Self Help Packet for Ambulance Appeals

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1. Introduction

Dear Medicare Beneficiary:

The Center for Medicare Advocacy has produced this packet to help you understand Medicare coverage and to file an appeal if appropriate.

Medicare is the national health insurance program to which many disabled individuals and most older people are entitled under the Social Security Act. All too often, Medicare claims are erroneously denied. It is your right to appeal an unfair denial and we urge you to do so.

For additional assistance, contact your State Health Insurance Assistance Program (SHIP). You can find your state program's information at https://shipnpr.shiptalk.org/shipprofile.aspx.

2. Checklist for Ambulance Appeals

There are several levels of appeal. The process begins when you receive the "Medicare Summary Notice." If you are being held financially responsible for your transport, appeal the denial. If the provider is being held financially responsible, call the Center for Medicare Advocacy to discuss whether or not to appeal.

☐ 1. (1st appeal level) After you receive the "Medicare Summary Notice," request a Redetermination for the denial.

- Follow the instructions on the last page of the MSN for how to file the appeal.
- You have 120 days to appeal the denial.
- Ask that the physician who ordered the transport or your primary care physician write a statement explaining why the transport was medically necessary.
- Send a copy of the letter and any other documentation in support of coverage along with your appeal.

☐ 2. Gather more support for your case.

- Request a copy of the transport run-sheet from the ambulance provider.
- If your transport was from a hospital or other inpatient provider, request your medical record. Note that some states allow facilities to charge a fee for copying medical records.

☐ 3. Receive the Redetermination decision.

☐ 4. (2nd appeal level) If the Redetermination decision is unfavorable, request a Reconsideration. Follow the instructions in the decision on how to do this.

- You have 180 days to request the Reconsideration.
- Include in your appeal request that you are a beneficiary appealing the denial because you met the Medicare requirements for coverage of your ambulance transport.
- Send copies of any additional documentation in support of coverage along with your request.

☐ 5. Receive the Reconsideration decision.

☐ 6. (3rd appeal level) If the Reconsideration decision is unfavorable, request an Administrative Law Judge (ALJ) Hearing.

- Follow the instructions in the decision on how to do this.
- You have 60 days to request an ALJ hearing.
- **Note on your appeal you are a "BENEFICIARY-APPELLANT."**
- Include in the appeal you are appealing because the ambulance transport was medically reasonable and necessary.
- Indicate that you would like the hearing to be held by Video-teleconference.
- Send copies of any documentation in support of coverage along with your request.

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7. Receive and respond to the written Notice of Hearing from the Office of Medicare Hearings and Appeals (OMHA).

- Follow the instructions in the Notice on how to respond.
- Be sure the notice states a Video-Teleconference (VTC) is scheduled. If the hearing is not VTC, call OMHA and request VTC.
- In the response letter, request a copy of the exhibit list and case file for your records.
- Be sure to note in the response if you will have someone testify at the hearing on your behalf.

8. Receive the hearing file.

- Be sure it includes all records you have obtained and submitted during your appeal; if it does not, send the missing records to the ALJ.

9. Attend the hearing and argue your case.

- Explain in detail to the ALJ why your transport was erroneously denied by Medicare.
- Be sure the ALJ has the additional records you submitted.

10. Receive the ALJ decision.

11. (4th appeal level) If the ALJ Decision is unfavorable, Request review by the Medicare Appeals Council.

- Follow the instructions in the decision on how to appeal
- **If ALJ Decision is favorable, send a copy of the decision to the ambulance provider and ask that your transport be reimbursed, or that it stop any collection efforts against you.**

3. Quick Screen for Medicare Coverage of Ambulance Transports

Medicare Part B pays up to 80% of Ambulance transport costs when transportation by any other means could endanger your health. The law requires that the transport was medically necessary, and that your health would have been jeopardized if you were transported any other way.

Coverage Depends on the Patient's Origin and Destination

There are certain origin and destination requirements for coverage. Medicare will pay for ambulance transportation:

1. From any point of origin to the nearest hospital, Critical Access Hospital (CAH), or Skilled Nursing Facility (SNF) – often called a nursing home – that is capable of furnishing the required level and type of care for the patient's illness or injury.
2. From a hospital, CAH, or SNF to the patient's home.
3. From a SNF to the nearest supplier of medically necessary services not available at the SNF when the beneficiary is a resident, including the return trip.
4. For a beneficiary who is receiving renal dialysis for treatment of End Stage Renal Disease (ESRD), from the patient's home to the nearest facility that furnishes renal dialysis, including the return trip.

Note: Generally Medicare will only cover ambulance transports to the nearest appropriate medical facility that can provide the level of care necessary to treat your illness or injury. If you elect to be transported to a facility farther away Medicare will only pay an amount based on the charge to the closest appropriate facility. If local facilities are unable to provide the appropriate level of care you require, Medicare will pay to transport you outside your locality to the nearest appropriate facility.

