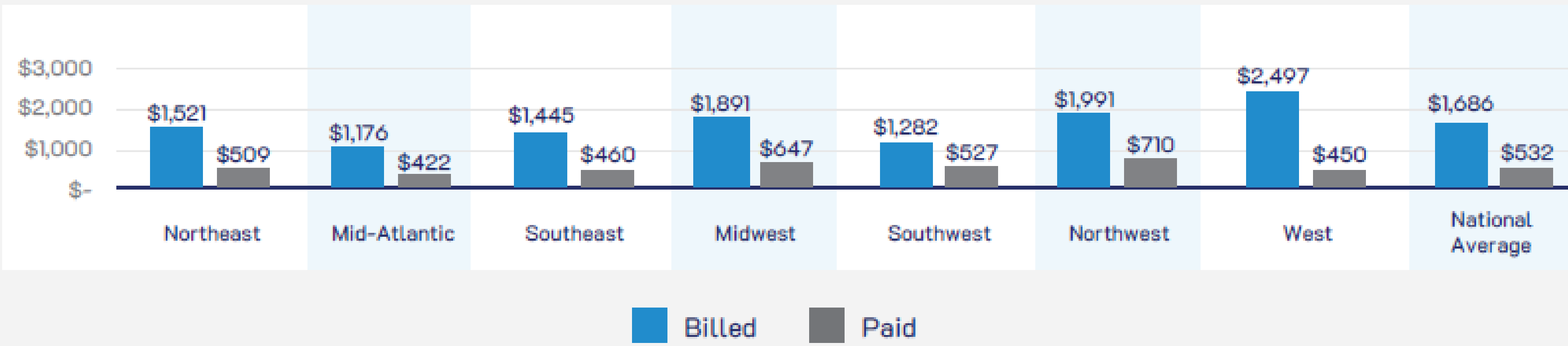
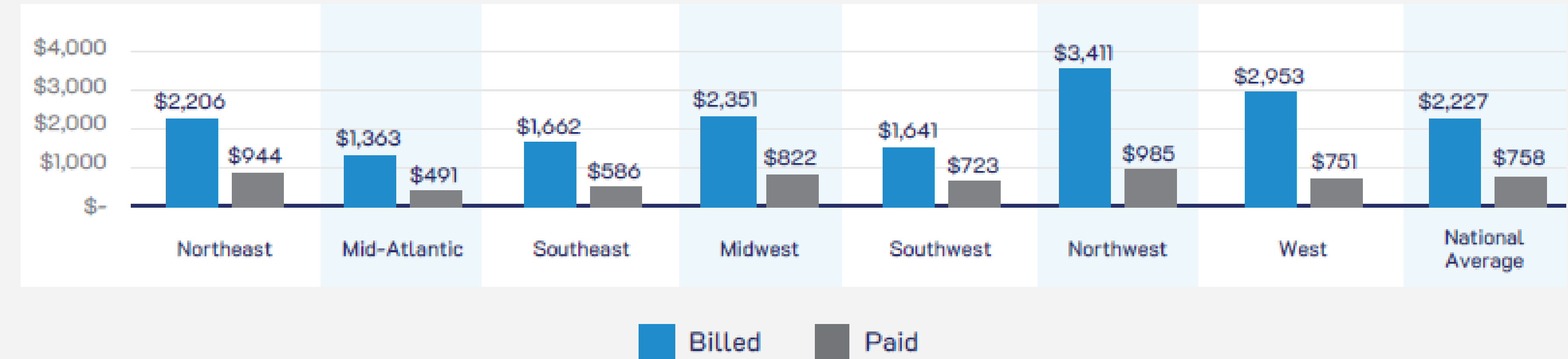
Demystifying Interfacility Transports

EMS|MC

Index: Inter-Hospital Transfer Services

Service Mix	Northeast	Mid-Atlantic	Southeast	Midwest	Southwest	Northwest	West	National
Inter-Hospital Transports	10,2791	50,135	48,946	84,264	16,838	3,778	9,161	223,401
% Emergency	11.9%	20.8%	38.1%	24.3%	40.7%	51.3%	83.2%	30.1%
% Non-Emergency	34.2%	69.9%	53.1%	69.6%	53.2%	41.2%	16.8%	60.6%
% BLS	36.2%	35.7%	44.1%	46.3%	49.9%	62.8%	39.6%	43.2%
% ALS	9.7%	55.0%	47.1%	47.7%	44.0%	29.6%	58.7%	47.3%
% ALS2	0.0%	1.7%	1.0%	1.5%	1.1%	0.1%	0.8%	1.3%
% SCT	53.8%	7.7%	7.8%	4.6%	5.0%	7.4%	0.8%	8.2%





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Index: Inter-Hospital Transfer Services

Payer Mix	Northeast	Mid-Atlantic	Southeast	Midwest	Southwest	Northwest	West	National
Medicare	18.7%	20.2%	20.2%	19.8%	16.6%	11.4%	19.1%	19.6%
Medicare Advantage	19.7%	27.1%	23.6%	23.4%	18.9%	9.8%	15.3%	23.3%
Medicaid	2.9%	3.7%	10.0%	4.3%	0.8%	8.6%	8.2%	5.3%
Medicaid MCO	12.0%	11.9%	3.8%	14.9%	7.4%	0.1%	21.3%	11.1%
Insurance	18.3%	19.0%	23.6%	17.8%	28.8%	13.9%	16.8%	20.1%
Patient	13.3%	8.5%	9.8%	9.2%	9.0%	45.2%	10.2%	9.9%
Facility	9.7%	5.7%	6.1%	7.1%	15.0%	9.6%	1.5%	7.1%
Other Government Payers	4.7%	3.6%	2.6%	2.8%	3.3%	0.5%	0.7%	3.0%
TPL	0.8%	0.3%	0.3%	0.2%	0.2%	0.0%	0.3%	0.3%
VA	0.0%	0.0%	0.0%	0.4%	0.0%	0.7%	1.3%	0.2%
Workers Comp	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.4%	0.0%
Other	0.0%	0.0%	0.0%	0.0%	0.0%	0.3%	4.9%	0.2%

What does CMS say?

