

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services



MLN Matters® Number: MM9761 **Revised** **Related Change Request (CR) #:** CR 9761

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Ambulance Staffing Requirements

Note: This article was revised on September 13, 2016, due to a revised Change Request (CR). The CR corrected the implementation date in the manual instruction section of the CR to December 12, 2016. The transmittal number, CR release date and the link to the CR also changed. All other information remains the same.

Provider Types Affected

This MLN Matters® Article is intended for ambulance providers and suppliers submitting claims to Medicare Administrative Contractors (MACs) for Part B ambulance services provided to Medicare beneficiaries.

Provider Action Needed

CR 9761 manualizes the Calendar Year (CY) 2016 revisions to the ambulance staffing requirements (80 FR 71078-71080) and provides clarifications on the definitions for ground ambulance services for Advanced Life Support, Level 1 (ALS1), ALS assessment, application for ALS, Level 2 (ALS2), Specialty Care Transport (SCT), Paramedic Intercept (PI), emergency response, and inter-facility transportation. Please make sure your billing staff is aware of these revisions.

Background

In the CY 2016 Physician Fee Schedule Final Rule (80 FR 71078-71080), the Centers for Medicare & Medicaid Services (CMS) finalized without modification their proposals to revise:

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1. 42 CFR 410.41(b) and the definition of Basic Life Support (BLS) in 42 CFR 414.605, to require that all Medicare covered ambulance transports be staffed by at least two people who meet both the requirements of state and local laws where the services are being furnished, and the current Medicare requirements;
2. 42 CFR 410.41(b) and the definition of BLS in 42 CFR 414.605 to clarify that for BLS vehicles, one of the staff members must be certified at a minimum as an EMT-Basic; and
3. To delete the last sentence in the definition of BLS in 42 CFR 414.605, which sets forth examples of certain state law provisions.

CR9761 updates Chapter 10, Sections 10.1.2; 30.1; and 30.1.1 of the “Medicare Benefit Policy Manual” (Pub. 100-02) to incorporate these revisions.

Key Points of CR9761

BLS Vehicles

BLS ambulances must be staffed by at least two people, who meet the requirements of state and local laws where the services are being furnished and where, at least one of whom must be certified at a minimum as an emergency medical technician-basic (EMT-basic) by the State or local authority where the services are being furnished and be legally authorized to operate all lifesaving and life-sustaining equipment on board the vehicle. These laws may vary from state to state or within a state.

ALS Vehicles

Advanced Life Support (ALS) vehicles must be staffed by at least two people, who meet the requirements of state and local laws where the services are being furnished and where at least one of whom must meet the vehicle staff requirements above for BLS vehicles and be certified as an EMT-Intermediate or an EMT-Paramedic by the state or local authority where the services are being furnished to perform one or more ALS services.

Ambulance Services

There are several categories of ground ambulance services and two categories of air ambulance services under the fee schedule. (Note that “ground” refers to both land and water transportation.) All ground and air ambulance transportation services must meet all requirements regarding medical reasonableness and necessity as outlined in the applicable statute, regulations and manual provisions.

Advanced Life Support, Level 1 (ALS1)

Definition: ALS1 is the transportation by ground ambulance vehicle and the provision of medically necessary supplies and services including the provision of an ALS assessment by ALS personnel or at least one ALS intervention.

ALS Assessment

Definition: An ALS assessment is an assessment performed by an ALS crew as part of an emergency response that was necessary because the patient's reported condition at the time

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of dispatch was such that only an ALS crew was qualified to perform the assessment. An ALS assessment does not necessarily result in a determination that the patient requires an ALS level of service. In the case of an appropriately dispatched ALS Emergency service, as defined below, if the ALS crew completes an ALS Assessment, the services provided by the ambulance transportation service provider or supplier may be covered at the ALS emergency level, regardless of whether the patient required ALS intervention services during the transport, provided that ambulance transportation itself was medically reasonable and necessary.

