Medicare Benefit Policy Manual
Chapter 10 - Ambulance Services

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(Rev. 243, 04-13-18)

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10 - Ambulance Service
(Rev. 1, 10-01-03)
B3-2120, A3-3114, HO-236

Ambulance services are separately payable only under Part B. There are certain circumstances in which the service is covered and payable as a beneficiary transportation service under Part A; however in this case the service cannot be classified and paid for as an ambulance service under Part B. (See §10.3.3 for a description of this exception. Also see §10.2.4 for the required documentation for ambulance services.)

Payment may be made for expenses incurred for ambulance service provided the conditions specified in the following subsections are met. (See the Medicare Claims Processing Manual, Chapter 15, "Ambulance," for instructions for processing ambulance service claims.)

The Medicare ambulance benefit is a transportation benefit and without a transport there is no payable service. When multiple ground and/or air ambulance providers/suppliers respond, payment may be made only to the ambulance provider/supplier that actually furnishes the transport.

10.1 - Vehicle and Crew Requirement
(Rev. 1, 10-01-03)
B3-2120.1, A3-3114, HO-236.1

10.1.1 - The Vehicle
(Rev. 1, 10-01-03)
B3-2120.1.A, A3-3114.A, HO-236.1.A

Any vehicle used as an ambulance must be designed and equipped to respond to medical emergencies and, in nonemergency situations, be capable of transporting beneficiaries with acute medical conditions. The vehicle must comply with State or local laws governing the licensing and certification of an emergency medical transportation vehicle. At a minimum, the ambulance must contain a stretcher, linens, emergency medical supplies, oxygen equipment, and other lifesaving emergency medical equipment and be equipped with emergency warning lights, sirens, and telecommunications equipment as required by State or local law. This should include, at a minimum, one 2-way voice radio or wireless telephone.

10.1.2 - Vehicle Requirements for Basic Life Support and Advanced Life Support
(Rev. 226, Issued: 09-12-16, Effective: 01-01-16, Implementation: 12-12-16)

Basic Life Support (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 (1) 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 (2) be legally authorized to operate all lifesaving and life-sustaining equipment on board the vehicle.

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 (1) meet the vehicle staff requirements above for BLS vehicles and (2) 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.

10.1.3 - Verification of Compliance

(Rev. 1, 10-01-03)
B3-2120.1.C, B3-2120.1.C, HO-236.1

In determining whether the vehicles and personnel of each supplier meet all of the above requirements, A/B MACs (B) may accept the supplier's statement (absent information to the contrary) that its vehicles and personnel meet all of the requirements if:

1. The statement describes the first aid, safety, and other patient care items with which the vehicles are equipped;

2. The statement shows the extent of first aid training acquired by the personnel assigned to those vehicles;

3. The statement contains the supplier's agreement to notify the A/B MAC (B) of any change in operation which could affect the coverage of ambulance services; and

4. The information provided indicates that the requirements are met.

The statement must be accompanied by documentary evidence that the ambulance has the equipment required by State and local authorities. Documentary evidence could include a letter from such authorities, a copy of a license, permit, certificate, etc., issued by the authorities. The A/B MAC (B) will keep the statement and supporting documentation on file.

When a supplier does not submit such a statement or whenever there is a question about a supplier's compliance with any of the above requirements for vehicle and crew (including suppliers who have completed the statement), A/B MACs (B) will take appropriate action including, where necessary, on-site inspection of the vehicles and verification of the qualifications of personnel to determine whether the ambulance service qualifies for reimbursement under Medicare. Since the requirements described above for coverage of ambulance services are applicable to the overall operation of the ambulance supplier's service, information regarding personnel and vehicles need not be obtained on an individual trip basis.

10.1.4 - Ambulance Services Furnished by Providers of Services

(Rev. 1, 10-01-03)
A3-3114, B3-2120.1, HO-236.1

The A/B MAC (A) is responsible for the processing of claims for ambulance service furnished under arrangements by participating hospitals, skilled nursing facilities, and home health agencies. Since provider ambulance services furnished “under arrangements” with suppliers can be covered only if the supplier meets the above requirements, the A/B MAC (A) may ask the A/B MAC (B) to identify those suppliers who meet the requirements. Where the "under arrangement" supplier also supplies ambulance services directly to Medicare beneficiaries, i.e., services that are not pursuant to an arrangement with a provider, the A/B MAC (A) contacts the A/B MAC (B) to ascertain whether it has already determined whether the crew and ambulance requirements are met. In such a situation, the A/B MAC (A) should accept the A/B MAC (B)’s determination without pursuing its own investigation.

10.1.5 - Equipment and Supplies

(Rev. 1, 10-01-03)
A3-3114.A, B3-2120.2.E

As mentioned above, the ambulance must have customary patient care equipment and first aid supplies, including reusable devices and equipment such as backboards, neckboards, and inflatable leg and arm splints. These are all considered part of the general ambulance service and payment for them is included in the payment rate for the transport.

10.2 - Necessity and Reasonableness

(Rev. 1, 10-01-03)
B3-2120.2, A3-3114.B, HO-236.2

To be covered, ambulance services must be medically necessary and reasonable.

10.2.1 - Necessity for the Service

(Rev. 1, 10-01-03)
B3-2120.2.A, A3-3114.B, HO-236.2

Medical necessity is established when the patient's condition is such that use of any other method of transportation is contraindicated. In any case in which some means of transportation other than an ambulance could be used without endangering the individual's health, whether or not such other transportation is actually available, no payment may be made for ambulance services. In all cases, the appropriate documentation must be kept on file and, upon request, presented to the A/B MAC (A) or (B). It is important to note that the presence (or absence) of a physician’s order for a transport by ambulance does not necessarily prove (or disprove) whether the transport was medically necessary. The ambulance service must meet all program coverage criteria in order for payment to be made.

In addition, the reason for the ambulance transport must be medically necessary. That is, the transport must be to obtain a Medicare covered service, or to return from such a service.

