CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-02 Medicare Benefit Policy	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 103	**Date: FEBRUARY 20, 2009**
	Change Request 6318

SUBJECT: Ambulance Services and Expiration of the Ambulance Fee Schedule Transition Period

I. SUMMARY OF CHANGES: This Change Request updates the manual to incorporate manual information that has been re-organized and/or deleted due to the termination of the fee schedule transition period.

New / Revised Material
Effective Date: January 5, 2009
Implementation Date: March 20, 2009

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
R=REVISED, N=NEW, D=DELETED

R/N/D	CHAPTER/SECTION/SUBSECTION/TITLE
R	10/10.2.2/Reasonableness of the Ambulance Trip
R	10/10.2.6/Effect of Beneficiary Death on Medicare Payment for Ground Ambulance Transports
R	10/10.3/Destination
R	10/10.3.3/Separately Payable Ambulance Transports Under Part B versus Patient Transportation that is Covered Under a Packaged Hospital Service
R	10/10.3.10/Multiple Patient Ambulance Transport
R	10/10.4/Air Ambulance Services
R	10/10.4.2/Medical Reasonableness
R	10/10.4.7/Documentation
R	10/10.4.9/Effort of Beneficiary Death on Program Payment for Air Ambulance Transports
R	10/20/Coverage Guidelines for Ambulance Service Claims
R	10/20.1.1/Managed Care Providers/Suppliers

R	10/20.1.2/Beneficiary Signature Requirements
R	10/30/Implementation of the Ambulance Fee Schedule
R	10/30.1/Definition of Ambulance Services
R	10/30.1.1/Ground Ambulance Services
D	10/30.1.2/Air Ambulance Services

III. FUNDING:
SECTION A: For Fiscal Intermediaries and Carriers:
No additional funding will be provided by CMS; contractor activities are to be carried out within their operating budgets.

SECTION B: For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the contracting officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the contracting officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:

Business Requirements
Manual Instruction

Unless otherwise specified, the effective date is the date of service.

Attachment – Business Requirements

Pub. 100-02	Transmittal: 103	Date: February 20, 2009	Change Request: 6318

SUBJECT: Ambulance Services and Expiration of the Ambulance Fee Schedule Transition Period

Effective Date: January 5, 2009
Implementation Date: March 20, 2009

I. GENERAL INFORMATION

A. Background: This Change Request updates the manual to incorporate manual information that has been re-organized and/or deleted due to the termination of the fee schedule transition period.

B. Policy: N/A

II. BUSINESS REQUIREMENTS TABLE

Use "Shall" to denote a requirement

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
6318.1	Contractors shall be in compliance with the instructions in Pub.100-02, Medicare Benefit Policy Manual, chapter 10.	X		X	X						

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
6318.2	A provider education article related to this instruction will be available at http://www.cms.hhs.gov/MLNMatters Article/shortly after the CR is released. You will receive notification of the article release via the established "MLN Matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web site and include information about it in a listserv message within 1 week of the availability of the provider education article. In addition, the provider education article shall be included in your next regularly scheduled bulletin. Contractors are free to supplement MLN Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.	X		X	X						

IV. SUPPORTING INFORMATION

Section A: For any recommendations and supporting information associated with listed requirements, use the box below:
Use "Should" to denote a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

Section B: For all other recommendations and supporting information, use this space:

V. CONTACTS

Pre-Implementation Contact(s): Roechel Kujawa, roechel.kujawa@cms.hhs.gov or on 410-786-9111.

Post-Implementation Contact(s): Roechel Kujawa, roechel.kujawa@cms.hhs.gov or on 410-786-9111.

VI. FUNDING

Section A: For *Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs)* and/or *Carriers:*

No additional funding will be provided by CMS; contractor activities are to be carried out within their operating budgets.

Section B: *For Medicare Administrative Contractors (MACs),* use the following statement:

The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the contracting officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the contracting officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

Medicare Benefit Policy Manual
Chapter 10 - Ambulance Services

Table of Contents
(Rev. 103, 02-20-09)

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.

10.2.6 - 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. 103; Issued: 02-20-09; Effective Date: 01-05-09; Implementation Date: 03-20-09)

An ambulance transport is covered to the nearest treatment 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);
- Beneficiary's home; or
- 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.)

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

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

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.

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 Medicare carrier or intermediary 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.) 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.

10.3.10 - 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, 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.

