Ambulance Transportation Manual 2026

CCPA

Cape County Private Ambulance Service, Inc.

573-335-3305

“OUR PROMISE TO YOU”

Since 1968, Cape County Private Ambulance Service has strived to provide high quality medical transportation service in a professional and caring manner. In doing so, we have become respected providers for Cape County and leaders in EMS in the region. We consider our growth and success to be due to the fact that you, the patient, customer, friend, and neighbor, appreciate not only the exemplary service we provide but also the manner in which it is given, with compassion, by individuals who care about your physical and personal well being.

We provide state of the art vehicles and equipment so that our staff of licensed personnel can provide quality treatment that makes a difference. We encourage our staff to give you, the customer, extraordinary service because “we care”. We attribute our success to the notion that if “we care” then the patient will feel “cared for.”

In order to serve you better we have compiled this medical transportation manual. It strives to explain our policies and information needs in a simple and concise manner. As many of these policies are dictated by various State and Federal operating rules and regulations, this manual is subject to change. The manual is based on our best understanding of the regulations and contractual obligations of the service in effect at the time of publication. If you have questions please contact our business office at 573-335-2191.

Thank you for choosing Cape County Private Ambulance Service, Inc.

Sincerely,

John J. Russell MD
President

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Transportation Policy

Cape County Private Ambulance Service, Inc. has a clear objective to provide the highest level of care and safe transportation to our patients. CCPA will not discriminate against any person, organization, or medical institution due to race, gender, religion, or age. There are procedures in place, which are strictly adhered to, clearly defining response and transport criteria, billing procedures, cost estimates for service, acceptable payment methods for requested service, and other general business and operational procedures. Payment and billing arrangements vary greatly among patients and situations, often due to constraints and rules applied by various governmental and insurance payers. It is our policy to provide as much assistance and education as possible to the customer involved in making arrangements for patients requesting ambulance transport.

Cape County Private Ambulance Service, Inc. has a contractual obligation to provide emergency service to the citizens and visitors of Cape Girardeau County. Any request for emergency service arising from the streets and highways, governmental buildings, or residences will be responded to regardless of ability to pay for the service. Payment for such service remains the responsibility of the patient or guardian. Transportation to, from, and between, nursing homes, hospitals, or other medical facilities, must abide by the various rules and regulations in force at the time of the transfer.

If there is any question about charges, payments, or account status please contact the business office at 573-335-2191.

Billing and Insurance Policy

In general, Cape County Private Ambulance Service, Inc. holds the user of our service as financially responsible for payment of charges for the service rendered. If undue hardship occurs, CCPA is able and willing to work with individuals and families to come to a mutual agreement over how to handle charges.

Private Insurance: CCPA is unable to bill or contract with every insurance company for charges, therefore we hold the patient responsible for all the transportation charges. We will bill most insurance companies if we have the insurance information available at the time of the trip. However it should be understood that insurance agreements are between the insured and the insurance company. The patient or guarantor will continue to receive regular statements regardless of the status of the claim. It is the responsibility of the patient to inform CCPA of any insurance coverages.

Medicare: Medicare is a form of specialized health insurance for the elderly and disabled provided by the federal government. As in private insurance coverage, the patient is ultimately responsible for payment of charges. CCPA is required to file and bill Medicare Claims for the beneficiary. Many ambulance trips do not qualify for Medicare reimbursement. We will attempt to identify these situations and notify the patient prior to transportation. If transportation is requested anyway, we may ask that an Advanced Beneficiary Notice (ABN) form be signed as acknowledgment that CCPA has identified the transportation as not likely to be covered by Medicare. Medicare has established a National Fee Schedule for Ambulance Service which limits the charges CCPA may bill to a patient for Medicare Services. Furthermore, the National Fee Schedule also sets the minimum charge for covered services.

Medicaid / MO HealthNet: If the patient qualifies for Medicaid coverage at the time of service, the patient must present their Medicaid card or information at the time of service; otherwise the patient will be held responsible for all charges. Not all types of ambulance service is covered by Medicaid. Generally speaking Medicaid only covers emergency transportation to the nearest appropriate facility. If the service provided is not covered, then the patient will be held responsible for charges due. CCPA staff will attempt to verify eligibility prior to transportation when feasible and will attempt to notify the patient when transportation charges may not be covered.

Workers' Compensation: If the patient is injured at work and the employer is responsible for the account, please supply CCPA with a written statement from the employer indicating this responsibility. CCPA will then bill the employer for the charges. Until CCPA receives verification that the charges are the responsibility of the employer, the patient will be held accountable for all charges due.