10.2.2 - Reasonableness of the Ambulance Trip

(Rev. 103; Issued: 02-20-09; Effective Date: 01-05-09; Implementation Date: 03-20-09)

Under the FS payment is made according to the level of medically necessary services actually furnished. That is, payment is based on the level of service furnished (provided they were medically necessary), not simply on the vehicle used. Even if a local government requires an ALS response for all calls, payment under the FS is made only for the level of service furnished, and then only when the service is medically necessary.

10.2.3 - Medicare Policy Concerning Bed-Confinement

(Rev. 1, 10-01-03)

As stated above, medical necessity is established when the patient's condition is such that the use of any other method of transportation is contraindicated. A/B MACs (A) and (B) may presume this requirement is met under certain circumstances, including when the beneficiary was bed-confined before and after the ambulance trip (see §20 for the complete list of circumstances).

A beneficiary is bed-confined if he/she is:

- Unable to get up from bed without assistance;
- Unable to ambulate; and
- Unable to sit in a chair or wheelchair.

The term "bed confined" is not synonymous with "bed rest" or "nonambulatory". Bed-confinement, by itself, is neither sufficient nor is it necessary to determine the coverage for Medicare ambulance benefits. It is simply one element of the beneficiary's condition that may be taken into account in the A/B MAC (A)'s or (B)'s determination of whether means of transport other than an ambulance were contraindicated.

10.2.4 - Documentation Requirements

In all cases, the appropriate documentation must be kept on file and, upon request, presented to the A/B MAC (B). It is important to note that neither the presence nor absence of a signed physician's order for an ambulance transport necessarily proves (or disproves) whether the transport was medically necessary. The ambulance service must meet all program coverage criteria in order for payment to be made.

10.2.5-Transport of Persons Other Than the Beneficiary

(Rev. 1, 10-01-03)

No payment may be made for the transport of ambulance staff or other personnel when the beneficiary is not onboard the ambulance (e.g., an ambulance transport to pick up a specialty care unit from one hospital to provide services to a beneficiary at another hospital). This policy applies to both ground and air ambulance transports.

10.2.6 - Effect of Beneficiary Death on Medicare Payment for Ground Ambulance Transports

(Rev. 103; Issued: 02-20-09; Effective Date: 01-05-09; Implementation Date: 03-20-09)

Because the Medicare ambulance benefit is a transport benefit, if no transport of a Medicare beneficiary occurs, then there is no Medicare-covered service. In general, if the beneficiary dies before being transported, then no Medicare payment may be made. Thus, in a situation where the beneficiary dies, whether any payment under the Medicare ambulance benefit may be made depends on the time at which the beneficiary is pronounced dead by an individual authorized by the State to make such pronouncements.

The chart below shows the Medicare payment determination for various ground ambulance scenarios in which the beneficiary dies. In each case, the assumption is that the ambulance transport would have otherwise been medically necessary.

Ground Ambulance Scenarios: Beneficiary Death	
Time of Death Pronouncement	**Medicare Payment Determination**
Before dispatch.	None.
After dispatch, before beneficiary is loaded onboard ambulance (before or after arrival at the point-of-pickup).	The provider's/supplier's BLS base rate, no mileage or rural adjustment; use the QL modifier when submitting the claim.
After pickup, prior to or upon arrival at the receiving facility.	Medically necessary level of service furnished.

10.3 - The Destination

(Rev.243; Issued: 04-13-18; Effective: 07-16-18; Implementation: 07-16-18)

An ambulance transport is covered to the nearest appropriate facility to obtain necessary diagnostic and/or therapeutic services (such as a CT scan or cobalt therapy) as well as the return transport. In addition to all other coverage requirements, this transport situation is

covered only to the extent of the payment that would be made for bringing the service to the patient.

Medicare covers ambulance transports (that meet all other program requirements for coverage) only to the following destinations:

- Hospital;
- Critical Access Hospital (CAH);
- Skilled Nursing Facility (SNF);
- *From a SNF to the nearest supplier of medically necessary services not available at the SNF where the beneficiary is a resident and not in a covered Part A stay, including the return trip;*
- Beneficiary's home;
- Dialysis facility for ESRD patient who requires dialysis; or
- A physician's office is not a covered destination. However, under special circumstances an ambulance transport may temporarily stop at a physician's office without affecting the coverage status of the transport.

As a general rule, **only** local transportation by ambulance is covered, and therefore, only mileage to the nearest appropriate facility equipped to treat the patient is covered. However, if two or more facilities that meet the destination requirements can treat the patient appropriately and the locality (see §10.3.5 below) of each facility encompasses the place where the ambulance transportation of the patient began, then the full mileage to any one of the facilities to which the beneficiary is taken is covered. Because all duly licensed hospitals and SNFs are presumed to be appropriate sources of health care, only in exceptional situations where the ambulance transportation originates beyond the locality of the institution to which the beneficiary was transported, may full payment for mileage be considered. And then, **only** if the evidence clearly establishes that the destination institution was the nearest one with appropriate facilities under the particular circumstances. (See §10.3.6 below.) The institution to which a patient is transported need not be a participating institution but must meet at least the requirements of

§1861(e)(1) or §1861(j)(1) of the Social Security Act (the Act.) (See Pub. 100-01 Medicare General Information, Eligibility, and Entitlement Manual, Chapter 5, "Definitions," for an explanation of these requirements.)

10.3.1 - Institution to Beneficiary's Home

(Rev. 1, 10-01-03)
A3-3114.C.1, HO-236.3.A

Ambulance service from an institution to the beneficiary's home is covered when the home is within the locality of such institution or where the beneficiary's home is outside of the locality of such institution but the institution, in relation to the home, is the nearest one with appropriate facilities.

10.3.2 - Institution to Institution

(Rev. 14, 05-28-04)
A3-3114.C.2, HO-236.3.B

Occasionally, the institution to which the patient is initially taken is found to have inadequate or unavailable facilities to provide the required care, and the patient is then transported to a second institution having appropriate facilities. In such cases, transportation by ambulance to both institutions would be covered to the extent of the mileage to be the nearest institution with appropriate facilities. Responsibility for payment would follow the rules in § 10.3.3. In these cases, transportation from such second institution to the patient's home could be covered if the home is within the locality served by that institution, or the locality served by the first institution to which the patient was taken.