Chapter 10 –

- 10.2.1 – Necessity of Service
- 10.2.2 – Reasonableness of Ambulance Transport
- 10.2.3 – Institution to Institution
- 10.3.3 – Separately Payable Ambulance Transportation vs. “Packaged” Hospital Service

Necessity of Service

Medical Necessity is established when the patient's condition is such that use of any other method of transportation is contraindicated.

Reasonableness of Ambulance Transport

Payment is based on the level of service furnished (provided they were medically necessary), not simply on the vehicle used.

Institution to Institution

The institution is found to have inadequate or unavailable facilities to provide the required care, and the patient is then transported to a second institution having appropriate facilities.

In such cases, transportation by ambulance to both institutions would be covered to the extent of the mileage to be the nearest institution with appropriate facilities.

Separately Payable Ambulance Transportation vs. “Packaged” Hospital Service

3-Part Rule

- Provider Numbers
  - If the Medicare-assigned provider numbers of the two providers are different, then the ambulance service is separately billable to the program. If the provider number of both providers is the same, then consider criterion 2, “campus”.

Separately Payable Ambulance Transportation vs. “Packaged” Hospital Service

3-Part Rule

- If the “Campus” of the two providers are different, then consider criterion 3
  - “Campus” means the physical area immediately adjacent to the provider’s main buildings, other areas and structures that are not strictly contiguous to the main buildings but are located within 250 yards of the main buildings, and any of the other areas determined on an individual case basis by the CMS regional office to be part of the provider’s campus.

Separately Payable Ambulance Transportation vs. “Packaged” Hospital Service

3-Part Rule

- Patient Status–Inpatient vs. Outpatient
  - If the patient is an inpatient at both providers, then the transport is not separately billable.
  - All other combinations are separately billable.
    - Outpatient to Inpatient
    - Inpatient to Outpatient
    - Outpatient to Outpatient

Confidential

Separately Payable Ambulance Transportation vs. “Packaged” Hospital Service

3-Part Rule

- Patient Status-Inpatient vs. Outpatient
  - *The discharge of a beneficiary from one department with subsequent admission to another provider, is payable as a Part B ambulance transport, because at the time that the beneficiary is in transit, the beneficiary is not a patient of either provider…*
  - *This includes an outpatient transfer from a remote, off-campus emergency department (ER) to becoming an inpatient or outpatient at the main campus hospital, even if the ER is owned and operated by the hospital.*

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What is a Physician Certification Statement (PCS)?

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A Physician Certification Statement (PCS) is a document **signed and dated** by the attending physician — or, in certain cases, by an authorized non-physician practitioner — that **certifies a patient's medical necessity for non-emergency ambulance transport** as required under **42 CFR § 410.40.**

It's important to note that the presence of a PCS form **does not automatically ensure coverage.** All other Medicare program requirements for medical necessity and documentation must also be satisfied.

Key Requirements at a Glance

Who Must Sign

The **attending physician** must sign for **scheduled or repetitive non-emergency transports.**

For **unscheduled or non-repetitive transports** — if the attending physician's signature cannot be obtained — an **authorized non-physician practitioner** may sign. Authorized practitioners include a **Physician Assistant (PA), Nurse Practitioner (NP), Clinical Nurse Specialist (CNS), Case Manager, Registered Nurse (RN), Social Worker, or Discharge Planner** with **direct knowledge of the patient's condition.**

What Must Be Included

- **Patient identification details** (name, date of transport, and other demographic information).
- A **clear medical statement** explaining why the patient's condition requires ambulance transport.
- The **signature, credentials, and date** of the signing practitioner. The signature must be **legible** or accompanied by a **printed name** if not legible.

Timing / Validity

- For **scheduled, repetitive non-emergency transports,** the PCS must be **dated no more than 60 days before** the transport.
- For **unscheduled or non-repetitive non-emergency transports,** the PCS may be obtained **within 48 hours after the transport** if the patient is a **facility resident under physician care.**

Medical Necessity Standard

Ambulance transport is **medically necessary** if:

- The patient's condition **contraindicates other forms of transport,** and an ambulance is required; or
- The patient is **bed-confined** (unable to rise without assistance, ambulate, or sit in a chair or wheelchair) and other transport means are contraindicated.

Documentation Retention

The ambulance supplier must **retain the PCS and all supporting documentation.** If a valid PCS — or documented effort to obtain one — is missing when requested, the claim may be **denied.**

Prior Authorization Requirements

- Traditional Medicare
  - Not Required Except for Repetitive Patients
    - Once-per-week for three weeks or 3-times in a 10-day period
- Medicare Advantage
  - May be more restrictive than Traditional Medicare
    - BCBS MCR and UHC MCR are amongst highest offenders
- Medicaid MCO
  - Most MCO plans partner with NEMT Broker and require authorization prior to transport
- Establish relationship with facilities – specifically discharge planners to identify those instances in which a PA is required

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