Budget Billing, Time Payments, Financial Hardship Plans: CCPA is happy to work with individuals who wish to pay for services with an individualized time payment or installment plan.

Credit Cards: CCPA accepts Discover, MasterCard, and Visa for payment of charges.

Emergency Transportation

Emergency transportation is defined as transportation arising from a request for immediate transportation (not-scheduled) from the streets, highways, residences, and governmental buildings of Cape Girardeau County, of a patient suffering from an acute or sudden condition which is considered to be potentially harmful to the health and well being of the individual.

CCPA is contractually obligated to respond to such requests for service. The patient will be held responsible for charges incurred. Emergency response, in and of itself, does not guarantee coverage by, and payment from, Medicare, Medicaid, or many other insurance programs.

Some insurance carriers may pay for ambulance response and treatment even though the patient is NOT transported to a local ER. Some insurance carriers may pay for emergency transportation to healthcare facilities other than a hospital Emergency Room.

Non-Emergency Transportation

In Cape Girardeau County:

When non-emergency transportation is requested with the origin and destination both being within Cape Girardeau County, CCPA will make the trip and bill the patient. The following applies:

Trip authorization and permission to treat must be signed at the time of the trip, either by the patient or responsible party.

Patient information must be available at the time of request for the transportation.

If a patient has Medicare and /or Medicaid coverage, then a Physician's Certification Statement must be signed by the attending physician prior to transport. If the trip does not meet coverage criteria from Medicare and /or Medicaid a "limitation of liability waiver" must be signed by the patient or responsible party. CCPA will try to aid in obtaining the needed information for these situations.

Out of County Trips:

When non-emergency transportation is requested with either the origin or the destination outside of Cape Girardeau County, the following applies:

Payment arrangements for the trip must be made and completed prior to loading the patient. These arrangements may include payment at the time of service with cash, check, credit card, budget billing arrangements, arrangements with a facility for payment with a purchase order or charge slip, or a statement of coverage from an insurance company with a promise to pay from the insurance carrier, or other agreement established by CCPA with the responsible party.

Any transportation to an out-of-county hospital or nursing facility must have a receiving physician who has agreed to receive and admit the patient. CCPA must be able to and will verify these arrangements before loading a patient.

Trip authorization and permission to treat must be signed at the time of the trip, either by the patient or responsible party. Patient information must be available at the time of request for the transportation.

If a patient has Medicare and /or Medicaid coverage, then a Physician's Certification Statement must be signed by the patient's attending physician prior to transport. If the trip does not meet coverage criteria from Medicare and /or Medicaid an ABN must be signed by the patient or responsible party. CCPA will try to aid in obtaining the needed information for these situations. Generally speaking Medicare and Medicaid will only cover ambulance transportation between hospitals when certain strict patient condition and facility capability criteria are met. Medicare will not cover this classification of service simply because of physician choice, perceived quality differences between hospitals or physicians, or returning a patient "closer to home".

Medicaid does not cover out-of-town transportation unless the patient is covered under the HCY (Healthy Children & Youth) program or special prenatal care programs. Each of these programs have special considerations and rules which apply only to those patients. Generally speaking pre-authorization from the program is required for coverage. Often these programs have specialized contract carriers to make these trips.

Most insurance companies, including Medicare / Medicaid, do not cover "non-emergency" transports. The conflict is that most insurers also state that transportation between medical facilities is "non-emergency" by default. In essence, they claim Federal law (COBRA '89, '90, and EMTALA) requires the first facility to stabilize the patient, thus negating the need for "emergency" transfer. Missouri TCD law requires hospitals and ambulance services to treat certain conditions such as Stroke, STEMI, and Trauma as emergencies in spite of payer coverage standards.

Hospital - Facility - Hospital Trips:

Round trips to and from a facility for special services not available at the originating hospital are required to be paid for by the originating hospital.

Trip authorization and permission to treat must be signed at the time of the trip, either by the patient or responsible party.

Patient information must be available at the time of request for the transportation.

Should the ambulance crew be delayed in loading the patient more than 30 minutes from the scheduled trip time, additional charges may apply.

A hospital charge slip or payment authorization slip must be available at the time of the trip.

Patient information must be available at the time of request for the transportation.

Medicare Guidelines for Coverage for Ambulance Service

Medicare coverage for ambulance transportation has changed dramatically in the last few years. At the time of publishing, the following was the best understanding of coverage allowed and not allowed by Medicare and examples of situations illustrating coverage and non-coverage.