10.3.3 - Separately Payable Ambulance Transport Under Part B versus Patient Transportation that is Covered Under a Packaged *Institutional* Service

(Rev.243; Issued: 04-13-18; Effective: 07-16-18; Implementation: 07-16-18)

Transportation of a beneficiary from his or her home, an accident scene, or any other point of origin is covered under Part B as an ambulance service only to the nearest hospital, critical access hospital (CAH), or skilled nursing facility (SNF) that is capable of furnishing the required level and type of care for the beneficiary's illness or injury and only if medical necessity and other program coverage criteria are met. *An ambulance transport from a SNF to the nearest supplier of medically necessary services not available at the SNF where the beneficiary is a resident and not in a covered Part A stay, including the return trip, is covered under Part B provided that the ambulance transportation was medically reasonable and necessary and all other coverage requirements are met.*

Medicare-covered ambulance services are paid either as separately billed services, in which case the entity furnishing the ambulance service bills Part B of the program, or as a packaged service, in which case the entity furnishing the ambulance service must seek payment from the provider who is responsible for the beneficiary's care. If either the origin or the destination of the ambulance transport is the beneficiary's home, then the ambulance transport is paid separately by Medicare Part B, and the entity that furnishes the ambulance transport may bill its A/B MAC (A) or (B) directly. If both the origin and destination of the ambulance transport are providers, e.g., a hospital, critical access hospital (CAH), skilled nursing facility (SNF), then responsibility for payment for the ambulance transport is determined in accordance with the following sequential criteria.

NOTE: These criteria must be applied in sequence as a flow chart and not independently of one another.

1. Provider Numbers:

If the Medicare-assigned provider numbers of the two providers are different, then the ambulance service is separately billable to the program. If the provider number of both providers is the same, then consider criterion 2, "campus".

2. Campus:

Following criterion 1, if the campuses of the two providers (sharing the same provider numbers) are the same, then the transport is not separately billable to the program. In this case the provider is responsible for payment. If the campuses of the two providers are different, then consider criterion 3, "patient status." "Campus" means the physical area immediately adjacent to the provider's main buildings, other areas and structures that are not strictly contiguous to the main buildings, but are located within 250 yards of the main buildings, and any of the other areas determined on an individual case basis by the CMS regional office to be part of the provider's campus.

3. Patient Status: Inpatient vs. Outpatient

Following criteria 1 and 2, if the patient is an inpatient at both providers (i.e., inpatient status both at the origin and at the destination, providers sharing the same provider number but located on different campuses), then the transport is not separately billable. In this case the provider is responsible for payment. All other combinations (i.e., outpatient-to-inpatient, inpatient-to-outpatient, outpatient-to-outpatient) are separately billable to the program.

In the case where the point of origin is not a provider, Part A coverage is not available because, at the time the beneficiary is being transported, the beneficiary is not an inpatient of any provider paid under Part A of the program and ambulance services are excluded from the 3-day preadmission payment window.

The transfer, i.e., the discharge of a beneficiary from one provider with a subsequent admission to another provider, is also payable as a Part B ambulance transport, provided all program coverage criteria are met, because, at the time that the beneficiary is in transit, the beneficiary is not a patient of either provider and not subject to either the inpatient preadmission payment window or outpatient payment packaging requirements. This includes an outpatient transfer from a remote, off-campus emergency department (ER) to becoming an inpatient or outpatient at the main campus hospital, even if the ER is owned and operated by the hospital.

Once a beneficiary is admitted to a hospital, CAH, or SNF, it may be necessary to transport the beneficiary to another hospital or other site temporarily for specialized care while the beneficiary maintains inpatient status with the original provider. This movement of the patient is considered "patient transportation" and is covered as an inpatient hospital or CAH service and as a SNF service when the SNF is furnishing it as a covered SNF service and payment is made under Part A for that service. (If the beneficiary is a resident of a SNF and must be transported by ambulance to receive dialysis or certain other high-end outpatient hospital services, the ambulance transport may be separately payable under Part B. *Also, if the beneficiary is a SNF resident and not in a Part A covered stay and must be transported by ambulance to the nearest supplier of medically necessary services not available at the SNF, the ambulance transport, including the return trip, may be covered under Part B.*) Because the service is covered and payable as a beneficiary transportation service under Part A, the service cannot be classified and paid for as an ambulance service under Part B. This includes intra-campus transfers between different departments of the same hospital, even where the departments are located in separate buildings. Such intra-campus transfers are not separately payable under the Part B ambulance benefit. Such costs are accounted for in the same manner as the costs of such a transfer within a single building.

10.3.4 – Transports to and from Medical Services for Beneficiaries who are not Inpatients

(Rev. 14, 05-28-04)
A3-3114.C.3, HO-236.3.C, AB-00-127, B3-2120.3C

Ambulance transports to and from a covered destination (i.e., two 1-way trips) furnished to a beneficiary who is not an inpatient of a provider for the purpose of obtaining covered medical services are covered, if all program requirements for coverage are met.

In addition, coverage of ambulance transports to and from a destination under these circumstances is limited to those cases where the transportation of the patient is less

costly than bringing the service to the patient. For frequent transports of this kind subject to the A/B MAC (A)'s or (B)'s discretion, additional information may be required supporting the need for ambulance services relative to the option of admission to a treatment facility.

Specialized services are covered services that are not available at the facility in which the beneficiary is a patient.

10.3.5 - Locality

(Rev. 236, Issued: 06-16-17, Effective: 09-18-17, Implementation: 09-18-17)

The term "locality" with respect to ambulance service means the service area surrounding the institution to which individuals normally travel or are expected to travel to receive hospital or skilled nursing services. The MACs have the discretion to define locality in their service areas.

