



ROWAN COUNTY EMS

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STANDARD PROCEDURE

INSURANCE GUIDELINES – Medicare

- Medicare coverage issues directly affect EMS operations. Certain types of trips are non-covered services. An example is a trip from the patient's residence to a doctor's office.
- Medicare pays for transport to the closest appropriate facility. Mileage to more distant hospitals selected for patient or family preference will not be paid.
- Medicare only pays when there is Medical Necessity for an ambulance. Medical necessity is met when transportation by any other means would harm the patient. So if the patient could go in a wheel chair van, Medicare will not pay for the ambulance even if there is no wheel chair van service.
- Medicare will not pay for services that could have been performed at the originating facility. Transfers from skilled nursing facilities for evaluation at the physician's office are not covered. However, a trip to the physician's office for a specialized test or x-ray that could not be done at the nursing home is paid.
- Medicare is available for the elderly and disabled. There are two types of Medicare; Part A (hospital insurance) and Part B (covers ambulance service). Some patients in skilled nursing facilities are covered under their Part A benefit.
- PPS refers to Prospective Payment System. This payment methodology pays the skilled nursing facility a per diem amount for those Medicare patients on Part A benefits.
- When responding to skilled nursing homes check whether the patient is PPS or not and note this information. Claims on PPS patients go to different insurance carriers.
- Documentation on non-emergency ambulance transportation is vital. Most need a medical necessity form.
- To qualify for Medicare coverage of a non-emergency trip the patient usually must be bed-confined.
- For payment purposes bed-confined means that the patient cannot get out of bed without assistance, cannot walk without assistance and cannot sit in a chair or wheel chair. All three criteria must be met.

INSURANCE GUIDELINES – Medicare (continued)

- Medicare requires a completed medical necessity statement on all **scheduled** non-emergency transports from a facility (skilled nursing home, hospital).
- Patients with scheduled non-emergency transports from a private residence do not need a medical necessity form. Usually these trips are non-covered services.
- Rest homes and domiciliary care homes are considered private residences.
- Scheduled is interpreted as pre-arranged. Any appointment made with less than 24 hours notice is considered unscheduled. So an appointment made this morning for 1500 hours this afternoon is treated as if it were unscheduled.
- In the case of unscheduled non-emergency trips the physician has 48 hours to submit the medical necessity form. If this trip originates from the ED get the medical necessity at the time of transport while the doctor is there.
- Medical necessity forms are valid for sixty days for those patients who have repetitive, scheduled non-emergency trips. A bed-ridden dialysis patient would fall into this category.
- Medical necessity forms are required on all inter-hospital transfers, even emergencies. Try to get these but do not compromise the patient with a long delay.
- In cases where the required documentation is unavailable, inform the patient and/or responsible party that Medicare is expected to deny payment for lack of medical necessity. Inform them that the county will file a claim but that we need their signature accepting financial responsibility if Medicare refuses to pay.
- Be polite and non-confrontational.
- If you suspect that the medical necessity statement is not accurate, make this clear by documenting the patient's condition. For example, the hospital information may say the patient is bed-confined. The physician may say the patient can go no other way but you observe the patient sitting in a wheel chair. **The patient is not bed-confined by Medicare payment guidelines.**
- If the county accepts Medicare payments based on false documentation, we and you are guilty of fraud. Avoid becoming a party to fraud by clearly documenting the patient's condition.
- EMS crews may assist the physician or health care facility by completing the medical necessity form. The key is descriptive information which explains the need for ambulance transportation. Focus on the patient's condition, not the diagnosis or test to be performed.
- Health care facilities inappropriately using county ambulance resources will be charged

for ambulance transports by Rowan County ordinance.
INSURANCE GUIDELINES – Medicaid

- Medicaid is funded by federal and state tax dollars. Recipients have low incomes. Medicaid clients are instructed to present their cards at the time of service.
- EMS is not required to accept Medicaid if the client has requested a non-covered service. For example, you find an able person with a minor medical problem requesting an ambulance for convenience, do not accept Medicaid.
- **Do not write the Medicaid number on the ACR.** Whenever a hospital insurance information sheet is available, staple it to the ACR.
- Once a Medicaid number is printed on the ACR, the county is legally obligated to file the claim. But we do not have to submit claims for non-covered services.
- Medicaid medical necessity requirements are like Medicare, i.e. if the patient can travel another way without endangering their health, no ambulance is needed.
- Medicaid denials must be written off because, we cannot follow with a bill to the patient.

INSURANCE GUIDELINES – Private Insurance

- Coverage guidelines vary among insurance companies. Collect complete numbers for all insurance policies whenever possible.
- Signatures from the patient or responsible party are essential for payment.
- List the patient's social security number on the ACR. This is often helpful in working with private insurance companies.

INSURANCE GUIDELINES – Fee Structure

- Rowan County EMS charges for a base fee which covers all EMT level services and transportation.
- We charge separately for oxygen, ALS supplies (services beyond EMT) and mileage outside the county.
- Charge a full base fee for transport to a helicopter landing zone.
- Changes in the fee structure are decided by the commissioners. New prices will be posted whenever the fee schedule is updated.
- County residents in fringe areas of the county will not be charged mileage for transport to the closest hospital even if it is outside Rowan County. For example transports from the southern portion of Rowan to Northeast Medical Center.

INSURANCE GUIDELINES – Fee Structure (continued)

- After the first 30 minutes at the destination, the patient will be billed \$10 for each 15 minute portion of the hour. Crews should discourage waiting time and help the patient get prompt attention.
- Patients receiving physical examinations and/or treatments who are not transported will be charged the ALS supply fee.
- A sticker with supplemental billing information, the “Kelley Sticker”, should be affixed to the bottom of the narrative page. Check the appropriate blocks.
- No Kelley Sticker is needed on the ACR when the patient is not transported.