ALS Intervention

Definition: An ALS intervention is a procedure that is in accordance with state and local laws, required to be done by an emergency medical technician-intermediate (EMT-Intermediate) or EMT-Paramedic.

Application: An ALS intervention must be medically necessary to qualify as an intervention for payment for an ALS level of service. An ALS intervention applies only to ground transports.

Advanced Life Support, Level 1 (ALS1) - Emergency

Definition: When medically necessary, the provision of ALS1 services, in the context of an emergency response.

Advanced Life Support, Level 2 (ALS2)

Definition: ALS2 is the transportation by ground ambulance vehicle and the provision of medically necessary supplies and services including at least three separate administrations of one or more medications by intravenous (IV) push/bolus or by continuous infusion (excluding crystalloid fluids) **or** ground ambulance transport, medically necessary supplies and services, and the provision of at least one of the following ALS2 procedures:

- Manual defibrillation/cardioversion
- Endotracheal intubation
- Central venous line
- Cardiac pacing
- Chest decompression
- Surgical airway
- Intraosseous line

Application: Crystalloid fluids include but are not necessarily limited to 5 percent Dextrose in water (often referred to as D5W), Saline and Lactated Ringer's. To qualify for the ALS2 level of payment, medications must be administered intravenously. Medications that are administered by other means, for example, intramuscularly, subcutaneously, orally, sublingually, or nebulized do not support payment at the ALS2 level rate.

IV medications are administered in standard doses as directed by local protocol or online medical direction. It is not appropriate to administer a medication in divided doses in order to

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meet the ALS2 level of payment. For example, if the local protocol for the treatment of Supraventricular Tachycardia (SVT) calls for a 6 mg dose of adenosine, the administration of three 2 mg doses in order to qualify for the ALS 2 level is not acceptable.

The administration of an intravenous drug by infusion qualifies as one intravenous dose. For example, if a patient is being treated for atrial fibrillation in order to slow the ventricular rate with diltiazem and the patient requires two boluses of the drug followed by an infusion of diltiazem then the infusion would be counted as the third intravenous administration and the transport would be billed as an ALS 2 level of service.

The fractional administration of a single dose (for this purpose, meaning a “standard” or “protocol” dose) of a medication on three separate occasions does not qualify for ALS2 payment. In other words, the administering 1/3 of a qualifying dose 3 times does not equate to three qualifying doses to support claiming ALS2-level care. For example, administering one-third of a dose of X medication 3 times might = Y (where Y is a standard/protocol drug amount), but the same sequence does not equal 3 times Y. Thus, if 3 administrations of the same drug are required to claim ALS2 level care, each administration must be in accordance with local protocols; the run will not qualify at the ALS2 level on the basis of drug administration if that administration was not according to local protocol. The criterion of multiple administrations of the same drug requires that a suitable quantity of the drug be administered and that there be a suitable amount of time between administrations, and that both are in accordance with standard medical practice guidelines.

Examples of drug administration that help explain this policy are in the revised manual sections that are attached to CR9761.

ALS Personnel

Definition: ALS personnel are individuals trained to the level of the emergency medical technician-intermediate (EMT-Intermediate) or paramedic.

Specialty Care Transport (SCT)

Definition: Specialty Care Transport (SCT) is the Inter-facility Transportation (as defined below) of a critically injured or ill beneficiary by a ground ambulance vehicle, including the provision of medically necessary supplies and services, at a level of service beyond the scope of the EMT-Paramedic. SCT is necessary when a beneficiary’s condition requires ongoing care that must be furnished by one or more health professionals in an appropriate specialty area, for example, emergency or critical care nursing, emergency medicine, respiratory care, cardiovascular care, or an EMT-Paramedic with additional training.

Application: SCT is necessary when a beneficiary’s condition requires ongoing care that must be furnished by one or more health professionals in an appropriate specialty area. The EMT-Paramedic level of care is set by each state. Medically necessary care that is furnished at a level above the EMT-Paramedic level of care may qualify as SCT.