EXAMPLE: Mr. A becomes ill at home and requires ambulance service to the hospital. The small community in which he lives has a 35-bed hospital. Two large metropolitan hospitals are located some distance from Mr. A's community and both regularly provide hospital services to the community's residents. The community is within the "locality" of both metropolitan hospitals and direct ambulance service to either of these (as well as to the local community hospital) is covered.

10.3.6 - Appropriate Facilities

(Rev. 1, 10-01-03)
A3-3114.C.6, HO-236.3.F

The term "appropriate facilities" means that the institution is generally equipped to provide the needed hospital or skilled nursing care for the illness or injury involved. In the case of a hospital, it also means that a physician or a physician specialist is available to provide the necessary care required to treat the patient's condition. However, the fact that a particular physician does or does not have staff privileges in a hospital is not a consideration in determining whether the hospital has appropriate facilities. Thus, ambulance service to a more distant hospital solely to avail a patient of the service of a specific physician or physician specialist does not make the hospital in which the physician has staff privileges the nearest hospital with appropriate facilities.

The fact that a more distant institution is better equipped, either qualitatively or quantitatively, to care for the patient does not warrant a finding that a closer institution does not have "appropriate facilities." Such a finding is warranted, however, if the beneficiary's condition requires a higher level of trauma care or other specialized service available only at the more distant hospital. In addition, a legal impediment barring a patient's admission would permit a finding that the institution did not have "appropriate facilities." For example, the nearest tuberculosis hospital may be in another State and that State's law precludes admission of nonresidents.

An institution is also not considered an appropriate facility if there is no bed available.

The A/B MAC (A) or (B), however, will presume that there are beds available at the local institutions unless the claimant furnished evidence that none of these institutions had a bed available at the time the ambulance service was provided.

EXAMPLE: Mr. A becomes ill at home and requires ambulance service to the hospital. The hospitals servicing the community in which he lives are capable of providing general hospital care. However, Mr. A requires immediate kidney dialysis, and the needed equipment is not available in any of these hospitals. The service area of the nearest hospital having dialysis equipment does not encompass the patient's home. Nevertheless, in this case, ambulance service beyond the locality to the hospital with the equipment is covered since it is the nearest one with appropriate facilities.

10.3.7 – Partial Payment

(Rev. 1, 10-01-03)
A3-3114.C.4, HO-236.3.D

Where ambulance service exceeds the limits defined in §§10.3 through 10.3.7, above, refer to §20, item #5 for instructions on partial payment.

10.3.8 - Ambulance Service to Physician's Office

(Rev. 1, 10-01-03)
A3-3114.C.7, HO-236.3.G, B3-2130.3.G

These trips are covered only under the following circumstances:

- The ambulance transport is enroute to a Medicare covered destination as described in §10.3 ; and

- During the transport, the ambulance stops at a physician's office because of the patient's dire need for professional attention, and immediately thereafter, the ambulance continues to the covered destination.

In such cases, the patient will be deemed to have been transported directly to a covered destination and payment may be made for a single transport and the entire mileage of the transport, including any additional mileage traveled because of the stop at the physician's office.

10.3.9 - Transportation Requested by Home Health Agency

(Rev. 1, 10-01-03)
A3-3114.C.8, HO-236.3.H, B3-2130.3.H

Where a home health agency has a beneficiary transported by ambulance to a hospital or skilled nursing facility to obtain needed medical services not otherwise available to the individual, the trip is covered as a Part B service only if the requirements are met for

ambulance transportation from wherever the patient is located (place of origin). Such transportation is not covered as a home health service.

10.3.10 - Multiple Patient Ambulance Transport

(Rev. 103; Issued: 02-20-09; Effective Date: 01-05-09; Implementation Date: 03-20-09)

Effective April 1, 2002, if two patients are transported to the same destination simultaneously, for each Medicare beneficiary, Medicare will allow 75 percent of the payment allowance for the base rate applicable to the level of care furnished to that beneficiary plus 50 percent of the total mileage payment allowance for the entire trip.

If three or more patients are transported to the same destination simultaneously, then the payment allowance for the Medicare beneficiary (or each of them) is equal to 60 percent of the base rate applicable to the level of care furnished to the beneficiary. However, a single payment allowance for mileage will be prorated by the number of patients onboard.

This policy applies to both ground and air transports.

10.4 - Air Ambulance Services

(Rev. 103; Issued: 02-20-09; Effective Date: 01-05-09; Implementation Date: 03-20-09)

Medically appropriate air ambulance transportation is a covered service regardless of the State or region in which it is rendered. However, A/B MACs (A) and (B) 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.

10.4.1 - Coverage Requirements

(Rev. 1, 10-01-03)
A3-3114.C.11.A, B3-2120.4A

Air ambulance transportation services, either by means of a helicopter or fixed wing aircraft, may be determined to be covered only if:

- The vehicle and crew requirements described in §10.1 are met;

- The beneficiary's medical condition required immediate and rapid ambulance transportation that could not have been provided by ground ambulance; and either

    1. The point of pickup is inaccessible by ground vehicle (this condition could be met in Hawaii, Alaska, and in other remote or sparsely populated areas of the continental United States), or

    2. Great distances or other obstacles are involved in getting the patient to the nearest hospital with appropriate facilities as described in §10.4.4.

Additionally, Medicare allows payment for an air ambulance service when the air ambulance takes off to pick up a Medicare beneficiary, but the beneficiary is pronounced dead before being loaded onto the ambulance for transport (either before or after the ambulance arrives on the scene). This is provided the air ambulance service would otherwise have been medically necessary. In such a circumstance, the allowed amount is the appropriate air base rate, i.e., fixed wing or rotary wing. However, no amount shall be allowed for mileage or for a rural adjustment that would have been allowed had the transport of a living beneficiary or of a beneficiary not yet pronounced dead been completed.

For the purpose of this policy, a pronouncement of death is effective only when made by an individual authorized under State law to make such pronouncements.

