

Use of this template is voluntary / optional

Non-Emergency Ambulance Transportation (NEAT)

Progress Note Template Guidance

Purpose

This template has been designed to assist a clinician in documenting the patient's medical condition supporting coverage of repetitive, scheduled Non-Emergency Ambulance Transportation (NEAT) under Medicare Part B. The medical documentation must substantiate the following:

- The patient is "bed-confined"; and
- The patient's condition is such that other methods of transportation are contraindicated; or,
- If his or her medical condition, regardless of bed confinement, is such that transportation by ambulance is medically required.

For the patient to be considered bed-confined the following criteria must be met:

- The Medicare beneficiary is unable to get up from bed without assistance;
- The Medicare beneficiary is unable to ambulate;
- The Medicare beneficiary is unable to sit in a chair or wheelchair.

[42CFR §410.40(d)(1) Coverage of ambulance services.]

Medicare covers medically necessary non-emergency, scheduled, repetitive ambulance services if the ambulance provider or supplier, before furnishing the service to the beneficiary, obtains a written order from the beneficiary's attending physician certifying that the medical necessity requirements of 42CFR 410.40, paragraph (d)(1) of this section are met, which are listed above.

Medicare requires that the certification and order must be dated no earlier than 60 days in advance of the transport for repetitive beneficiaries whose transportation is scheduled in advance. (42CFR §410.40)

This template is available to the clinician and can be kept on file within the patient's medical record or can be used to develop a progress note for use with the system containing the patient's electronic medical record.

Patient eligibility

Eligibility for coverage of NEAT services under Medicare requires a physician, or qualified Non-Physician Practitioner (NPP)¹, to complete a written order certifying that the medical necessity requirements listed above, [§410.40(d)(1) - Coverage of ambulance services], are met. This helps to ensure the NEAT services to be provided are consistent with the physician's order and supported in the patient's medical record.

¹ A Medicare allowed NPP as defined is a nurse practitioner, clinical nurse specialist, or physician assistant (as those terms are defined in section 1861 (aa) (5) of the Social Security Act) who is working in accordance with State law.

Special rule for scheduled, repetitive NEAT Services [42 § 410.40(d)(2)]

Medicare covers medically necessary non-emergency, scheduled, repetitive ambulance services if the ambulance provider or supplier, before furnishing the service to the beneficiary, obtains a written order from the beneficiary's attending physician certifying that the medical necessity requirements of paragraph (d)(1) of this section are met. [42 CFR §410.40(d)(1)] The physician's order must be dated no earlier than 60 days before the date the service is furnished.

The special rule for scheduled, repetitive NEAT Services also requires:

- *In all cases, the provider or supplier must keep appropriate documentation on file and, upon request, present it to the contractor. The presence of the signed physician certification statement does not alone demonstrate that the ambulance transport was medically necessary. All other program criteria must be met in order for payment to be made. [§410.40(d)(2)(ii)]*

Special rule for unscheduled or non-repetitive NEAT services.

Medicare covers medically necessary NEAT services that are either unscheduled or that are scheduled on a non-repetitive basis under one of the following circumstances[§410.40(d)(3)(i-v)]:

- *For a resident of a facility who is under the care of a physician if the ambulance provider or supplier obtains a written order from the beneficiary's attending physician, within 48 hours after the transport, certifying that the medical necessity requirements of paragraph (d)(1) of this section are met.*
- *For a beneficiary residing at home or in a facility who is not under the direct care of a physician. A physician certification is not required. (Note: the ambulance provider must submit trip sheets with documentation that support medical necessity of the transport.)*
- *If the ambulance provider or supplier is unable to obtain a signed physician certification statement from the beneficiary's attending physician, a signed certification statement must be obtained from either the physician assistant (PA), nurse practitioner (NP), clinical nurse specialist (CNS), registered nurse (RN), or discharge planner, who has personal knowledge of the beneficiary's condition at the time the ambulance transport is ordered or the service is furnished. This individual must be employed by the beneficiary's attending physician or by the hospital or facility where the beneficiary is being treated and from which the beneficiary is transported. Medicare regulations for PAs, NPs, and CNSs apply and all applicable State licensure laws apply; or,*
- *If the ambulance provider or supplier is unable to obtain the required certification within 21 calendar days following the date of the service, the ambulance supplier must document its attempts to obtain the requested certification and may then submit the claim. Acceptable documentation includes a signed return receipt from the U.S. Postal Service or other similar service that evidences that the ambulance supplier attempted to obtain the required signature from the beneficiary's attending physician or other individual named in paragraph (d)(3)(iii) of this section.*
- *In all cases, the provider or supplier must keep appropriate documentation on file and, upon request, present it to the contractor. The presence of the signed certification statement or signed return receipt does not alone demonstrate that the ambulance transport was medically necessary. All other program criteria must be met in order for payment to be made.*