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To be clear, if EMT-Paramedics - without specialty care certification or qualification - are permitted to furnish a given service in a State, then that service does **not** qualify for SCT. The phrase “EMT-Paramedic with additional training” recognizes that a state may permit a person who is not only certified as an EMT-Paramedic, but who also has successfully completed additional education as determined by the state in furnishing higher level medical services required by critically ill or injured patients, to furnish a level of service that otherwise would require a health professional in an appropriate specialty care area (for example, a nurse) to provide. “Additional training” means the specific additional training that a State requires a paramedic to complete in order to qualify to furnish specialty care to a critically ill or injured patient during an SCT.

Paramedic Intercept (PI)

Definition: Paramedic Intercept services are ALS services provided by an entity that does not provide the ambulance transport. This type of service is most often provided for an emergency ambulance transport in which a local volunteer ambulance that can provide only Basic Life Support (BLS) level of service is dispatched to transport a patient. If the patient needs ALS services such as EKG monitoring, chest decompression, or IV therapy, another entity dispatches a paramedic to meet the BLS ambulance at the scene or once the ambulance is on the way to the hospital. The ALS paramedics then provide services to the patient.

Paramedic intercept services furnished on or after March 1, 1999, are payable separate from the ambulance transport when all the requirements in the following three conditions are met:

I. The intercept service(s) is:

- Furnished in a rural area (as defined below) ;
- Furnished under a contract with one or more volunteer ambulance services; and,
- Medically necessary based on the condition of the beneficiary receiving the ambulance service.

II. The volunteer ambulance service involved must:

- Meet Medicare’s certification requirements for furnishing ambulance services;
- Furnish services only at the BLS level at the time of the intercept; and,
- Be prohibited by state law from billing anyone for any service.

III. The entity furnishing the ALS paramedic intercept service must:

- Meet Medicare’s certification requirements for furnishing ALS services; and,
- Bill all recipients who receive ALS paramedic intercept services from the entity, regardless of whether or not those recipients are Medicare beneficiaries.

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For purposes of the paramedic intercept benefit, a rural area is an area that is designated as rural by a State law or regulation or that is located in a rural census tract of a metropolitan statistical area (as determined under the most recent version of the Goldsmith Modification). (The Goldsmith Modification is a methodology to identify small towns and rural areas within large metropolitan counties that are isolated from central areas by distance or other features). The current list of these areas is periodically published in the Federal Register. See the “Medicare Claims Processing Manual,” [Chapter 15](#), “Ambulance,” Section 20.1.4 for payment of paramedic intercept services.

Inter-facility Transportation

For purposes of SCT payment, an inter-facility transportation is one in which the origin and destination are one of the following:

- A hospital or Skilled Nursing Facility (SNF) that participates in the Medicare program, or
- A hospital-based facility that meets Medicare’s requirements for provider-based status.

Emergency Response

Definition: Emergency response is a BLS or ALS1 level of service that has been provided in immediate response to a 911 call or the equivalent. An immediate response is one in which the ambulance provider/supplier begins as quickly as possible to take the steps necessary to respond to the call. The nature of an ambulance’s response (whether emergency or not) does not independently establish or support medical necessity for an ambulance transport. Rather, Medicare coverage always depends on, among other things, whether the service(s) furnished is actually medically reasonable and necessary based on the patient’s condition at the time of transport.

Additional Information

The official instruction, CR9761, issued to your MAC regarding this change is available at <https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R226BP.pdf>.

If you have any questions, please contact your MAC at their toll-free number. That number is available at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/index.html>.

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Document History

Date of Change	Description
September 13, 2016	The article was revised due to a revised CR. The CR corrected the implementation date in the manual instruction section of the CR to December 12, 2016. The transmittal number, CR release date and the link to the CR also changed.
September 10, 2016	Initial article released

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