Medicare will pay for **Air Ambulance** transport (airplane or helicopter) in emergency situations requiring immediate/urgent transport or when a ground ambulance would otherwise be inappropriate. Examples include transport over long distances or to exceedingly rural or remote areas that would otherwise impede access by a ground ambulance.

Coverage for Non-Emergencies

Medicare will cover **nonemergency** transportation by ambulance if you are bed-confined (unable to get up from your bed without assistance; unable to ambulate; and unable to sit in a chair or wheelchair) *and* your medical condition is such that other methods of transportation would be unsafe *or* jeopardize your help. Medicare will also cover nonemergency transportation simply because ambulance transportation is medically required.

Further Limits on Coverage

- As a general rule, paramedic intercepts are not covered by Medicare.
- Medicare does not pay for "wheelchair van" transportation.

Notice Requirements

An Advance Beneficiary Notice (ABN) is a legal document given to Medicare beneficiaries when healthcare providers believe the care or service about to be rendered will not be covered by Medicare. Often when providers fail to give these notices, the provider will be financially responsible for the care or service. In other words, the provider will not be able to bill the beneficiary. Prior to a non-emergency transport, ambulance transportation providers should give the patient an Advance Beneficiary Notice (ABN) under the following circumstances:

- An ambulance provider is going to transport a patient from one location to another and the provider has a reasonable reason to believe that the care could be done at the first location.

- Air Ambulance provider has a reasonable basis to believe that the transport can be done safely and effectively by ground ambulance transportation.

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4. Ambulance Transport Appeal Details

Typical Scenario:

You are a Medicare beneficiary who had surgery at a hospital. Prior to your discharge, it is determined by your doctor that you will need therapy at a skilled nursing facility and that you should be transported from the hospital to the skilled nursing facility by ambulance. The hospital arranged transportation to the skilled nursing facility via ambulance and you were transported without incident. At the skilled nursing facility you received excellent care and you were able to return home. A couple of weeks later, you received a bill from the ambulance company. When you called the ambulance company to find out why it was billing you, you were told that Medicare denied the claim. Take the following steps:

1. Watch For and Review Your Medicare Summary Notice (MSN)

- Medicare beneficiaries receive Medicare Summary Notices (MSN) in the mail on a quarterly basis. It is important to review these documents because they reflect what providers have billed Medicare for the beneficiary's care.
- If the ambulance transportation was denied coverage, it will be reflected on the Medicare Summary Notice.
- **You have only 120 days to appeal these denials**.

2. Consider Whether to Appeal

- If your Medicare Summary Notice (MSN) indicates that your ambulance transportation has been denied coverage, look to see whether you or the ambulance provider has been held financially responsible.
- If **you** were held financially responsible, you should certainly appeal.
- If the provider has been held financially responsible, you may want to call the Center for Medicare Advocacy to discuss whether appealing the decision is in your best interest.

3. Ask Your Physician for Support

- Ask your physician to write a letter explaining why your ambulance transportation was medically reasonable and necessary.
- Ask him or her to **include information about possible medical harm that might have occurred** had you not been transported by ambulance.

4. Request a Redetermination

- Follow the instructions on the MSN regarding how to file an appeal.
- Circle the denial of payment for your ambulance transportation.
- Write that you are appealing the denial because the transportation was medically necessary.
- Attach a copy of your physician's letter of support.

5. Gather Additional Documentation in Support of Coverage

- If the ambulance transport was from a hospital or other inpatient provider, request copies of your medical record.
- Ask for physician orders and notes; Physician Certification Statement; nursing narratives; and discharge summary.
- Contact the ambulance provider and request a copy of the "transport run-sheet."

- Note that providers may charge you for copying and sending the documents. These charges are not allowed in some states, including Connecticut and Massachusetts.
- If you've not done so already, ask the physician who ordered the ambulance transport or your primary care physician to write a statement in support of coverage and explaining the medical necessity of the transport.

6. Request a Reconsideration

- You should receive a "Redetermination" decision in the mail for your ambulance transport.
- If it is "unfavorable" you will have **180 days** to request the next level of appeal.
- Follow the directions on the form for requesting a "Reconsideration."
- On the appeal request, write that you are appealing because you met the Medicare requirements for coverage of your ambulance transport.
- If you have received additional records or letters from physicians in support of your case, send copies with your request.

7. Request an ALJ Hearing

- You should receive a "Reconsideration" decision in the mail.
- If it is "unfavorable" you will have **60 days** to request the next level of appeal, which is a hearing with an Administrative Law Judge (ALJ).
- Follow the directions on the form for requesting an ALJ hearing.
- Write on the request that you are appealing because the ambulance transportation was medically reasonable and necessary.
- Indicate that you would like the hearing scheduled via video teleconference (VTC) rather than by telephone.
- If you have received any additional documentation in support of coverage, submit copies with your request.
- On the request, indicate in bold letters that you are a **BENEFICIARY-APPELLANT.** Also write this information on the outside of the envelope. Doing so will help ensure that your request is processed in a timely manner.