When Medicare was enacted in 1963, coverage for ambulance service was included but not well defined. As a consequence, many different coverage rules and rates of reimbursement arose in different areas of the country. In February 1999, new rules went into effect to clarify the situation. As is often the case, the new regulations left a number of unanswered questions, and disrupted the understanding of many issues that were thought long settled. Effective 2008 Wisconsin Physician Services is the Medicare carrier for ambulance services in Missouri.

Emergency:

Medicare covers Emergency Transportation.

Medicare defines emergency transportation as transportation arising as a request for immediate transportation "resulting in the **destination being a hospital emergency department** after the onset of a medical condition manifesting itself by acute symptoms of sufficient severity, such that the absence of medical attention could reasonably be expected to result in:

placing the patient's health in serious jeopardy;
serious impairment to bodily functions;
serious dysfunction of any bodily part."

Examples:

A 72 year old male calls 911 because he is having chest pain and shortness of breath. The patient is seen in the emergency room and later admitted for a possible heart attack. This would be a covered trip.

A 68 year female calls 911 because she is having back pain. On arrival the ambulance crew discovers she walks and answers the door and has had pain for 3 weeks and her doctor wanted her to get x-rays. The patient is transported to the emergency department and x-rays are taken. This is a non-covered trip.

Non-Emergency:

Patient conditions not meeting the definition of emergency are considered non-emergency. Medicare and Medicaid consider hospital to hospital transfers as non-emergency by default.

Medicare will pay for non-emergency ambulance transportation only if certain strict medical necessity criteria and destination criteria are met and documented.

Non-Emergency Transportation will only be considered if:

Patient is bed confined or
Patient requires restraints or
Patient requires isolation for contagious life threatening disease or
Patient requires specialized care / equipment during transport, for example IV fluids or ventilator monitoring.

For the purposes of reimbursement, Medicare defines "bed-confined" very narrowly and strictly. Bed Confined is defined as:

Not able to ambulate
AND
Not able to sit in chair or wheelchair
AND
Not able to get out of bed without assistance.

Documentation must be available to support these criteria before a claim can be filed with Medicare for non-emergency transportation. In addition to these stipulations, a Physician's Certification Statement must be obtained prior to filing the claim.

Qualifying destinations are defined as Hospital, Critical Access Hospital, Skilled Nursing Facility or dialysis unit. Transportation to the nearest local facility that can provide the service the patient needs is covered. More distant facilities that may be chosen due to patient choice, physician choice, or transferring facility choice are not covered and require an ABN be signed before transport.

Examples: A patient with severe muscular dystrophy is bed confined and needs to go to the hospital for a chest x-ray and lab work. This is a covered trip.

A nursing home patient is scheduled to see her cardiologist in his office for heart failure and increasing shortness of breath. She has been sitting up to breath better and her daughter is afraid to take her in her car. This is a non-covered trip.

A patient with a post op infection wants to return to the hospital where her surgeon is but the original facility normally provides similar services. This is a non covered trip.

Physician's Certification Statement:

A Physician's Certification Statement (PCS), previously known as a Certificate of Medical Necessity (CMN) is required on all Non-Emergency Trips filed to Medicare / Medicaid. *A PCS does not guarantee payment or coverage of the service*, but is only one of many documents used to support or deny the claim.

PCS's are required to be signed 24 hours in advance of scheduled non-emergency transport. PCS's are required to be signed within 48 hours after unscheduled non-emergency transport.

A PCS must be signed by the patient's normal attending physician at the time of transport. Other licensed healthcare providers as on the PCS statement may sign a PCS as a verbal or telephone order but the order must be physically counter-signed by the attending physician before a claim can be filed.

For repetitive transport patients, for example End-Stage Renal Dialysis patients or Radiation Therapy patients, a blanket PCS covering the repetitive service, may be signed in advance of the service, and will be good for 60 days, after which a new PCS must be obtained. **Repetitive service requests are required to have pre-authorization approval from CMS.**

Examples: A nursing home calls to have a stroke patient, bed confined due to contractures, transported to the hospital for a direct admission for pneumonia. This trip requires a PCS to be signed with in 48 hours of the trip.

The hospital calls to schedule a transfer of a ventilator patient to a long term care facility the day after tomorrow. This trip requires a PCS to be signed 24 hours before the trip.