This policy also states no amount shall be allowed if the dispatcher received pronouncement of death and had a reasonable opportunity to notify the pilot to abort the flight. Further, no amount shall be allowed if the aircraft has merely taxied but not taken off or, at a controlled airport, has been cleared to take off but not actually taken off.

10.4.2 - Medical Reasonableness

(Rev. 103; Issued: 02-20-09; Effective Date: 01-05-09; Implementation Date: 03-20-09)

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. Following is an advisory list of examples of cases for which air ambulance could be justified. 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.

- Intracranial bleeding - requiring neurosurgical intervention;
- Cardiogenic shock;
- Burns requiring treatment in a burn center;
- Conditions requiring treatment in a Hyperbaric Oxygen Unit;
- Multiple severe injuries; or
- Life-threatening trauma.

10.4.3 - Time Needed for Ground Transport

(Rev. 1, 10-01-03)
A3-3114.C.11.C, B3-2120.4.C

Differing Statewide Emergency Medical Services (EMS) systems determine the amount and level of basic and advanced life support ground transportation available. However, there are very limited emergency cases where ground transportation is available but the time required to transport the patient by ground as opposed to air endangers the beneficiary's life or health. As a general guideline, when it would take a ground ambulance 30-60 minutes or more to transport a beneficiary whose medical condition at the time of pick-up required immediate and rapid transport due to the nature and/or severity of the beneficiary's illness/injury, A/B MACs (A) and (B) should consider air transportation to be appropriate.

10.4.4 - Hospital to Hospital Transport

(Rev. 1, 10-01-03)
A3-3114.C.11.E, B3-2120.4.E

Air ambulance transport is covered for transfer of a patient from one hospital to another if the medical appropriateness criteria are met, that is, transportation by ground ambulance would endanger the beneficiary's health and the transferring hospital does not have adequate facilities to provide the medical services needed by the patient. Examples of such specialized medical services that are generally not available at all type of facilities may include but are not limited to: burn care, cardiac care, trauma care, and critical care. A patient transported from one hospital to another hospital is covered only if the hospital to which the patient is transferred is the nearest one with appropriate facilities. Coverage

is not available for transport from a hospital capable of treating the patient because the patient and/or the patient's family prefer a specific hospital or physician.

10.4.5 - Special Coverage Rule
(Rev. 1, 10-01-03)
A3-3114.C.11.F, B3-2120.4.F

Air ambulance services are not covered for transport to a facility that is not an acute care hospital, such as a nursing facility, physician's office, or a beneficiary's home.

10.4.6 - Special Payment Limitations
(Rev. 133, Issued: 10-22-10, Effective: 01-01-11, Implementation: 01-03-11)

If a determination is made to order transport by air ambulance, but ground ambulance transport would have sufficed, payment for the air ambulance transport is based on the amount payable for ground ambulance transport.

If the air transport was medically appropriate (that is, ground transportation was contraindicated, and the beneficiary required air transport to a hospital), but the beneficiary could have been treated at a hospital nearer than the one to which they were transported, the air transport payment is limited to the rate for the distance from the point of pickup to that nearer hospital.

10.4.7 - Documentation
(Rev. 103; Issued: 02-20-09; Effective Date: 01-05-09; Implementation Date: 03-20-09)

In order to determine the medical appropriateness of air ambulance services the A/B MAC (A) or (B) may request that documentation be submitted that indicates the air ambulance services are reasonable and necessary to treat the beneficiary's life-threatening condition. The contractor's medical staff may consider reviewing all claims for air ambulance services.

10.4.8 - Air Ambulance Transports Canceled Due to Weather or Other Circumstances Beyond the Pilot's Control
(Rev. 1, 10-01-03)

The chart below shows the Medicare payment determination for various air ambulance scenarios in which the flight is aborted due to bad weather, or other circumstance beyond the pilot's control.

Air Ambulance Scenarios: Aborted Flights	
Aborted Flight Scenario	**Medicare Payment Determination**

Any time before the beneficiary is loaded onboard (i.e., prior to or after take-off to point-of-pickup.)	None.
Transport after the beneficiary is loaded onboard.	Appropriate air base rate, mileage, and rural adjustment.

10.4.9 - Effect of Beneficiary Death on Program Payment for Air Ambulance Transports

(Rev. 103; Issued: 02-20-09; Effective Date: 01-05-09; Implementation Date: 03-20-09)

Because the Medicare ambulance benefit is a transport benefit, if no transport of a Medicare beneficiary occurs, then there is no Medicare-covered service. In general, if the beneficiary dies before being transported, then no Medicare payment may be made. Thus, in a situation where the beneficiary dies, whether any payment under the Medicare ambulance benefit may be made depends on the time at which the beneficiary is pronounced dead by an individual authorized by the State to make such pronouncements.

The chart below shows the Medicare payment determination for various air ambulance scenarios in which the beneficiary dies. In each case, the assumption is that the ambulance transport would have otherwise been medically necessary. If the flight is aborted for other reasons, such as bad weather, the Medicare payment determination is based on whether the beneficiary was onboard the air ambulance.

Air Ambulance Scenarios: Beneficiary Death	
Time of Death Pronouncement	**Medicare Payment Determination**
Prior to takeoff to point-of-pickup with notice to dispatcher and time to abort the flight.	None. **NOTE:** This scenario includes situations in which the air ambulance has taxied to the runway, and/or has been cleared for takeoff, but has not actually taken off.)
After takeoff to point-of-pickup, but before the beneficiary is loaded.	Appropriate air base rate with no mileage or rural adjustment; use the QL modifier when submitting the claim.
After the beneficiary is loaded onboard, but prior to or upon arrival at the receiving facility.	As if the beneficiary had not died.

