



Provider Inquiry Assistance

Updates to the Internet Only Manual Publication 100-02, Chapter 10 (of the *Medicare Benefit Policy Manual*) - JA6318

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Key Words MM6318, CR6318, R103BP, Benefit, Policy, IOM, Ambulance

Contractors Affected

- Part A/B Medicare Administrative Contractors (A/B MACs)
- Medicare Carriers
- Fiscal Intermediaries (FIs)

Provider Types Affected Ambulance providers and suppliers submitting claims to Medicare Carriers, FIs, and/or A/B MACs for ambulance services provided to Medicare beneficiaries



Change Request (CR) 6318 is informational in nature and highlights the revisions to the *Medicare Benefit Policy Manual*, Chapter 10 - Ambulance Services.

Revisions to the *Medicare Benefit Policy Manual*

Chapter 10, Section 10.4

Provider Needs to Know...

- Medically appropriate air ambulance transportation is a covered service, regardless of the state or region in which it is rendered.
- However, Medicare contractors approve claims only if the beneficiary's medical condition is such that transportation by either basic or advanced life support ground ambulance is not appropriate.

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- There are two categories of air ambulance services: fixed wing (airplane) and rotary wing (helicopter) aircraft:
 - **Fixed Wing Air Ambulance (FW):** Fixed wing air ambulance is furnished when the beneficiary's medical condition is such that transport by ground ambulance, in whole or in part, is not appropriate.
 - **Rotary Wing Air Ambulance (RW):** Rotary wing air ambulance is furnished when the beneficiary's medical condition is such that transport by ground ambulance, in whole or in part, is not appropriate.

Generally, transport by FW or RW air ambulance may be necessary because the beneficiary's condition requires rapid transport to a treatment facility, and either great distances or other obstacles (e.g., heavy traffic, preclude such rapid delivery to the nearest appropriate facility). Transport by FW or RW air ambulance may also be necessary because the beneficiary is inaccessible by a ground or water ambulance vehicle.

- The higher operational costs of the two types of aircraft are recognized with two distinct payment amounts for air ambulance mileage. The air ambulance mileage rate is calculated per actual loaded (patient onboard) miles flown and is expressed in statute miles (not nautical miles).

Chapter 10, Section 10.4.2

- Medical **reasonableness** is only established when the beneficiary's condition is such that the time needed to transport a beneficiary by ground, or the instability of transportation by ground, poses a threat to the beneficiary's survival or seriously endangers the beneficiary's health.
- A list of examples of cases for which air ambulance could be justified is available in Section 10.4.2, which is attached to CR6318 and can be found at <http://www.cms.hhs.gov/Transmittals/downloads/R103BP.pdf> on the CMS website.
- The list is not inclusive of all situations that justify air transportation, nor is it intended to justify air transportation in all locales in the circumstances listed.

Chapter 10, Section 20/20.1.2 - Beneficiary Signature Requirements

- Medicare requires the signature of the beneficiary, or that of his or her representative, for both the purpose of accepting assignment and submitting a claim to Medicare.
 - If the beneficiary is unable to sign because of a mental or physical condition, the following individuals may sign the claim form on behalf of the beneficiary:
 - The beneficiary's legal guardian;
 - A relative or other person who receives social security or other governmental benefits on behalf of the beneficiary;
 - A relative or other person who arranges for the beneficiary's treatment or exercises other responsibility for his or her affairs;
 - A representative of an agency or institution that did not furnish the services for
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which payment is claimed, but furnished other care, services, or assistance to the beneficiary;

- A representative of the provider or of the nonparticipating hospital claiming payment for services it has furnished, if the provider or nonparticipating hospital is unable to have the claim signed in accordance with 42 Code of Federal Regulations 424.36(b) (1 – 4); and/or
- A representative of the ambulance provider or supplier who is present during an emergency and/or nonemergency transport, provided that the ambulance provider or supplier maintains certain documentation in its records for at least 4 years from the date of service.

Note: A provider/supplier (or his/her employee) cannot request payment for services furnished except under circumstances fully documented to show that the beneficiary is unable to sign and that there is no other person who could sign.

Chapter 10, Section 30.1.1

- This section is revised to add information regarding Advanced Life Support (ALS) assessments.
- The determination to respond emergently with an ALS ambulance must be in accord with the local 911 or equivalent service dispatch protocol.
- If the call came in directly to the ambulance provider/supplier, then the provider's/supplier's dispatch protocol must meet, at a minimum, the standards of the dispatch protocol of the local 911 or equivalent service.
- In areas that do not have a local 911 or equivalent service, then the protocol must meet, at a minimum, the standards of a dispatch protocol in another similar jurisdiction within the state, or if there is no similar jurisdiction within the state, then the standards of any other dispatch protocol within the state.
- Where the dispatch was inconsistent with this standard of protocol, including where no protocol was used, the beneficiary's condition (for example, symptoms) at the scene determines the appropriate level of payment.

Background

- Chapter 15, Section 20.1.4 (Components of the Ambulance Fee Schedule) of the *Medicare Claims Processing Manual* was revised via previously released Transmittal AB-02-130.
- CR6318 revises *Medicare Benefit Policy Manual* to incorporate the changes made by Transmittal AB-02-130.

Operational

N/A

Impact

Reference
Materials

The related MLN Matters article can be found at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM6318.pdf> on the CMS website.

The official instruction (CR6318) issued regarding this change may be found at <http://www.cms.hhs.gov/Transmittals/downloads/R103BP.pdf> on the CMS website.

Providers may also want to review the related Chapter 15, Section 20.1.4 (Components of the Ambulance Fee Schedule) in the *Medicare Claims Processing Manual*, which is available at <http://www.cms.hhs.gov/manuals/downloads/clm104c15.pdf> on the CMS website.