8. Respond to the Notice of Hearing

- You will receive a written notice of hearing in the mail.
- Respond to the notice as directed.
- Make sure that the notice states that a video teleconference is scheduled. If it does not, contact the ALJ's legal assistant and request that the hearing be rescheduled as a video teleconference.
- Also ask the legal assistant to send you a copy of the exhibit list and hearing file for you to review.

9. Prepare for the Hearing

- When you receive the hearing file, make sure that it includes all the records that you have obtained and submitted in support of coverage.
- If it does not, send the missing records to the ALJ's legal assistant.

10. Argue your Case

- Attend the hearing at the date and time scheduled.
- Make sure the judge has any additional records that you sent in.

- Explain to the judge that your transport was erroneously denied by Medicare and that you met requirements for coverage as outlined in this self-help packet.
- If the transport was non-emergent, explain the medical necessity of ambulance transport and why any other mode of transport would have posed an unacceptable risk.
- If the transport was denied due to lack of bed-confinement, be sure to point out that bed confinement is not the sole criterion in determining the medical necessity of ambulance transportation and address any contradictions that may be present in the record.
- Ask the judge to find that your transport was medically necessary and coverable by Medicare Part B.
- **Note:** If the transport was non-emergent and the ambulance provider should have expected that the transport would be denied by Medicare due to lack of medical necessity, it should have given you an Advance Beneficiary Notice of Non-Coverage (ABN). **You may be eligible for a waiver of your financial liability if the provider failed to do so.** If you did not receive an ABN prior to transport ask that the judge waive your financial liability.

11. Watch For and Review the ALJ Decision

- You will receive the administrative law judge's decision in the mail.
- If it is favorable, send a copy to the provider.
- If it is unfavorable, follow the directions on the hearing decision for filing a Medicare Appeals Council request.

Conclusion

Navigating the Medicare appeals process can be difficult and take a long time. Should you have questions during the process, contact your State Health Insurance Assistance Program (SHIP). You can find your state program's information at https://shipnpr.shiptalk.org/shipprofile.aspx.

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5. Additional Information

Glossary of Terms

Advance Beneficiary Notice of Non-Coverage (ABN)

Notice given to a beneficiary when the provider believes that Medicare will not cover the services to be provided. The form must be completed and given to the patient to sign prior to providing the service.

BENEFICIARY

An individual enrolled in the Medicare program.

CLAIMANT

An individual requesting reimbursement from Medicare for expenses incurred for medical care (or the individual requesting payment on behalf of a Medicare enrollee).

CO-INSURANCE

The amount a beneficiary must pay as his or her share of the cost of a given service. For example, there is a co-insurance (20% of the reasonable charge) which must be paid for Part A or B services.

CMS (Centers for Medicare and Medicaid Services)

The federal agency which administers the Medicare program: part of the Unites States Department of Health and Human Services.

Critical Access Hospital

A hospital certified under a set of Medicare Conditions of Participation (CoP), which are structured differently than the acute care hospital CoP. See http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-LN/MLNProducts/downloads/CritAccessHospfctsht.pdf.

HEALTH INSURANCE CLAIM NUMBER

The Social Security number under which you receive benefits. This number is the number on your health insurance (Medicare) card.

MEDICARE ADVANTAGE

Medicare offered by private, for-profit insurance companies subsidized by the federal government. Coverage is required to be equivalent to traditional Medicare, but choice is generally limited.

MEDICARE CLAIM DETERMINATION

The written notice of denial of Medicare coverage issued by the intermediary.

MEDICARE CONTRACTOR

An agent of the federal government, often an insurance company, which makes Part A Medicare claim determinations for skilled nursing facility and home health coverage, and issues payments to providers.

MEDIGAP

Private insurance which covers the “gaps” in Medicare (such as deductibles and co-insurance amounts).

Significantly, these policies generally do not pay when Medicare refuses coverage.

PARAMEDIC INTERCEPT

Advanced life support (ALS) services delivered by paramedics who furnish services separately from the agency that furnishes the ambulance transport. Generally, Medicare payment for these services may be made only to the ambulance company furnishing the ambulance transport. Paramedic intercept services are most often furnished for an emergency ambulance transport in which a local volunteer ambulance that can furnish only basic life support (BLS) services is dispatched to transport a beneficiary.

SHIP

State Health Insurance Assistance Program. These programs are funded to help beneficiaries with insurance choices, enrollment and appeals. See www.shiptalk.org.

SKILLED NURSING FACILITY (SNF)

A skilled nursing facility, or "SNF," is a nursing home which delivers a relatively substantial degree of skilled nursing and rehabilitative care, and personal care. In order to receive Medicare coverage for nursing home care, a patient must receive daily skilled care in a Medicare-certified skilled nursing facility.

WHEELCHAIR VAN

Also called an "ambulette." A wheelchair-accessible van that provides non-emergency transportation for people with disabilities.