Skilled Nursing Facilities and Medicare Part A or P.P.S. System:

Beginning in 1998, the Balanced Budget Act of 1997 required Skilled Nursing Facilities to provide services to residents falling into the Part A coverage period (generally the first 100 days following discharge from an acute care facility or hospital for a qualifying diagnosis and length of stay) under a Prospective Payment System. In a nutshell, SNF's now get paid a fixed per day rate to provide all services to these patients including ambulance service. The following table outlines when the SNF is responsible for payment of ambulance transportation charges during this period. Recent audits have resulted in payment edits designed to reduce Medicare costs for services that should be paid by the nursing home.

Type of Trip	***CCPA*** **Bills:** **Patient / Part B****	**SNF**
1. Initial Admission to SNF	X	
2. Discharge from SNF		
a. To Patient's Home (no return to SNF)	X	
b. To Patient's Home (return to SNF same day)		X
c. To another SNF for elevated level of care		X *
3. Inpatient Hospital Admission:		
a. To acute care hospital for admission	X	
b. To SNF from hospital (hospital discharge)	X	
4. Trip to Beneficiary's Home for Medicare Home Health Services	X	
5. Trip to Hospital for OUTPATIENT SERVICES		
a. Physical, Occupational, or Speech Therapy		X
b. Diagnostic Tests or Services Routinely Provided By SNFs.		X
c. Dialysis ***	X	
d. Evaluation or Treatment Services not covered in Section 6 below including Emergency Room visits		X
6. Trip to HOSPITAL for the following extraordinary services		
a. Emergency (as defined by Medicare)	X	
b. Cardiac Catheterization	X	
c. C/T Scans	X	
d. MRI Scans	X	
e. Surgery requiring an operating room	X	
f. Angiography	X	
g. Lymphatic and Venous Procedures	X	
h. Radiation Therapy	X	
7. Trip to FREE STANDING FACILITY for services or tests		X
a. Except to a Dialysis Center for an ESRD patient	X***	

* Discharging SNF responsible for transportation.

** If non-emergency, Physician Certification Statement required and patient must meet Medicare's criteria for Medical Necessity.

*** ESRD carve out effective April 1, 2000, SNF responsible till then.

Medicaid Services

Medicaid only pays for ambulance service in “life-threatening” emergencies to the nearest “appropriate” facility. Generally, Medicaid does not allow for payment of inter-facility transportation except in cases involving the HCY program. Inter-facility transportation coverage requires that a specific service available at the destination facility that is not available at the originating facility be noted on the PCS and COBRA forms. HCY recipients must have a PCS signed and the transportation pre-approved by the State Department of Health Services before the non-emergency trip is covered. Contact the patient’s case worker or the CCPA business office for help in obtaining such service.

When a patient has both Medicare and Medicaid coverage, assignment of the Medicare claim to CCPA is required. Medicaid is automatically the secondary insurer. If the trip is not covered by Medicare, Medicaid is not likely to cover the trip and the charges become the responsibility of the patient or guardian.

Medicaid may perform post payment audits and required refunds for certain trips previously reimbursed by Medicaid. In the case of this event Medicaid makes a post payment determination that the charges are non-covered and thus the responsibility of the patient.

Quick Guide

Patient discharged from Hospital to a Nursing Facility

CCPA will need to know when calling to request service:

1. Name of your facility
2. The date and time of the requested service
3. The specific location of the patient (room number, wing, building, etc...)
4. Your name and phone or extension number
5. Location of patient's destination
6. Patient information
    - Name, first, last and middle initial
    - Gender
    - Address
    - Social Security Number
    - Date of Birth
    - Guarantor name and address if different from patient
7. Any special needs the patient may have (oxygen, suction, IVs, etc...)

General Billing information:

Medicare will cover this type of trip so long as medical necessity guidelines are met.
A PCS must be signed if the patient is covered by Medicare.
Medicaid will not cover this type of trip.
This trip may be billable to the Nursing Facility under the SNF P.P.S. rules.

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Patient discharged from Hospital to a Private Residence

CCPA will need to know when calling to request service:

1. Name of your facility
2. The date and time of the requested service
3. The specific location of the patient (room number, wing, building, etc...)
4. Your name and phone or extension number
5. Location of patient's destination (street address, apt. number, etc...)
6. Patient information
    - Name, first, last and middle initial
    - Gender
    - Address
    - Social Security Number
    - Date of Birth
    - Guarantor name and address if different from patient
7. Any special needs the patient may have (oxygen, suction, IVs, etc...)

General Billing information:

Medicare will cover this type of trip so long as medical necessity guidelines are met.
A PCS must be signed if the patient is covered by Medicare.
Medicaid will not cover this type of trip.

