Medicare Desk Reference for Hospitals

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A-C

Ambulance Services

Ambulance services involve the care and treatment of patients while they are transported from one destination to another. Some hospitals own their own ambulance company; however, most are privately owned or are part of a governmental agency such as a city fire department. Nevertheless, the staff in the emergency room (ER) and the ambulance staff develop strong communication processes that help care for the patient.

Telecommunications equipment in most ERs provide the physicians and nurses the means to give health care instructions to the ambulance crew. At the same time, it allows the crew to alert the ER staff of the patient's condition so they it be prepared for the patient's arrival.

Medicare covers ambulance services that are furnished to a beneficiary whose medical condition is such that other means of transportation would be contraindicated. While physician certification allows the ambulance supplier to assert that transportation was reasonable and necessary, the beneficiary's medical documentation must support the coverage of the transportation.

All ambulance suppliers must accept assignment. This means that suppliers cannot bill or collect from the beneficiary any amount other than any unmet Part B deductible and/or Part B coinsurance amounts.

Coverage Criteria

Medicare coverage guidelines for ambulance services require that level of service, medical necessity, and origin and destination requirements are met. Medicare Part A covers ambulance services when a hospital inpatient is transported to and from another hospital for specialized treatment. Payment for these services is included in the prospective payment rate. Medicare Part B covers ambulance services when Part A coverage is unavailable and the following criteria are met:

- The transport of the beneficiary actually takes place
- The beneficiary is transported to the correct place
- The transport is medically necessary
- The ambulance provider meets all vehicle, billing, staffing, and reporting standards
- The transport is not part of a Part A service

Medical Necessity

Coverage of ambulance services is based on medical necessity established when the patient's condition warrants ambulance transport and any other method of transportation is contraindicated. Detailed conditions of coverage are stipulated in the *Medicare Benefit Policy Manual*, Pub. 100-02, and include the vehicle and crew requirements, the destination, medical necessity, and coverage guidelines.

Medicare pays for medically necessary ambulance services only when other methods of transportation would endanger the beneficiary's health. Only ambulance transport to local facilities is covered unless the necessary services are not available locally. Then transportation to the nearest facility furnishing the necessary services would be covered. To better achieve these goals, the coverage rules tighten the requirements for determining medical necessity, require improved documentation from ambulance companies, and require physician certification for nonemergency ambulance transport.

The medical necessity requirements specifies when a beneficiary is considered bed-confined and, therefore, eligible for ambulance transport. A patient is eligible for ambulance transport when all other forms of transportation are contraindicated by the patient's condition.

Also required for nonemergency, scheduled ambulance services is a written order from the beneficiary's attending physician certifying that the bed-confined requirements listed above are met. The ambulance supplier must get the certification prior to furnishing the service, but no earlier than 60 days before the date the service is furnished.

A physician certification statement is not required for the following ambulance services:

- For an emergency transport
- For a nonemergency, unscheduled ambulance transport for a beneficiary who was living at home or in a facility and was not under the direct care of a physician

Air Ambulance

There are two types of air ambulances: fixed wing (airplane) and rotary wing (helicopter) aircraft. The air ambulance mileage rate takes into account the higher operational costs. Air ambulance mileage rate is calculated per actual loaded (patient onboard) miles flown and is expressed in statute miles (not nautical miles).

Hemodialysis

See "End-Stage Renal Disease" section.

Hemophilia Blood Clotting Factors

Hemophilia is an inherited bleeding or coagulation disorder. Persons with hemophilia lack the ability to stop bleeding because of the low levels of, or complete absence of, specific proteins called "factors" in their blood that are necessary for clotting. Proper clotting of blood helps prevent excessive bleeding. There are several types of hemophilia, but the most common and well known include the following:

- Hemophilia A—lack of factor VIII
- Hemophilia B—lack of factor IX

In the US, there are about 20,000 persons who have hemophilia, and each year approximately 400 babies are born with the disease.

Coverage Criteria

The Balanced Budget Act of 1997 reinstated the add-on payment for the costs of administering blood clotting factors to Medicare hemophiliacs who are hospital inpatients. Hemophilia clotting factors may be billed with revenue code 0636 Drugs requiring detailed coding, on an inpatient prospective payment system (IPPS) claim. The add-on payment is based on the median average wholesale price of several products, discounted by 5 percent.

Under the outpatient prospective payment system (OPPS), these drugs are assigned their own ambulatory payment classification (APC) and are separately payable:

For 2010, HCPCS code J7197 Antithrombin III (human), per IU has a status indicator of K, meaning this code is paid a separate APC payment under OPPS. Previously CMS included the clotting factor furnishing fee in the payment limit for HCPCS code J7197. This code does not describe a hemophilia-clotting factor. Therefore, the payment limit will not include the clotting factor furnishing fee. Code J7199 Hemophilia clotting factor, not otherwise classified, is not reportable by facilities.