Prior Authorization (PA) of NEAT Services

Repetitive, scheduled, non-emergency, medically necessary ambulance transportation 3 or more times in a 10-day period or at least once a week for 3 weeks or more from an ambulance company based in New Jersey, Pennsylvania, South Carolina, Delaware, the District of Columbia, Maryland, North Carolina, Virginia and West Virginia will require prior approval (called “prior authorization”). These are states where a 3-year “prior authorization” (PA) demonstration is currently being conducted. Under this demonstration, the ambulance company may use the (PA) process and send a request for prior authorization to Medicare before the fourth trip in a 30-day period.

This request may be made by the Ambulance Company, or Medicare beneficiary.

For any service to be covered by Medicare it must:

- Be eligible for a defined Medicare benefit category,
- Be reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member, and
- Meet all other applicable Medicare statutory and regulatory requirements.

Important Information

It is important to understand that the PA program does not create new documentation requirements for the physician/NPP or suppliers. It simply requires the documentation to be submitted prior to submitting a claim. As the ordering/certifying physician/practitioner, you are required to supply the ambulance supplier or beneficiary the physician certification statement as well as any other documentation that supports medical necessity for the repetitive, scheduled non-emergency ambulance transports.

The NEAT PA program applies to the following Healthcare Common Procedure Coding System (HCPCS) codes:

- A0425 – Ground mileage, per statute mile,
- A0426 - Ambulance service, Advanced Life Support (ALS), non-emergency transport, Level 1, and
- A0428 - Ambulance service, Basic Life Support (BLS), non-emergency transport.

The ambulance supplier or beneficiary submits the PA request with the necessary accompanying documentation to the appropriate Medicare Administrative Contractor (MAC).

The PA request must include all relevant documentation to support Medicare coverage of the scheduled, repetitive NEAT. This includes, but is not limited to:

- Documentation from the medical record to support the medical necessity of repetitive, scheduled NEAT
 - Documentation must show transportation by other means is contraindicated
 - Vague statements, such as “patient is bed-confined”, are insufficient
 - Diagnosis of disease or illness may not be enough without corroborating evidence/statements
 - Attestation statements concerning the patient’s requirements for ambulance transportation are not sufficient without corroborating evidence in the medical documentation
- Physician Certification Statement (PCS), including the certifying physician’s name, National Provider Identifier (NPI) and address
 - The PCS must be supported by the medical documentation

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- Bed-confinement or need for transportation cannot only be stated on the PCS
- Procedure codes
- Number of transports requested
 - The PA decision, justified by the beneficiary's condition, may affirm up to 40 round trips per PA request in a 60-day period
- Information on the origin and destination of the transports
- Any other relevant document as deemed necessary by the MAC to process the PA request

Completing the NEAT Progress Note Template does not guarantee eligibility and coverage but does provide guidance in support of repetitive, scheduled NEAT services.

The NEAT Progress Note Template may be use with the NEAT PA Request Template and/or the NEAT Order/PCS Template.

Qualifying Documentation

Qualifying documentation should include information regarding bed confinement or address the patient's medical condition, regardless of bed confinement, supporting that transportation by ambulance is medically required. Examples of medical conditions that may support the need for NEAT services include, but are not limited to, the following listed below:

- Bed Confined
 - Unable to ambulate;
 - Unable to get out of bed without assistance;
 - Unable to safely sit up in a chair or wheelchair;
 - Unable to maintain erect sitting position in a chair for time needed to transport,
 - Unable to sit in a chair or wheelchair due to Grade II or greater decubitus ulcers on buttocks
- Third party assistance/attendant required to apply, administer, or regulate or adjust oxygen en route
- IV medications/fluids required during transport
- Special handling en route – isolation
- Contractures that impair mobility and result in bed confinement
- Non-healed fractures that impair mobility
- Moderate to severe pain on movement that impairs mobility
- DVT requiring elevation of one or both lower extremities
- Morbid obesity impairing mobility and requiring additional personnel/equipment to handle
- Orthopedic device (e.g., backboard, halo, use of pins in traction, etc.) requiring special handling
- Severe muscular weakness and de-conditioned state precludes any significant mobility related physical activity
- Restraints (physical or chemical) anticipated or used during transport
- Danger to self or others – monitoring
- Risk of falling off wheelchair or stretcher while in motion (not related to obesity)
- Danger to self or others – seclusion (flight risk)
- Confused, combative, lethargic, comatose

Who can complete this progress note template?