10.5 - Joint Responses

(Rev. 125, Issued 05-14-10, Effective: 01-04-10, Implementation: 06-15-10)

A. BLS/ALS Joint Responses

In situations where a BLS entity provides the transport of the beneficiary and an ALS entity provides a service that meets the fee schedule definition of an ALS intervention (e.g., ALS assessment, Paramedic Intercept services, etc.), the BLS supplier may bill Medicare the ALS rate provided that a written agreement between the BLS and ALS entities exists prior to submitting the Medicare claim. Providers/suppliers must provide a copy of the agreement or other such evidence (e.g., signed attestation) as determined by **their A/B MAC (A) or (B) upon request.** A/B MACs (A) and (B) must refer any issues that cannot be resolved to the regional office.

Medicare does not regulate the compensation between the BLS entity and the ALS entity. If there is no agreement between the BLS ambulance supplier and the ALS entity furnishing the service, then only the BLS level of payment may be made. In this situation, the ALS entity's services are not covered, and the beneficiary is liable for the expense of the ALS services to the extent that these services are beyond the scope of the BLS level of payment.

B. Ground to Air Ambulance Transports

When a beneficiary is transported by ground ambulance and transferred to an air ambulance, the ground ambulance may bill Medicare for the level of service provided and mileage from the point of pickup to the point of transfer to the air ambulance.

20 - Coverage Guidelines for Ambulance Service Claims

(Rev. 103; Issued: 02-20-09; Effective Date: 01-05-09; Implementation Date: 03-20-09)

Payment may be made for expenses incurred by a patient for ambulance service provided conditions l, 2, and 3 in the left-hand column have been met. The right-hand column indicates the documentation needed to establish that the condition has been met.

Conditions	**Review Action**
1. Patient was transported by an approved supplier of ambulance services.	1. Ambulance suppliers are explained in greater detail in §10.1.3
2. The patient was suffering from an illness or injury, which contraindicated transportation by other means. (§10.2)	2. (a) The A/B MAC (A) or (B) presumes the requirement was met if the submitted documentation indicates that the patient: • Was transported in an emergency situation, e.g., as a result of an accident, injury or acute illness, or • Needed to be restrained to prevent injury to the beneficiary or others; or • Was unconscious or in shock; or • Required oxygen or other emergency treatment during transport to the nearest appropriate facility; or • Exhibits signs and symptoms of acute respiratory distress or cardiac distress such as shortness of breath or chest pain; or • Exhibits signs and symptoms that indicate the possibility of acute stroke; or • Had to remain immobile because of a fracture that had not been set or the possibility of a fracture; or • Was experiencing severe hemorrhage; or • Could be moved only by stretcher; or • Was bed-confined before and after the ambulance trip. (b)

Conditions	Review Action
	In the absence of any of the conditions listed in (a) above additional documentation should be obtained to establish medical need where the evidence indicates the existence of the circumstances listed below: (i) Patient's condition would not ordinarily require movement by stretcher, or (ii) The individual was not admitted as a hospital inpatient (except in accident cases), or (iii) The ambulance was used solely because other means of transportation were unavailable, or (iv) The individual merely needed assistance in getting from his room or home to a vehicle. (c) Where the information indicates a situation not listed in 2(a) or 2(b) above, refer the case to your supervisor.
3. The patient was transported from and to points listed below. (a) From patient's residence (or other place where need arose) to hospital or skilled nursing facility.	3. Claims should show the ZIP Code of the point of pickup. (a) i. Condition met if trip began within the institution's service area as shown in the A/B MAC (B)'s locality guide. ii. Condition met where the trip began outside the institution's service area if the institution was the nearest one with appropriate facilities.

NOTE: A patient's residence is the place where he or she makes his/her home and dwells permanently, or for an extended period of time. A skilled nursing facility is one, which is listed in the Directory of Medical Facilities as a participating SNF or as an institution which meets §1861(j)(1) of the Act.

NOTE: A claim for ambulance service to a participating hospital or skilled nursing facility should not be denied on the grounds that there is a nearer nonparticipating institution having appropriate facilities.

(b) Skilled nursing facility to a hospital or hospital to a skilled nursing facility.	(b) (i) Condition met if the ZIP Code of the pickup point is within the service area of the destination as shown in the A/B MAC (B)'s locality guide. (ii) Condition met where the ZIP Code of the pickup point is outside the service area of the destination if the destination institution was the nearest appropriate facility.

Conditions	Review Action
(c) Hospital to hospital or skilled nursing facility to skilled nursing facility.	(c) Condition met if the discharging institution was not an appropriate facility and the admitting institution was the nearest appropriate facility.
(d) From a hospital or skilled nursing facility to patient's residence.	(d) (i) Condition met if patient's residence is within the institution's service area as shown in the A/B MAC (B)'s locality guide. (ii) Condition met where the patient's residence is outside the institution's service area if the institution was the nearest appropriate facility.
(e) Round trip for hospital or participating skilled nursing facility inpatients to the nearest hospital or nonhospital treatment facility.	(e) Condition met if the reasonable and necessary diagnostic or therapeutic service required by patient's condition is not available at the institution where the beneficiary is an inpatient.

NOTE: Ambulance service to a physician's office or a physician-directed clinic is not covered. See §10.3.8 above, where a stop is made at a physician's office en route to a hospital and §10.3.3 for additional exceptions.)

4. Ambulance services involving hospital admissions in Canada or Mexico are covered (Medicare Claims Processing Manual, Chapter 1, "General Billing Requirements, "§10.1.3.) if the following conditions are met:	4. (a) The foreign hospitalization has been determined to be covered; and (b) The ambulance service meets the coverage requirements set forth in §§10-10.3. If the foreign hospitalization has been determined to be covered on the basis of emergency services (See the Medicare Claims Processing Manual, Chapter 1, "General Billing Requirements," §10.1.3), the necessity requirement (§10.2) and the destination requirement (§10.3) are considered met.
5. The A/B MAC (B) will make partial payment for otherwise covered ambulance service, which exceeded limits defined in item 6. The A/B MAC (B) will base the payment on the amount payable had the patient been transported:	5 & 6 (a) From the pickup point to the nearest appropriate facility, or 5 & 6 (b) From the nearest appropriate facility to the beneficiary's residence where he or she is being returned home from a distant institution.