Quick Guide

Patient Transported from Nursing Facility to Hospital for Admission

CCPA will need to know when calling to request service:

1. Name of your facility
2. The date and time of the requested service
3. The specific location of the patient (room number, wing, building, etc...)
4. Your name and phone or extension number
5. Location of patient's destination
6. Patient information
    - Name, first, last and middle initial
    - Gender
    - Address
    - Social Security Number
    - Date of Birth
    - Guarantor name and address if different from patient
7. Any special needs the patient may have (oxygen, suction, IVs, etc...)
8. Admitting diagnosis or reason for transport
9. Admitting and / or referring physician

General Billing information:

Medicare will cover this type of trip so long as medical necessity guidelines are met.
A PCS must be signed if the patient is covered by Medicare.
Medicaid will not cover this type of trip.
This trip may be billable to the Nursing Facility under the SNF P.P.S. rules if the patient is not hospitalized for at least 72 hours.

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Patient requiring Round Trip Transport from the Hospital

CCPA will need to know when calling to request service:

1. Name of your facility
2. The date and time of the requested service
3. The specific location of the patient (room number, wing, building, etc...)
4. Your name and phone or extension number
5. Location of patient's destination
6. Patient information
    - Name, first, last and middle initial
    - Gender
    - Address
    - Social Security Number
    - Date of Birth
    - Guarantor name and address if different from patient
7. Any special needs the patient may have (oxygen, suction, IVs, etc...)
8. What type of appointment does the patient have? (MRI, Dr's visit, CT scan ...)
9. Is this a repetitive type trip, for example Radiation therapy, and can all trips be booked for you now?
10. Is this a wait & return time frame?

General Billing information:

This type trip is charged to the hospital and requires a hospital charge slip / authorization at the time of trip.

Quick Guide

Patient requiring Round Trip Transport from a Nursing Facility

CCPA will need to know when calling to request service:

1. Name of your facility
2. The date and time of the requested service
3. The specific location of the patient (room number, wing, building, etc...)
4. Your name and phone or extension number
5. Location of patient's destination
6. Patient information
    - Name, first, last and middle initial
    - Gender
    - Address
    - Social Security Number
    - Date of Birth
    - Guarantor name and address if different from patient
7. Any special needs the patient may have (oxygen, suction, IVs, etc...)
8. What type of appointment does the patient have (MRI, Dr's visit, CT scan ...)
9. Is this a repetitive type trip, for example Radiation therapy, and can all trips be booked for you now?
10. Is this a wait & return time frame?

General Billing information:

This type trip may be charged to the SNF under the Part A P.P.S. rules.
This type trip may be covered by Medicare if the criteria for medical necessity for non-emergency transportation are met.
A PCS must be signed if the patient is covered by Medicare
Medicaid may cover the "to hospital" trip leg if certain conditions and criteria are met.
Generally Medicaid will not cover the "return leg" trip.

Quick Guide

Patient requiring Transport to a Facility Outside of Cape Girardeau County

CCPA will need to know when calling to request service:

1. Name of your facility
2. The date and time of the requested service
3. The specific location of the patient (room number, wing, building, etc...)
4. Your name and phone or extension number
5. Location and phone number of patient's destination
6. Patient information
    - Name, first, last and middle initial
    - Gender
    - Address
    - Social Security Number
    - Date of Birth
    - Guarantor name and address if different from patient
7. Any special needs the patient may have (oxygen, suction, IVs, etc...)
8. Name and phone number of receiving physician
9. Patient must have a receiving facility and physician who has agreed to accept and admit the patient. Verification will be made by CCPA

General Billing information:

This type trip may be charged to the hospital and may require a hospital charge slip / authorization at the time of trip.
A PCS must be signed if the patient is covered by Medicare
Medicaid requires pre-authorization.
Please see the policy about payment arrangements for Out of County Transportation.
Payment arrangements must be made with the patient or guardian prior to transportation if not charged to the originating or receiving facility.
Medicaid will not cover this type of trip unless the patient is covered by the HCY program or the transfer is for emergency treatment at the nearest appropriate facility.
A COBRA form must be completed and signed by the attending physician prior to transport.

Quick Guide

Patient requiring Critical Care Transportation

What is a critical care patient? Generally speaking any patient that requires a cardiac or other monitor, IV therapy and/or pharmacological support, or ventilator support. *Critical Care Transportation may be emergency or non-emergency.* Cape County Private Ambulance Service will schedule one of our Advanced Life Support ambulances for this call, staffed and equipped with paramedic level service.