Physician or allowed NPP who certifies the patient's eligibility and need for repetitive, scheduled NEAT services.

Note: If this template is used:

- 1) CDEs in black Calibri are required
- 2) CDEs in *burnt orange Italics Calibri* are required if the condition is met
- 3) CDEs in blue Times New Roman are recommended but not required

Version R1.0e

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Non-Emergency Ambulance Transportation Progress Note Template			
Patient information:			
Last name: _____ First name: _____ MI: _____			
DOB (MM/DD/YYYY): _____ Gender: ___M___F___Other Medicare ID: _____			
Provider (physician/NPP) who performed the evaluation, <i>if different from signing provider:</i>			
<i>Last name:</i> _____ <i>First name:</i> _____ <i>MI:</i> _____ <i>Suffix:</i> _____			
<i>NPI:</i> _____ Place of employment: _____			
Telephone number and extension: (____) _____ - _____ x _____			
Direct address: _____			
Date of evaluation (MM/DD/YYYY): _____			
Is this an evaluation for Non-Emergency Ambulance Transportation and related services? ___Yes ___No			
<i>If No, purpose of the encounter:</i> _____			
Diagnoses (status: acute, chronic, acute-chronic, resolved, resolving, managed)			
ICD-10-CM	Description	Start Date	Status
Principal (related to the need for ordered services)			
Other Pertinent Diagnoses			
Chief complaint / history of present illness and associated signs / symptoms: _____			
Related past medical / surgical history: _____			
Procedures (e.g. surgical) (Code = ICD-10-CM, CPT, or HCPCS if available)			
Code	Description	Date	

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Medications relevant to transport					
RxNorm	Description	Dose	Frequency	Route	Status
_____	_____	_____	_____	_____	Active
_____	_____	_____	_____	_____	Active
_____	_____	_____	_____	_____	Active
Other medications (Status: N=New, A=Active, C=Changed, D=Discontinued)					
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

Allergies (all allergies, not just to medications) (Include RxNorm if known)			
RxNorm	Description	RxNorm	Description
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Review of systems (Significant as per history of present problem and need for NEAT):

General: ___ weight gain, ___ weight loss, ___ sleeping problems, ___ fatigue, ___ fever,
 ___ chills, ___ night sweats / diaphoresis
 ___ other: _____

Skin: ___ pressure ulcers, ___ rashes, ___ changes in nails/hair, ___ eczema, ___ pruritus,
 ___ other: _____

Lymphatic: ___ swollen glands/masses: ___ in the neck, ___ axilla, ___ groin,
 ___ other: _____

Head: ___ fainting, ___ dizziness, ___ headaches,
 ___ other: _____

Eyes: ___ diplopia, ___ glasses/contact lenses, ___ redness/discharge, ___ blurred vision,
 ___ glaucoma, ___ cataracts,
 ___ other: _____

Ears: ___ tinnitus, ___ discharge, ___ hearing loss,
 ___ other: _____

Nose: ___ epistaxis, ___ sinus infections, ___ discharge, ___ polyps,
 ___ other: _____

