Questions and answers from our July 11, 2018 webcast on Ambulance Services: New Policy and Review Updates (A/B).

July 11, 2018 -- Follow-up questions and answers

Ambulance Services: New Policy and Review Updates (A/B)

The following questions originated in the above-referenced event. The questions are followed by the appropriate answer and the sources of the information are provided. For additional information or details, please refer to the frequently-asked questions (FAQs) page and the recording of the webcast on First Coast University.

1Q: What are Medicare's guidelines regarding use of an Advance Beneficiary Notice (ABN) in relation to ambulance services?

1A: The Centers for Medicare & Medicaid Services (CMS) Medicare Claims Processing Manual states:

> *A. Advance Beneficiary Notice of Noncoverage (ABN) issuance in emergency or urgent situations:*
>
> *In general, a notifier may not issue an ABN to a beneficiary who has a medical emergency or is under similar duress. Forcing delivery of an ABN during an emergency may be considered coercive. ABN usage in the ER may be appropriate in some cases where the beneficiary is medically stable with no emergent health issues.*
>
> *B. ABN issuance for ambulance transport*
>
> *Issuance of the ABN is mandatory for ambulance transport services if all of the following three criteria are met:*
>
> *1. The service being provided is a Medicare covered ambulance benefit under §1861(s)(7) of the Social Security Act and regulations under this section as stipulated in 42 Code of Federal Regulations §410.40 -.41;*
>
> *2. The provider believes that the service may be denied, in part or in full, as "not reasonable and necessary" under §1862(a)(1)(A) for the beneficiary on that particular occasion; and*
>
> *3. The ambulance service is being provided in a non-emergency situation. (The patient is not under duress.)*
>
> *ABN issuance is mandatory only when a beneficiary's covered ambulance transport is modified to a level that is not medically reasonable and necessary and will incur additional costs. If an ambulance transport is statutorily excluded from coverage because it fails to meet Medicare's definition of the ambulance benefit, a voluntary ABN may be issued to notify the beneficiary of his/her financial liability as a courtesy.*

Source: CMS Internet-Only Manuals Publication 100-04, Chapter 30, Section 50.15.2

2Q: If an ambulance provider is purposefully submitting a claim using the GY modifier to acknowledge that the service is/will be statutorily excluded, is the dual diagnosis requirement still in effect (i.e., is there still a requirement that a secondary diagnosis via a Z-code be submitted?)

2A: Although the GY modifier (defined as "item or service statutorily excluded or does not meet the definition of any Medicare benefit") may be a determinant of claim processing, based on local coverage determination (LCD) L37697-*Emergency and Non-Emergency Ground Ambulance Services*, effective on June 28, 2018, all ambulance transports require a dual diagnosis.

Source: LCD L37697 - effective 06/28/2018

3Q: What changes have been made relating to consolidated billing for ambulance transportation for skilled nursing facility (SNF) residents according to transmittal MM10550**?**

***3*A:** Based on Medicare Learning Network (MLN®) Matters® (MM) 10550, CMS is revising the Medicare Benefit Policy Manual and Medicare Claims Processing Manual to clarify that a medically necessary ambulance transport from a SNF to the nearest supplier of medically necessary services not available at the SNF where the beneficiary is a resident (including the return trip) may be covered under Part B. This applies to beneficiaries who are in a SNF stay not covered by Part A, but who have Part B benefits.

To address questions relating to this change, the points below have been highlighted:

- If the beneficiary is a resident of a SNF and must be transported by ambulance to receive dialysis or certain high-end outpatient hospital services, the ambulance transport may be separately payable under Part B.

- If the beneficiary is a SNF resident and not in a Part A covered stay and must be transported by ambulance to the nearest supplier of medically necessary services not available at the SNF, the ambulance transport, including the return trip, may be covered under Part B.
- When billing for ambulance transports of SNF residents, suppliers should indicate whether the transport was part of a SNF Part A covered stay, using the appropriate origin/destination modifier.
- The following may be billed as Part B services:
  - The ambulance trip is to or from a hospital based or non-hospital based ESRD facility (either one of any Healthcare Common Procedure Coding System-HCPCS code ambulance modifiers is G [Hospital based dialysis facility] or J [Non-hospital based dialysis facility] and the other modifier is N [SNF]).
  - An ambulance transport from a SNF to the nearest supplier of medically necessary services not available at the SNF where the beneficiary is a resident and not in a covered Part A stay, including the return trip, is covered under Part B provided that the ambulance transportation was medically reasonable and necessary and all other coverage requirements are met.

Other coverage guidelines and requirements relating to billing for ambulance transports of SNF residents remain unchanged and can be found in Chapter 15 of the Medicare Claims Processing Manual.

Source: Centers for Medicare & Medicaid Services (CMS) Internet-Only Manuals, Publication 100-04, Chapter 15 - Ambulance