CCPA will need to know when calling to request service:

1. Name of your facility
2. The date and time of the requested service
3. The specific location of the patient (room number, wing, building, etc...)
4. Your name and phone or extension number
5. Location and phone number of patient's destination
6. Patient information
    - Name, first, last and middle initial
    - Gender
    - Address
    - Social Security Number
    - Date of Birth
    - Guarantor name and address if different from patient
7. Is the facility sending medical personnel with this patient ? (nurse, RT...)
8. What is the patient's medical status? What, if any, are the resuscitation orders?
9. Any special needs the patient may have (oxygen, suction, IVs, etc...)
10. Name and phone number of receiving physician
11. Patient must have a receiving facility and physician who has agreed to accept and admit the patient. Verification will be made by CCPA

General Billing information:

This type trip may be charged to the hospital may require a hospital charge slip / authorization at the time of trip.
Medicare may cover this trip if services not available at the originating facility.
A PCS must be signed if the patient is covered by Medicare.
Please see the policy about payment arrangements for Out of County Transportation. If the patient is going to an Out of County destination, payment arrangements must be made with the patient or guardian prior to transportation.
Medicaid will not cover this type of trip unless the patient is covered by the HCY program or it is a life threatening condition and the service the patient needs are not available at the originating facility for any patient. Pre-approval is required. A COBRA form must be completed and signed by the attending physician prior to transport.

Patient requiring Transport to a Psychiatric Facility

A patient may be admitted to a psychiatric facility under court order or a voluntary commitment. If there is a question about the patient's compliance with a voluntary commitment the admitting or referring physician may obtain a court order. Missouri Statue 190.240.4 allows for Emergency Physicians to place an involuntary hold on the patient for purposes of transport. CCPA can not hold or transport a patient against the patient's will unless under a court order, the patient is under arrest and in custody of a law enforcement agency, or under an Emergency Physician hold order duly documented.
CCPA will need to know when calling to request service:

1. Name of your facility
2. The date and time of the requested service
3. The specific location of the patient (room number, wing, building, etc...)
4. Your name and phone or extension number
5. Location and phone number of patient's destination
6. Patient information
    - Name, first, last and middle initial
    - Gender
    - Address
    - Social Security Number
    - Date of Birth
    - Guarantor name and address if different from patient
7. Any special needs the patient may have (oxygen, suction, IVs, etc...)
8. Name and phone number of receiving physician
9. Will the status of the patient require restraints? If so, a physician's order for 4 point restraints must accompany the patient. Any orders for chemical restraint must accompany the patient if different from standing Field Treatment and Protocols.
10. Admitting diagnosis and /or reason for trip.

General Billing information:

This type trip may be charged to the hospital and require a hospital charge slip / authorization at the time of trip.
Medicare may cover this trip if the medical necessity guidelines for non-emergency transportation are met.
Please see the policy about payment arrangements for Out of County Transportation.
Medicaid will not cover this type of trip unless the patient is covered by the HCY program or the patient is being transported to the nearest appropriate facility that can provide service. Pre-authorization is required.
A COBRA and PCS form must be completed and signed by the attending physician prior to transport.
Law enforcement may be used for this type of trip in some circumstances.

Quick Guide

Patient requiring Transport to a Veterans Administration Hospital or Clinic

CCPA will need to know when calling to request service:

1. Name of your facility
2. The date and time of the requested service
3. The specific location of the patient (room number, wing, building, etc...)
4. Your name and phone or extension number
5. Location and phone number of patient's destination
6. Patient information
    - Name, first, last and middle initial
    - Gender
    - Address
    - Social Security Number
    - Date of Birth
    - Guarantor name and address if different from patient
7. Any special needs the patient may have (oxygen, suction, IVs, etc...)
8. Name and phone number of receiving physician
9. Patient must have a receiving facility and physician who has agreed to accept and admit the patient. Verification will be made by CCPA

General Billing information:

VA has contract transportation services that may transport the patient at VA request. This type trip may be charged to the hospital may require a hospital charge slip / authorization at the time of trip.
Please see the policy about payment arrangements for Out of County Transportation. Payment arrangements must be made with the patient or guardian prior to transportation.

If authorization for payment is expected from the VA , the receiving VA facility must issue it. The VA will require all the information above as well as CCPA's VA vendor number, T01075571. Total transport costs will also be requested. If authorized, a purchase order number will be issued by the VA. This number must appear on CCPA's invoice and will be verified by CCPA dispatch prior to making the trip. The name and phone number of the person issuing the purchase order is also required. If the VA refuses to issue a trip authorization, as they frequently do, the policy for transport to an Out of County facility apply. Many Veterans have other insurance coverages which may apply including Medicare and Medicaid. VA, Tricare, ChampVA are all considered secondary payers.
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SECTION I – GENERAL INFORMATION

Patient's Name:_____Date of Birth:_____Medicare #: _____

Transport Date:_____(Valid for round trips this date, or for scheduled repetitive trips for 60 days from date signed below.)

