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), 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.

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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 trop 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
  o Documentation must show transportation by other means is contraindicated
  o Vague statements, such as “patient is bed-confined”, are insufficient
  o Diagnosis of disease or illness may not be enough without corroborating evidence/statements
  o 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
  o The PCS must be supported by the medical documentation
DRAFT

- 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
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, if different from signing provider:
Last name: ___________________________ First name: ___________________________ MI: ______
NPI: ____________________________ 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
If No, purpose of the encounter: ____________________________

Diagnoses (status: acute, chronic, acute-chronic, resolved, resolving, managed)
<table>
<thead>
<tr>
<th>ICD-10-CM</th>
<th>Description</th>
<th>Start Date</th>
<th>Status</th>
</tr>
</thead>
</table>

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)
<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Date</th>
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</table>
### Medications relevant to transport

<table>
<thead>
<tr>
<th>RxNorm</th>
<th>Description</th>
<th>Dose</th>
<th>Frequency</th>
<th>Route</th>
<th>Status</th>
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**Other medications** (Status: N=New, A=Active, C=Changed, D=Discontinued)

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<tr>
<th>RxNorm</th>
<th>Description</th>
<th>Dose</th>
<th>Frequency</th>
<th>Route</th>
<th>Status</th>
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### Allergies (all allergies, not just to medications) (Include RxNorm if known)

<table>
<thead>
<tr>
<th>RxNorm</th>
<th>Description</th>
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<th>Description</th>
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### 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:
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:

Physical examination:
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)

Vital signs: T=_________ P=_________ R=_________ BP=_________/_________ Height=_______ Weight=_________

O2 Sat:_________ (RA at Rest) O2 Sat:_______ (with supplemental O2 at _______LPM)
<table>
<thead>
<tr>
<th>Section</th>
<th>NEAT</th>
<th>SERV Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>General appearance</td>
<td></td>
<td></td>
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<tr>
<td>Head and neck</td>
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<tr>
<td>Chest / lungs</td>
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<tr>
<td>Cardiovascular</td>
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<tr>
<td>Abdominal</td>
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<tr>
<td>Musculoskeletal / extremities</td>
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<tr>
<td>Neurological</td>
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<tr>
<td>Psychiatric</td>
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<tr>
<td>Visual Exam</td>
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<tr>
<td>Other</td>
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</tbody>
</table>
**Physician/NPP assessment / summary:**

<table>
<thead>
<tr>
<th>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:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Mobility</strong></td>
</tr>
<tr>
<td>Bed confined (all three criteria must be met):</td>
</tr>
<tr>
<td>1) Unable to ambulate,</td>
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<tr>
<td>2) Unable to get out of bed without assistance,</td>
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<tr>
<td>3) Unable to safely sit in a chair or wheelchair</td>
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<tr>
<td>Unable to maintain erect sitting position in a chair for time needed to transport, due to moderate muscular weakness and de-conditioning</td>
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<tr>
<td>Risk of falling off wheelchair or stretcher while in motion (not related to obesity)</td>
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<tr>
<td><strong>Musculoskeletal</strong></td>
</tr>
<tr>
<td>Non-healed fractures requiring ambulance</td>
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<tr>
<td>Contractures that impair mobility and result in bed confinement</td>
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<tr>
<td>Incapacitating Osteoarthritis</td>
</tr>
<tr>
<td>Severe muscular weakness and de-conditioned state precludes any significant physical activity</td>
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<tr>
<td>Orthopedic device required in transit</td>
</tr>
<tr>
<td>Amputation(s)</td>
</tr>
<tr>
<td><strong>Cardiovascular</strong></td>
</tr>
<tr>
<td>CVA with sequela (late effect of CVA) that impair mobility and result in bed confinement</td>
</tr>
<tr>
<td>DVT requires elevation of lower extremity</td>
</tr>
<tr>
<td><strong>Neurological</strong></td>
</tr>
<tr>
<td>Spinal Cord Injury – Paralysis</td>
</tr>
<tr>
<td>Progressive demyelinating disease</td>
</tr>
<tr>
<td>Moderate to severe pain on movement</td>
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<tr>
<td><strong>Wound</strong></td>
</tr>
<tr>
<td>Unable to sit in chair or wheelchair due to Grade II or greater decubitus ulcers on buttocks</td>
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<tr>
<td>Chronic wounds requiring immobilization</td>
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<tr>
<td><strong>Attendant required during transport</strong></td>
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<tr>
<td>Morbid obesity requires additional personnel/equipment to handle</td>
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<td>Third party attendant required to regulate or adjust oxygen en route</td>
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<td>Special handling en route – isolation</td>
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<td>IV medications/fluids required during transport</td>
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<td>Restraints (physical or chemical) anticipated or used during transport</td>
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<tr>
<td><strong>Mental</strong></td>
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<tr>
<td>Danger to self or others</td>
</tr>
<tr>
<td>Confused, combative, lethargic, comatose</td>
</tr>
</tbody>
</table>
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: __________________________