20.1 - Mandatory Assignment Requirements
(Rev. 1, 10-01-03)

When an ambulance provider/supplier, or a third party under contract with the provider/supplier, furnishes a Medicare-covered ambulance service to a Medicare beneficiary and the service is not statutorily excluded under the particular circumstances, the provider/supplier must submit a claim to Medicare and accept assignment of the beneficiary's right to payment from Medicare.

20.1.1 - Managed Care Providers/Suppliers
(Rev. 103; Issued: 02-20-09; Effective Date: 01-05-09; Implementation Date: 03-20-09)

Mandatory assignment for ambulance services, in effect with the implementation of the ambulance fee schedule, applies to ambulance providers/suppliers under managed care as well as under fee-for-service. The ambulance fee schedule is effective for claims with a date of service on or after April 1, 2002.

Any provider or supplier without a contract establishing payment amounts for services provided to a beneficiary enrolled in a Medicare Advantage (MA) coordinated care plan or MA private fee-for-service plan must accept, as payment in full, the amounts that they could collect if the beneficiary were enrolled in original Medicare. The provider or supplier can collect from the MA plan enrollee the cost-sharing amount required under the MA plan, and collect the remainder from the MA organization.

20.1.2 - Beneficiary Signature Requirements
(Rev. 190, Issued: 07-11-14, Effective: 08-12-14, Implementation: 08-12-14)

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:

(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).

(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. 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.

Medicare does not require that the signature to authorize claim submission be obtained at the time of transport for the purpose of accepting assignment of Medicare payment for ambulance benefits. When a provider/supplier is unable to obtain the signature of the beneficiary, or that of his or her representative, at the time of transport, it may obtain this signature any time prior to submitting the claim to Medicare for payment. (**Note:** there is a 12 month period for filing a Medicare claim, depending upon the date of service.)

If the beneficiary/representative refuses to authorize the submission of a claim, including a refusal to furnish an authorizing signature, then the ambulance provider/supplier may not bill Medicare, but may bill the beneficiary (or his or her estate) for the full charge of the ambulance items and services furnished. If, after seeing this bill, the beneficiary/representative decides to have Medicare pay for these items and services, then a beneficiary/representative signature is required and the ambulance provider/supplier must afford the beneficiary/representative this option within the claims filing period.

30 - Implementation of the Ambulance Fee Schedule

(Rev. 103; Issued: 02-20-09; Effective Date: 01-05-09; Implementation Date: 03-20-09)

The Medicare program ambulance fee schedule (FS) is effective for ambulance items and services furnished on or after April 1, 2002. Under the FS, payment for ambulance services covered under the program is based on the lower of the actual billed amount or the ambulance fee schedule amount.

The fee schedule was phased in over a 5-year period. The fee schedule replaced the retrospective reasonable cost reimbursement system for providers and the reasonable charge system for ambulance suppliers. During the transition period, payment was based on a blend of the FS amount and the amount under its current billing methodology.

The fee schedule applies to all ambulance services, including volunteer, municipal, private, independent, and institutional providers, i.e., hospitals, skilled nursing facilities and home health agencies covered under Medicare Part B, except for services furnished by certain critical access hospitals (CAH). Payment for ambulance items and services furnished by a CAH, or by an entity that is

owned and operated by a CAH, is based on reasonable cost if the CAH or entity is the only provider or supplier of ambulance services that is located within a 35-mile drive of such CAH. The provision is effective for ambulance services furnished on or after December 21, 2000.

30.1 - Definition of Ambulance Services

(Rev. 226, Issued: 09-12-16, Effective: 01-01-16, Implementation: 12-12-16)

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.

30.1.1 - Ground Ambulance Services

(Rev. 236, Issued: 06-16-17, Effective: 09-18-17, Implementation: 09-18-17)

Basic Life Support (BLS)

Definition: BLS is transportation by ground ambulance vehicle (as defined in section 10.1, above) and the provision of medically necessary supplies and services (as defined in section 10.2, above), including BLS ambulance services as defined by the state.

The ambulance vehicle must be staffed by at least two people who meet the requirements of the state and local laws where the services are being furnished, and at least one of the staff members 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.

Basic Life Support (BLS) - Emergency

Definition: When medically necessary, the provision of BLS services, as specified above, in the context of an emergency response (as defined below).

Advanced Life Support, Level 1 (ALS1)

Definition: Advanced life support, level 1 (ALS1) is the transportation by ground ambulance vehicle (as defined in section 10.1, above) and the provision of medically necessary supplies and services (as defined in section 10.2, above) including the provision of an ALS assessment by ALS personnel or at least one ALS intervention**.**

Advanced Life Support Assessment

Definition: An ALS assessment is an assessment performed by an ALS crew as part of an emergency response (as defined below) that was necessary because the patient's

reported condition at the time 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 shall 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, as defined in section 10.2, above and all other coverage requirements are met.

Advanced Life Support 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, as specified above, in the context of an emergency response, as defined below.

Advanced Life Support, Level 2 (ALS2)

Definition: Advanced life support, level 2 (ALS2) is the transportation by ground ambulance vehicle and the provision of medically necessary supplies and services including (1) at least three **separate administrations** of one or more medications by intravenous (IV) push/bolus or by continuous infusion (excluding crystalloid fluids) or (2) ground ambulance transport, medically necessary supplies and services, and the provision of at least one of the ALS2 procedures listed below:

a. Manual defibrillation/cardioversion;

b. Endotracheal intubation;

c. Central venous line;

d. Cardiac pacing;

e. Chest decompression;

f. Surgical airway; or

g. 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.

The 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 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.

