



**News Flash** – A Special Edition MLN Matters provider education article is now available at <http://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnmattersarticles/downloads/SE0837.pdf> on the CMS website. This Special Edition article assists all providers who will be affected by Medicare Administrative Contractor (MAC) implementations. It provides information to make you aware of what to expect as your FI or carrier transitions its work to a MAC. This article alerts providers as to what to expect and how to prepare for the MAC implementations and will help to minimize any disruption in your Medicare business.

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Related Change Request (CR) #: 6318

Related CR Release Date: February 20, 2009

Effective Date: January 5, 2009

Related CR Transmittal #: R103BP

Implementation Date: March 20, 2009

**Note:** This article was updated on December 17, 2012, to reflect current Web addresses. All other information remains unchanged.

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

### Provider Types Affected

Ambulance providers and suppliers submitting claims to Medicare Contractors (carriers, Fiscal Intermediaries (FIs), and/or Medicare Administrative Contractors (MACs)) for ambulance services provided to Medicare beneficiaries.

### Provider Action Needed

This article is based on Change Request (CR) 6318 and alerts providers that the Centers for Medicare & Medicaid Services (CMS) is issuing CR6318 to highlight the revisions to the Medicare Benefit Policy Manual, Chapter 10 - Ambulance Services. The article is informational in nature, since CR 6318 revises that manual to incorporate information previously released via Transmittal AB-02-130 and updates to the Medicare Claims Processing Manual, Chapter 15, which is available at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c15.pdf> on the CMS website.

#### Disclaimer

This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents.

## Key Points

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The key updates made to Chapter 10 of the Medicare Benefit Policy Manual are as follows:

- **Chapter 10/Section 10.4.** 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. There are two categories of air ambulance services: fixed wing (airplane) and rotary wing (helicopter) aircraft. 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).
  1. **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. Generally, transport by fixed wing 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 fixed wing air ambulance may also be necessary because the beneficiary is inaccessible by a ground or water ambulance vehicle.
  2. **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 rotary wing 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 rotary wing air ambulance may also be necessary because the beneficiary is inaccessible by a ground or water ambulance vehicle.
- **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. 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

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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:

1. The beneficiary's legal guardian;
2. A relative or other person who receives social security or other governmental benefits on behalf of the beneficiary;
3. A relative or other person who arranges for the beneficiary's treatment or exercises other responsibility for his or her affairs;
4. A representative of an agency or institution that did not furnish the services for which payment is claimed, but furnished other care, services, or assistance to the beneficiary;
5. 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 CFR 424.36(b) (1 – 4); and/or
6. 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.

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## Additional Information

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If you have questions, please contact your Medicare FI, carrier or MAC at their toll-free number which may be found at <http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html> on the CMS website.

The official instruction (CR6318) issued to your Medicare FI, carrier or MAC is available at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R103BP.pdf> on the CMS website.

**News Flash - It's Not Too Late to Give and Get the Flu Shot!** In the United States, the peak of flu season typically occurs anywhere from late December through March; however, flu season can last as late as May. Each office visit presents an opportunity for you to talk with your patients about the importance of getting an annual flu shot and a one time pneumococcal vaccination. Protect yourself, your patients, and your family and friends by getting and giving the flu shot. **Don't Get the Flu. Don't Give the Flu.** Remember - Influenza and pneumococcal vaccinations plus their administration are covered Part B benefits. Note that influenza and pneumococcal vaccines are NOT Part D covered drugs. Health care professionals and their staff can learn more about Medicare's Part B coverage of adult immunizations and related provider education resources, by reviewing Special Edition *MLN Matters* article SE0838 <http://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnmattersarticles/downloads/SE0838.pdf> on the CMS website.

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