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;
- Car*d*iogenic shock;
- Burns requiring treatment in a burn center;
- Conditions requiring treatment in a Hyperbaric Oxygen Unit;
- Multiple severe injuries; or
- Life-threatening trauma.

10.4.7 - 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 contractor *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.

10.4.9 - 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.

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 contractor 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)

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.

3. Claims should show the ZIP Code of the point of pickup.

(a) From patient's residence (or other place where need arose) to hospital or skilled nursing facility.	(a) i. Condition met if trip began within the institution's service area as shown in the carrier'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 *C*ode of the pickup point is within the service area of the destination as shown in the carrier's locality guide. (ii) Condition met where the ZIP *C*ode of the pickup point is outside the service area of the destination if the destination institution was the nearest appropriate facility.
(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 carrier'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 carrier will make partial payment for otherwise covered ambulance service, which exceeded limits defined in item 6. The carrier 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.

20.1.1 - 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* (M*A*) coordinated care plan or M*A* 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 M*A* plan enrollee the cost-sharing amount required under the M*A* plan, and collect the remainder from the M*A* organization.

20.1.2 - Beneficiary Signature Requirements

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

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 15 to 27 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. *T*he fee schedule replace*d* 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. 103; Issued: 02-20-09; Effective Date: 01-05-09; Implementation Date: 03-20-09)

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.)

30.1.1 - Ground Ambulance Services

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

Basic Life Support (BLS)

Definition: Basic life support (BLS) is transportation by ground ambulance vehicle and the provision of medically necessary supplies and services, including BLS ambulance services as defined by the State. The ambulance must be staffed by an individual who is qualified in accordance with State and local laws as an emergency medical technician-basic (EMT-Basic). These laws may vary from State to State or within a State. For example, only in some jurisdictions is an EMT-Basic permitted to operate limited equipment onboard the vehicle, assist more qualified personnel in performing assessments and interventions, and establish a peripheral intravenous (IV) line.

Basic Life Support (BLS) - Emergency

Definition: When medically necessary, the provision of BLS services, as specified above, in the context of an emergency response. An emergency response is one that, at the time the ambulance provider or supplier is called, it responds immediately. 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.

Advanced Life Support, Level 1 (ALS1)

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

Advanced Life Support Assessment

Definition: An advanced life support (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 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.

Application: *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.*

Advanced Life Support Intervention

Definition: An advanced life support (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. An emergency response is one that, at the time the ambulance provider or supplier is called, it responds immediately. 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.

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 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. urgical airway; or

g. Intraosseous line.

Application: *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.*

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: Specialty care transport (SCT) is the interfacility transportation 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 a paramedic with additional training.

Application: The EMT-Paramedic level of care is set by each State. *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.* Care above that level that is medically necessary and that is furnished at a level of service above the EMT-Paramedic level of care is considered SCT. That is to say, 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 critically 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 I.V. 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 only when the claim was submitted by the entity that actually furnished the ambulance transport. Payment could not be made directly to the intercept service provider. In those areas where State laws prohibit 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, may be payable separate from the ambulance transport, subject to the requirements specified below.

The intercept service(s) is:

- Furnished in a rural area;
- 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.

In addition, the volunteer ambulance service involved must:

- Meet the program'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.

Finally, the entity furnishing the ALS paramedic intercept service must:

- Meet the program'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 any area outside of a Metropolitan Statistical Area or in New England, outside a New England County Metropolitan Area as defined by the Office of Management and Budget. The current list of these areas is periodically published in the **Federal Register**.

See the Medicare Claims Processing Manual, Chapter 15, "Ambulance," *§20.1.4 for payment of paramedic intercept services.*

Services in a Rural Area

Definition: *Services in a rural area are services that are furnished (1) in an area outside a Metropolitan Statistical Area (MSA); or, (2) in New England, outside a New England County Metropolitan Area (NECMA); or, (3) an area identified as rural using 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.*

Application: *The phrase "911 call or 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 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, then both 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.*

Relative Value Units

Definition: *Relative value units (RVUs) measure the value of ambulance services relative to the value of a base level ambulance service.*

Application: *The RVUs for the ambulance fee schedule are as follows:*

Service Level RVUs
BLS 1.00

BLS – Emergency 1.60

ALS1 1.20

ALS1 – Emergency 1.90

ALS2 2.75

SCT 3.25

PI 1.75

RVUs are not applicable to FW and RW services.