Oral: ___ dysphagia, ___ hoarseness, ___ teeth/dentures,
 ___ other: _____

Neck: ___ lumps, ___ pain on movement
 ___ other: _____

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Breast:	___ masses/tumors, ___ tenderness, ___ discharge, ___ gynecomastia, ___ other:
Pulmonary:	___ cough, ___ shortness of breath, ___ pain, ___ wheezing, ___ hemoptysis, ___ sputum production ___ other:
Cardiac:	___ chest pain, ___ palpitations, ___ orthopnea, ___ murmur, ___ syncope ___ other:
Vascular:	___ edema, ___ claudication, ___ varicose veins, ___ thrombophlebitis, ___ ulcers ___ other:
Gastrointestinal:	___ swallowing problems, ___ abdominal pain, ___ constipation, ___ diarrhea, ___ incontinence, ___ nausea, ___ vomiting, ___ ulcers, ___ melena, ___ rectal bleeding, ___ jaundice, ___ heartburn, ___ hematemesis ___ other:
Renal:	___ dysuria, ___ frequency, ___ urgency, ___ hesitation, ___ flank pain, ___ hematuria, ___ incontinence, ___ nocturia, ___ polyuria, ___ other:
Musculoskeletal:	___ pain, ___ swelling, ___ stiffness, ___ limitation of range of motion, ___ arthritis ___ gout, ___ cramps, ___ myalgia, ___ fasciculation, ___ atrophy, ___ fracture, ___ deformity, ___ weakness, ___ other:
Neurologic:	___ seizures, ___ poor memory, ___ poor concentration, ___ numbness / tingling, ___ pins and needles sensation, ___ hyperpathia, ___ dysesthesia, ___ weakness, ___ paralysis, ___ tremors, ___ involuntary movements, ___ unstable gait, ___ fall, ___ vertigo, ___ headache, ___ stroke, ___ speech disorders ___ other:
Psychiatric:	___ hallucinations, ___ delusions, ___ anxiety, ___ nervous breakdown, ___ mood changes ___ other:
Hematology:	___ anemia, ___ bruising, ___ bleeding disorders (conditional) ___ other:
Endocrine:	___ heat or cold intolerance, ___ diabetes, ___ lipid disorders, ___ goiter ___ other:
Other:	_____
<p>Physical examination: <i>For each section indicate if it is relevant to the need for Non-Emergency Ambulance Transport (NEAT) and /or services needed away from the patient's location (SERV)</i></p> <p>Vital signs: T=_____ P=_____ R=_____ BP=_____/_____ Height=_____ Weight=_____</p> <p>O2 Sat:_____ (RA at Rest) O2 Sat:_____ (with supplemental O2 at _____LPM)</p>	

General appearance: ___ NEAT ___ SERV Description: _____

Head and neck: ___ NEAT ___ SERV Description: _____

Chest / lungs: ___ NEAT ___ SERV Description: _____

Cardiovascular: ___ NEAT ___ SERV Description: _____

Abdominal: ___ NEAT ___ SERV Description: _____

Musculoskeletal / extremities: ___ NEAT ___ SERV Description: _____

Neurological: ___ NEAT ___ SERV Description: _____

Psychiatric: ___ NEAT ___ SERV Description: _____

Visual Exam: ___ NEAT ___ SERV Description: _____

Other: ___ NEAT ___ SERV Description: _____

Physician/NPP assessment / summary: _____

Reason(s) that non-emergency ground transport by ambulance is required and other means of transport is contraindicated. Summarizes supporting documentation in the progress note and the patient's medical record. Check all that apply:

Mobility

___ *Bed confined (all three criteria must be met):*

- 1) Unable to ambulate,*
- 2) Unable to get out of bed without assistance,*
- 3) Unable to safely sit in a chair or wheelchair*

___ *Unable to maintain erect sitting position in a chair for time needed to transport, due to moderate muscular weakness and de-conditioning*

___ *Risk of falling off wheelchair or stretcher while in motion (not related to obesity)*

Musculoskeletal

___ *Non-healed fractures requiring ambulance*

___ *Contractures that impair mobility and result in bed confinement*

___ *Incapacitating Osteoarthritis*

___ *Severe muscular weakness and de-conditioned state precludes any significant physical activity*

___ *Orthopedic device required in transit*

___ *Amputation(s)*

Cardiovascular

___ *CVA with sequela (late effect of CVA) that impair mobility and result in bed confinement*

___ *DVT requires elevation of lower extremity*

Neurological

___ *Spinal Cord Injury – Paralysis*

___ *Progressive demyelinating disease*

___ *Moderate to severe pain on movement*

Wound

___ *Unable to sit in chair or wheelchair due to Grade II or greater decubitus ulcers on buttocks*

___ *Chronic wounds requiring immobilization*

Attendant required during transport

___ *Morbid obesity requires additional personnel/equipment to handle*

___ *Third party attendant required to regulate or adjust oxygen en route*

___ *Special handling en route – isolation*

___ *IV medications/fluids required during transport*

___ *Restraints (physical or chemical) anticipated or used during transport*

Mental

___ *Danger to self or others*

___ *Confused, combative, lethargic, comatose*

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Other

___ Other, describe: _____

Are there services **that cannot be provided in the patient's current setting**? ___ Yes ___ No

If Yes, specify by checking one or more of the following and adding a description:

___ Dialysis; ___ Wound care; ___ Radiation therapy; ___ Chemotherapy; ___ O&P services;
___ Imaging; ___ Outpatient therapy; ___ Other

Description: _____

Treatment plan (required if new or changed from prior progress note):

Orders:

Transport Order:

Start date: _____ End date: _____ Round trip: ___ Yes ___ No

Transport from ___ Home, or _____ To: _____

Medications: _____

Supplies: _____

Investigations (Diagnostic Testing): _____

Consults: _____

Other: _____

Signature, Name, Date and NPI of physician or NPP

Signature: _____

Name (Printed): _____

Date (MM/DD/YYYY): _____ NPI: _____