An example of a single dose of medication administered fractionally on three separate occasions that would not qualify for the ALS2 payment rate is the administration of a single 1 mg dose of IV Epinephrine in partial increments to treat an adult pulseless Ventricular Tachycardia/Ventricular Fibrillation (VF/VT) patient. The American Heart Association (AHA), Advanced Cardiac Life Support (ACLS) protocol calls for Epinephrine to be administered in 1 mg increments every 3 to 5 minutes. Therefore, administering IV Epinephrine in separate increments of 0.25 mg, 0.25 mg, and 0.50 mg (for a total of 1 mg) over the course of a single 3 to 5 minute episode would not qualify for the ALS2 level of payment. Conversely, administering three separate 1 mg doses of IV Epinephrine over the requisite protocol-based time period to a patient with unresolved

VF/VT would qualify for an ALS2 level of service. **NOTE:** refer to and abide by your authorized protocols; AHA's ACLS protocols are referenced here only by way of widely recognized example.

Another example that **would not qualify** for the ALS2 payment level is administering Adenosine in three 2 mg increments (for a total of 6 mg) in treating an adult patient with Paroxysmal Supraventricular Tachycardia (PSVT). ACLS guidelines dictate treating PSVT with 6 mg of Adenosine by rapid intravenous push (IVP) over 1 to 2 seconds. Should the initial 6 mg dose not eliminate the PSVT within 1 to 2 minutes, guidelines dictate that another 12 mg of Adenosine IVP should be administered where the PSVT persists, followed by another 12 mg dose 1 to 2 minutes later; for a total of 30 mg of Adenosine. Administering a total of 30 mg of Adenosine, involving three episodes of administration in a complete cycle of treatment as outlined above, **would** qualify for ALS2 payment.

Endotracheal (ET) intubation (which includes intubating and/or monitoring/maintaining an ET tube inserted prior to transport) is a service that qualifies for the ALS2 level of payment. Therefore, it is not necessary to consider medications administered by ET tube to determine whether the ALS2 rate is payable.

Advanced Life Support (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: SCT is the interfacility 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. 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 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.

This tiered approach to life saving is cost effective in many areas because most volunteer ambulances do not charge for their services and one paramedic service can cover many communities. Prior to March 1, 1999, Medicare payment could be made for these services, but could not be made directly to the intercept service provider; rather, Medicare payment could be made only when the claim was submitted by the entity that actually furnished the ambulance transport. In those areas where state laws prohibited volunteer ambulances from billing Medicare and other health insurance, the intercept service could not receive payment for treating a Medicare beneficiary and was forced to bill the beneficiary for the entire service.

Paramedic intercept services furnished on or after March 1, 1999, are payable separate from the ambulance transport when all of 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.

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 Pub. 100-04, Medicare Claims Processing Manual, Chapter 15, "Ambulance," §20.1.4 for payment of paramedic intercept services.

Services in a Rural Area

Definition: For purposes other than the paramedic intercept benefit (as defined above), services in a rural area are services that are furnished (1) in an area outside a Metropolitan Statistical Area (MSA); or, (2) an area identified as rural using the most recent version of the **Goldsmith Modification** even though the area is within an MSA.

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.

Application: The phrase "911 call or the equivalent" is intended to establish the standard that the nature of the call at the time of dispatch is the determining factor. Regardless of the medium by which the call is made (e.g., a radio call could be appropriate) the call is of an emergent nature when, based on the information available to the dispatcher at the time of the call, it is reasonable for the dispatcher to issue an emergency dispatch in light of accepted, standard dispatch protocol. An emergency call need not come through 911 even in areas where a 911 call system exists. However, the

determination to respond emergently with a BLS or 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 and the dispatcher's actions 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, the protocol and the dispatcher's actions must meet, at a minimum, the standards of the dispatch protocol in another similar jurisdiction within the state, or if there is no similar jurisdiction, 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.

EMT-Intermediate

Definition: EMT-Intermediate is an individual who is qualified, in accordance with state and local laws, as an EMT-Basic and who is also certified in accordance with state and local laws to perform essential advanced techniques and to administer a limited number of medications.

EMT-Paramedic

Definition: EMT-Paramedic possesses the qualifications of the EMT-Intermediate and, in accordance with state and local laws, has enhanced skills that include being able to administer additional interventions and medications.

Interfacility Transportation

Definition: For purposes of SCT payment, an interfacility transportation is one in which the origin and destination are one of the following: a hospital or skilled nursing facility that participates in the Medicare program or a hospital-based facility that meets Medicare's requirements for provider-based status.

30.1.2 - Air Ambulance Services

(Rev. 187, Issued: 05-01-14; Effective: 08-04-14; Implementation: 08-04-14)

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.

Transmittals Issued for this Chapter

Rev #	Issue Date	Subject	Impl Date	CR#
R243BP	04/13/2018	Ambulance Transportation for a Skilled Nursing Facility (SNF) Resident in a Stay Not Covered by Part A - Medicare Benefit Policy Manual, Chapter 10 and Medicare Claims Processing Manual, Chapter 15	07/16/2018	10550
R236BP	06/17/2017	Medicare Benefit Policy Manual - Chapter 10, Ambulance Locality and Advanced Life Support (ALS) Assessment	09/18/2017	10110
R225BP	09/09/2016	Ambulance Staffing Requirements	12/12/2016	9761
R190BP	07/11/2014	Beneficiary Signature Requirements for Ambulance Services	08/12/2014	8760
R187BP	05/01/2014	Update to the Medicare Benefit Policy Manual to Restore Missing Air Ambulance Definitions	08/04/2014	8706
R133BP	10/22/2010	Air Ambulance Services	01/03/2011	7161
R130BP	07/29/2010	Definition of Ambulance Services	01/03/2011	7058
R125BP	05/14/2010	Ambulance Services-Joint Responses	06/15/2010	6949
R115BP	11/13/2009	Ambulance Services	01/04/2010	6707
R103BP	02/20/2009	Ambulance Services and Expiration of the Ambulance Fee Schedule Transition Period	03/20/2009	6318
R68BP	03/30/2007	Ambulance Fee Schedule – Ground Ambulance Services – Revision to the Specialty Care Transport (SCT) Definition	04/30/2007	5533
R14BP	05/28/2004	Ambulance Benefit Policy-Payment for Ambulance Services	07/01/2004	3225
R1BP	10/01/2003	Introduction to the Benefit Policy Manual	N/A	N/A

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