Origin:_____ Destination:_____

Is the Patient's stay covered under Medicare Part A (PPS/DRG?) ☐ YES ☐ NO

Closest appropriate facility? ☐ YES ☐ NO If no, why was the patient transported to another facility? _____

_____

If hospital to hospital transfer, describe services needed at 2nd facility not available at 1st facility: _____

If hospice Pt, is this transport related to Pt's terminal illness? ☐ YES ☐ NO Describe:_____

SECTION II – MEDICAL NECESSITY QUESTIONNAIRE

Ambulance Transportation is medically necessary only if other means of transport are contraindicated or would be potentially harmful to the patient. To meet this requirement, the patient must be either "bed confined" or suffer from a condition such that transport by means other than an ambulance is contraindicated by the patient's condition. **The following questions must be answered by the healthcare professional signing below for this form to be valid:**

1) Describe the MEDICAL CONDITION (physical and/or mental) of this patient AT THE TIME OF AMBULANCE TRANSPORT that requires the patient to be transported in an ambulance, and why transport by other means is contraindicated by the patient's condition:

_____

_____

_____

2) Is this patient "bed confined" as defined below? ☐ Yes ☐ No
To be "bed confined" the patient must satisfy all three of the following criteria: (1) *unable* to get up from bed without assistance; AND (2) *unable* to ambulate; AND (3) *unable* to sit in a chair or wheelchair.

3) Can this patient safely be transported by car or wheelchair van (i.e., may safely sit during transport, without an attendant or monitoring?) ☐ Yes ☐ No

4) ***In addition*** to completing questions 1-3 above, please check any of the following conditions that apply*:
**Note: supporting documentation for any boxes checked must be maintained in the patient's medical records*

☐ Contractures ☐ Non-healed fractures ☐ Patient is confused ☐ Patient is comatose ☐ Moderate/severe pain on movement

☐ Danger to self/others ☐ IV meds/fluids required ☐ Patient is combative ☐ Need, or possible need, for restraints

☐ DVT requires elevation of a lower extremity ☐ Medical attendant required ☐ Requires oxygen – unable to self-administer

☐ Special handling/isolation/infection control precautions required ☐ Unable to tolerate seated position for time needed to transport

☐ Hemodynamic monitoring required enroute ☐ Unable to sit in a chair or wheelchair due to decubitus ulcers or other wounds

☐ Cardiac monitoring required enroute ☐ Morbid obesity requires additional personnel/equipment to safely handle patient

☐ Orthopedic device (backboard, halo, pins, traction, brace, wedge, etc.) requiring special handling during transport

☐ Other (specify) _____

SECTION III – SIGNATURE OF PHYSICIAN OR OTHER AUTHORIZED HEALTHCARE PROFESSIONAL

I certify that the above information is accurate based on my evaluation of this patient, and that the medical necessity provisions of 42 CFR 410.40(e)(1) are met, requiring that this patient be transported by ambulance. I understand this information will be used by the Centers for Medicare and Medicaid Services (CMS) to support the determination of medical necessity for ambulance services. I represent that I am the beneficiary's attending physician; or an employee of the beneficiary's attending physician, or the hospital or facility where the beneficiary is being treated and from which the beneficiary is being transported; that I have personal knowledge of the beneficiary's condition at the time of transport; and that I meet all Medicare regulations and applicable State licensure laws for the credential indicated.

☐ **If this box is checked**, I also certify that the patient is physically or mentally incapable of signing the ambulance service's claim form and that the institution with which I am affiliated has furnished care, services or assistance to the patient. My signature below is made on behalf of the patient pursuant to 42 CFR §424.36(b)(4). In accordance with 42 CFR §424.37, ***the specific reason(s) that the patient is physically or mentally incapable of signing the claim form is as follows***:

_____

X_____ _____

Signature of Physician* or Authorized Healthcare Professional — Date Signed (For scheduled repetitive transport, this form is not valid for transports performed more than 60 days after this date).

_____

Printed Name and Credentials of Physician or Authorized Healthcare Professional (MD, DO, RN, etc.)