Billing and Coding Rules ⦿

Hemophilia blood clotting factors administered to hospital inpatients must be billed with revenue code 0636 and an appropriate HCPCS code must be reported in FL 44 HCPCS/Rates. Effective January 1, 2011, use the following HCPCS codes:

J7185	Injection, factor VIII (antihemophilic factor, recombinant) (XYNTHA), per IU
J7186	Antihemophilic factor viii/von Willebrand factor complex, (human), per factor viii IU
J7187	Von Willebrand factor complex, human, ristocetin cofactor, per IU VWF:RCO
J7189	Factor VIIa (antihemophilic factor, recombinant), per 1 mcg
J7190	Factor VIII (antihemophilic factor, human) per IU
J7191	Factor VIII (antihemophilic factor (porcine)), per IU
J7192	Factor VIII (antihemophilic factor, recombinant) per IU
J7193	Factor IX (antihemophilic factor, purified, nonrecombinant) per IU
J7194	Factor IX complex, per IU
J7195	Factor IX (antihemophilic factor, recombinant) per IU
J7197	Antithrombin III (human), per IU
J7198	Antiinhibitor, per IU

Any other use of revenue code 0636 on an inpatient claim is incorrect. Other inpatient drugs are billed without HCPCS codes using 0250 Pharmacy.

The units of blood clotting factor also must be reported in FL 46. To determine the number of units to report on the claim, divide the number of international units (IU) administered by 100 and round the answer to the nearest whole number. For example, 100 IU of any of the clotting factors are reported as one billing unit in FL 46 (i.e., 100 IU = one billing unit). For units between 1 and 49, round down to the next unit. For units of 50 to 99, round up to the next unit.

For example, 1,249 IU are reported as 12 units in FL 46; 1,250 IU are reported as 13 units.

Organ or Disease-Oriented Panels

A laboratory panel test is several tests combined under one HCPCS code. For example, an electrolyte panel (HCPCS code 80051) is composed of the following laboratory tests:

- Carbon dioxide (82374)
- Chloride (82435)
- Potassium (84132)
- Sodium (84295)

All of the tests within a panel must be medically necessary to be covered.

Coverage Criteria

When an organ or disease-oriented panel code is billed, the provider must be able to support the medical necessity of all tests that comprise the panel. Organ and disease panels and component tests billed to a federally funded program must be based on a written order and be medically necessary. Chemistry components will be bundled to the panel level when all of the tests in the panel are ordered and performed.

Billing and Coding Rules

If one of the organ or disease-oriented panels (CPT code) listed below is billed, the provider must have performed all of the tests that are shown with the panel.

Organ/Disease Panel Codes

Must Include Automated Multichannel Chemistry Tests	
80047	82330, 82374, 82435, 82565, 82947, 84132, 84295, 84520
80048	82310, 82374, 82435, 82565, 82947, 84132, 84295, 84520
80050	80053, 85025 or 85027 and 85004, OR 85027 and 85007 or 85009, 84443
80051	82374, 82435, 84132, 84295
80053	82040, 82247, 82310, 82374, 82435, 82565, 82947, 84075, 84132, 84155, 84295, 84450, 84460, 84520
80055	85025 or 85027 and 85004 OR 85027 and 85007 or 85009, 87340, 86762, 86592, 86850, 86900 AND 86901
80061	82465, 83718, 84478
80069	82040, 82310, 82374, 82435, 82565, 82947, 84100, 84132, 84295, 84520
80074	86709, 86705, 86803, 87340
80076	82040, 82247, 82248, 84075, 84155, 84450, 84460

Repeated laboratory tests, including overlapping components of panels, may be billed when the tests are medically necessary, which is indicated by reporting modifier 91. Report Modifier 91 only when in the course of treating a patient, it is necessary to repeat the same laboratory test on the same day to obtain subsequent test results. This modifier may not be reported when tests are rerun to confirm initial results; due to testing problems with specimens or equipment; or for any other reason when a normal, one-time, reportable result is all that is required. This modifier may not be used when other code(s) describe a series of test results (e.g., glucose tolerance tests, evocative or suppression testing).

Reimbursement Issues

If organ and disease panels and new automated panel codes are billed on the same claim, the FI will determine whether any of the individual automated tests are included in the organ and disease panel. If no individual automated tests are included in the panel, then reimbursement will be for both the organ and disease panel and the automated panel code. If there are duplicate tests, the duplicates will not be reimbursed.

References

Clinical diagnostic laboratory fee schedule

Medicare Claims Processing Manual, Pub. 100-04, chap. 3, sec. 40.4; chap. 16, secs. 30, 30.3, 90.2 (trans. 1451, February 15, 2008); chap. 23, secs. 20.9, 20.9.2, 20.9.3, 20.9.4, 20.9.5, 20.9.6