covered by a patient's insurance. Long distant transports, transports to avail the patient of his preferred physician, and transports that constitute a downgrade in care are not covered. In this situation, the patient needs to be informed of this prior to the transport. We work the family and the facility to resolve such issues.

For more information, please call Capstone Claims at:
(888) 828-0911

Managing the Course of a Patient's

"Guidelines for an integrated transportation industry, which highlight the forms and legal requirements for **Continuum of Care**

Developed by:
Carolyn Howell, Medical Analyst
Capstone Claims

"Dedicated to providing personalized and professional care to our community

PATIENT DISCHARGE/TRANSFER

The payer source may differ depending on the type of insurance but the premise does not. A patient is to be a) transported to the most appropriate facility and b) be transported by the most appropriate mode of transportation.

All discharges should be going to the nearest appropriate facility whether to another hospital or to a nursing home.

Almost all payors requires PCS forms, transfer forms (when hospital to hospital), and signatures of beneficiary. If your transfer or discharge varies from these specifics, you may wish to consider contacting our office to protect the patient from bearing the cost of ambulance transport.

HOSPITAL TO HOSPITAL TRANSFER

- A claim cannot be filed without a signed PCS **and** transfer orders indicating what has been done to the patient **and** what care is expected to be needed in route. (A COBRA [EMTALA] requirement).
- Patient must have been accepted by the receiving facility.
- Patient needs to be going for a higher level of care.
- Details of why the patient requires a stretcher or a medical attendant **and** why other modes of transport are contraindicated should be documented.
- The PCS or Transfer Order should specify the upgrade in care to be provided.

HOSPITAL TO NURSING HOME TRANSFER

- A claim cannot be filed without a signed PCS.
- Detail why the patient requires a stretcher or a medical attendant and why other modes of transport are contraindicated on the PCS

HOSPITAL TO HOME

- A claim cannot be filed without a signed PCS
- The PCS should explain why other modes of transport are contraindicated and what mental, medical, or physical condition required a stretcher of medical attendant.

NORTHSTAR INSURANCE SPECIFICS

All insurance carriers, both public and private, require:

- Patient signatures
- Physician Certification Statement for non-emergent transports
- Require that transports be reasonable and medically necessary.

No insurance carrier will pay to take a patient from a hospital to dialysis or to a doctor's office.

Medicare (Traditional)

- All Medicare pay for ambulance transport under Part B. Medicare Part A does not pay for ambulance transport.
- Traditional Medicare has a 20% co-pay after deductible, covers both emergency and non-emergency transports meeting reasonableness and medical necessity requirements.
- It covers trips from hospital to nursing home, transports from nursing home to free standing diagnostic facilities, and trips from hospital to home.
- Medicare does not pay to be transported to a physician's office or clinic regardless of the condition of the patient.

Medicare Advantage Plans (VIVA, HealthSpring, Seniors First, Blue Advantage, etc.)

- Some leave patients with co-pays on every transport that may be $150 or more.
- Some use strictly contracted services.
- Most do not cover non-emergency without prior authorization. An exception to this is Blue Advantage.
- All signature and PCS requirements apply as with traditional Medicare.
- HealthSpring, Senior's First, Secure Horizons, etc. require prior authorization on all non-emergency transports.
- VIVA uses contracted transport services only.

Workers' Compensation

Workers' Compensation require prior authorization before non-emergency transports.

Private Insurance Policies (BCBS, UHC, etc.)

- Most private insurance policies will not reimburse to take a patient home or back to a nursing home.
- Policies are based on the contract initiated by employer group's plan.
- Most policies do not cover non-emergent transports unless the case manager from the insurance company deems such as covered.

Alabama Medicaid

- Not all Medicaid offers transport services. Only going on the Medicaid Web can coverage be determined.
- As an entitlement program, it covers some services not covered by primary insurance carriers.
- Depending on aid category, it may cover transports from hospital to dialysis, home to physician's office and even hospital to physician's office.
- Our transport coordinators will gladly research to see what services are offered based on the aid category of the patient.
- Medicaid requires prior authorization and proof of medical necessity for all transports over 99 miles.

Prospectus Payment Services (PPS)

Under PPS, any patient continued as a Medicare Part A in-patient yet transport out and returned for service not available at the hospital or nursing home, the transport services must be billed to the in-patient facility. (An example would be the Scan machine not operational and patient must go out for the Scan but will be returned to the facility).

VA Patients

- If patient has Medicare, Medicare regulations apply.
- If patient is solely covered by VA, with few exceptions, payment is made only to the current contracted service.