**Form must be signed only by patient's attending physician for scheduled, repetitive transports. For non-repetitive ambulance transports, if unable to obtain the signature of the attending physician, any of the following may sign (please check appropriate box below):*

☐ Physician Assistant ☐ Clinical Nurse Specialist ☐ Licensed Practical Nurse ☐ Case Manager

☐ Nurse Practitioner ☐ Registered Nurse ☐ Social Worker ☐ Discharge Planner

Patient name:
Identification number: *(optional)*

Cape County Private Ambulance
1458 N Kingshighway St
Cape Girardeau MO 63701
(573)335-2191, Fax:(573)335-8891

Advance Beneficiary Notice of Non-coverage (ABN)

Medicare doesn't pay for everything, even some care you or your health care provider think you need. **We expect Medicare may not pay for the item, test, service or care listed below.** If Medicare doesn't pay, you may have to pay.

Item, test, service or care	Reason Medicare may not pay	Estimated cost
Ambulance Transport (including mileage)	☐ Medicare does not pay for ambulance service that is not medically necessary ☐ Medicare does not pay for transportation from residence or SNF for services that could more economically be performed at the residence or the SNF	$_____
Ambulance Mileage	☐ Medicare does not pay for mileage beyond the closest appropriate facility	$_____

What to do now

- Read this notice to make an informed decision about your care.
- Ask any questions you have.
- Choose one option below to let us know if you still want to get the item, test, service or care.

Choose ONE option below. We can't choose for you.

If you choose Option 1 or 2, we may help you use any other insurance you might have, but Medicare can't require us to do this.

○ **Option 1: I want the item, test, service or care listed above, and I want Medicare to be billed for an official decision on payment, which I'll get on a Medicare Summary Notice (MSN).** You can ask to be paid now. I understand that if Medicare doesn't pay, I'm responsible to pay, but I can appeal to Medicare by following the directions on the MSN. If Medicare does pay, you'll refund any payments I made to you, minus co-pays or deductibles.

○ **Option 2: I want the item, test, service or care listed above, but don't bill Medicare.** You can ask to be paid now and I'm responsible to pay. I understand that I can't appeal, since Medicare isn't billed.

○ **Option 3: I don't want the item, test, service or care listed above.** I understand I'm not responsible for payment and I can't appeal to see if Medicare would pay.

Additional information:

This notice gives our opinion, not an official Medicare decision. For other questions about this notice or Medicare billing, call 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048. Signing below means you received and understand this notice. You can ask to get a copy.

Signature	**Date** (mm/dd/yyyy)

You have the right to get Medicare information in an accessible format, like large print, Braille, or audio. You also have the right to file a complaint if you feel you've been discriminated against. Visit Medicare.gov/about-us/accessibility-nondiscrimination-notice.

PRA Disclosure Statement: According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0566. This information collection is for providers, suppliers, Hospice and Religious Non-medical HealthCare Institutes and Home Health Agencies to notify original Medicare beneficiaries of their potential financial liability under specific conditions. The time required to complete this information collection is estimated to average less than 7 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, to review and complete the information collection. This information collection is mandatory under Section 1879 of the Social Security Act, 42 CFR 411.404(b) and (c) and 411.408(d)(2) and (f). If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

Form CMS-R-131 (Exp. 03/31/2029) Form Approved OMB No. 0938-0566

Helpful notes:

MTM Number: 636-561-5686, 1-866-269-5944

MTM is the contract carrier for NEMT for MOHealthnet and MOHealthnet managed care plans.

Missouri Home State Health Plan Provider Services Department 1-855-694-HOME (4663)
All pysch transfers for Home State and MissouriCare require preauthorization.

Illinois Public Aid prefers Illinois licensed ambulance services to transport IPA patients whenever possible. CCPA can refer you to the most appropriate Illinois licensed service. An ABN must be filled out if CCPA transports and the patient must understand they will be responsible for charges or a facility charge may be requested and issued.

Remember to document why the destination is the closest appropriate facility. MO Healthnet has a 99 mile transport limit. Transport beyond 99 miles requires the originating facility to be responsible for all charges.

VA is secondary to everyone. VA-Jefferson Barracks has their own transport service and may pick the patient up for you.

Lakeland Behavior Health, Springfield, MO has their own transport service and can pick the patient up for you. When arranging for admission be sure and ask for the transportation office to make arrangements.

Court ordered admissions and transfers are to be done by Sheriff's Department unless a medical issue requires medical intervention or monitoring. A sheriff's deputy may be required to accompany the patient.

Cape Girardeau Police Department has grant funds available to pay for off duty police officers to transport behavioral health patients.

CTA has wheelchair van service available.