COVID-19 FAQ

3. Does transport of an individual with isolation precautions due to confirmed (or suspected) COVID-19 meet the Medicare medical necessity requirement?

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Answer: We are not aware of any guidance issued by Medicare as to whether a COVID-19 positive test *alone* meets medical necessity. The 10 presumed criteria (from Medicare Benefit Policy Manual 100-02, Chapter 10, Section 20) does **not** mention contamination or isolation as a condition for which medical necessity is supported – especially for a non-emergency ambulance transport. Contagion alone does not necessarily meet medical necessity, but with this current trend of isolation, social distancing, and quarantine, preventing the spread is paramount.

Whether medical necessity is met (such that other forms of transport are contraindicated) largely depends on the degree of precautions being taken. A simple mask would likely not meet the "isolation requirements." But, if the EMS crew was in full PPE such that there were significant barrier precautions in place, there is a stronger argument for medical necessity (as such precautions would not be available in alternative forms of transport). Some other things to consider:

- From the original list of Medicare condition codes: "Special Handling enroute-Isolation. Includes patients with communicable diseases… who must be isolated from public…" (ICD-9 041.9, which converts to ICD-10 B96.89). It would seem this is precisely the type of situation for which CMS created this code. Remember: simply using an ICD-10 Code does not guarantee payment.

- Transport of a dialysis patient with knowns/suspected COVID-19 infection in a shuttle or wheelchair van (when neither those vehicles nor those drivers likely have access to PPE or the training on its proper use even if they did have PPE access) is likely contraindicated by the patient's condition. In contrast, EMS personnel *are* trained on communicable disease transmission, the use of barrier protections and other PPE, and proper cleaning and disinfecting of surfaces that patients come into contact with. None of this training or these procedures can reasonably be expected of non-healthcare personnel such as van or shuttle drivers.

- Since each transport is judged for medical necessity on its own, proper and complete documentation practices must apply to each transport. Crews should **not** write things like "see prior PCR" and should not simply "copy and paste" a narrative from a prior transport. Each PCR should contain a detailed and accurate assessment specific to each time of service. Of course, all the other standard documentation practices should apply as well, including a complete assessment, vitals, reassessment, treatment, etc.

Therefore, the documentation and the degree of precautions used become relevant factors. For example, consider the potential differences between the following:

a) Patient ambulates out of the main entrance of the hospital wearing only a mask and loads him/herself onto the stretcher independently. Upon arrival at home, patient ambulates into his/her home with minimal assistance. While crew was in the rear of the vehicle with the patient, no interventions were performed, and no protective equipment was used by the EMS crew. Under the facts of this case, medical necessity for ambulance is weak.

b) Patient is in a hospital bed, or wheelchair, with protective equipment in place. EMS crew dons PPE gear and transports patient out of the hospital in an isolated area of the facility, used specifically for entrance and exit of presumed or known positive corona patients. The patient is ultimately transported home where there are safety precautions in place (i.e., protective equipment and quarantine measures to protect other family members, etc.). The facts of this case help support medical necessity.

Bottom line, COVID-19 alone does not create a presumption of medical necessity. Whether or not medical necessity is met will depend on the documentation on the PCR and (as always) medical necessity must be decided on a case-by-case basis.