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Welcome to Medicare Learning Network® Podcasts at the Centers for Medicare and Medicaid Services, or "CMS." These podcasts are developed and produced by the Medicare Learning Network® within CMS, and they provide official information that health care professionals can trust.

Are you an ambulance provider or supplier? Then this podcast is for you. Based on the "Ambulance Fee Schedule" or "Ambulance F-S" Fact Sheet, it provides important information on the Medicare ambulance transport benefit, ambulance providers and suppliers, Advanced Beneficiary Notice of Coverage, or A-B-N, payments, how payment rates are set, updates to the ambulance fee schedule, and available resources.

Let's start out with the background. The information in this podcast applies only to the Medicare Fee-for-Service Program, also known as Original Medicare. Section forty-five thirty-one (4531)(b)(2) of the Balanced Budget Act of 1997 added section eighteen thirty-four (1834)(l) to the Social Security Act, or the Act, which mandated the implementation of a national Ambulance Fee Schedule, or F-S, for Medicare Part B ambulance transport claims with dates of service on or after April 1, 2002. The Ambulance F-S applies to all ambulance transports.

Section eighteen thirty-four (1834)(l) of the Act also required mandatory assignment for all ambulance transports, which means you will be paid the Medicare-allowed amount as payment in full for your transports. In addition, you may bill or collect only any unmet Part B deductible and coinsurance amounts from the beneficiary.

Next, we will discuss the Medicare ambulance transport benefit. This benefit is a transport by an ambulance. Medicare may cover the transport when the use of any other method of transportation is contraindicated due to the beneficiary's condition and the following four (4) coverage requirements are met:

One (1) – The transport is medically reasonable and necessary;

Two (2) – A Medicare beneficiary is transported;

Three (3) – The destination is local; and

Four (4) – The facility is appropriate.

For more information about ground and air ambulance transport coverage requirements, refer to page two (2) of the "Ambulance Fee Schedule" Fact Sheet.

Now, let's discuss ambulance providers and suppliers. An ambulance provider is a provider that owns and operates an ambulance transportation service in addition to its institutionally-based operations.

The Ambulance F-S applies to the following six (6) providers:

First – Hospitals;

Second – Critical Access Hospitals;

Third – Skilled Nursing Facilities;

Fourth – Comprehensive Outpatient Rehabilitation Facilities;

Fifth – Home Health Agencies; and

Sixth – Hospice Programs.

An ambulance supplier is not owned or operated by a provider and is enrolled in Medicare as an independent ambulance supplier. The Ambulance F-S applies to the following four (4) suppliers:

First – Volunteer fire and/or ambulance companies;

Second – Local government ambulance companies;

Third – Privately-owned and operated ambulance companies; and

Fourth – Independently-owned and operated ambulance companies.

Next, we will discuss A-B-N guidance for an ambulance transport. Generally, you must not issue an A-B-N to a beneficiary who has an acute medical emergency or is under duress. You must issue an ABN only when a beneficiary's covered ambulance transport is modified to a level that is not medically reasonable and necessary and will incur additional costs. To assist you in determining whether an ambulance transport requires an A-B-N, ask yourself the following three (3) questions:

One (1) – Is this service a covered ambulance benefit?

Two (2) – Will payment for part or all of this service be denied because it is not reasonable and necessary?

Three (3) – Is the beneficiary stable and the transport non-emergent?

If the answer is "Yes" to **all** three questions, you must issue an A-B-N.

Now, let's discuss general A-B-N guidance for Fee-for-Service, or F-F-S, providers. You must give written notice to a F-F-S Medicare beneficiary before you provide items or services that are usually covered by Medicare, but are not expected to be paid in a specific instance (for example, a ground ambulance transport is medically necessary, but the beneficiary insists on an air transport). Ambulance providers and suppliers use the Advance Beneficiary Notice of Noncoverage (A-B-N), Form CMS-R-131, for this purpose.

The A-B-N allows the beneficiary to make an informed decision about whether to get the item or service that may not be covered and accept financial responsibility if Medicare does not pay**. If you don't issue the A-B-N when notice is required, the beneficiary may not be held financially liable if Medicare denies payment.** If you properly notify the beneficiary that the item or service may not be covered and the beneficiary agrees to pay, you may seek payment from the beneficiary.

You **must** keep a copy of the A-B-N in the medical record and give the beneficiary a copy.

If you furnish items or services to the beneficiary based on the referral or order of another provider or supplier you are responsible for notifying the beneficiary that the services may not be covered by Medicare and that the beneficiary can be held financially liable for them if payment is denied.

You are not required to notify the beneficiary before you provide items or services that Medicare never covers (for example, an ambulance transport by wheelchair van). However, you may choose to issue a voluntary A-B-N or a similar notice as a courtesy to alert the beneficiary about his or her forthcoming financial liability. When you issue the A-B-N as a voluntary notice, the beneficiary doesn't need to check an option box or sign the notice to be held liable for the excluded service.

Next, we will discuss payments. Medicare pays for an ambulance transport under Part A as a packaged service or under Part B as a separately billed service. If an ambulance transport is covered and payable under Part A, it will **not** be covered or payable under Part B.

Payment for ambulance transports under the Ambulance F-S includes the following three items:

First – Includes a base rate payment (level of service provided) plus a separate payment for mileage to the nearest appropriate facility;

Second – Covers both the transport of the beneficiary to the nearest appropriate facility and all medically necessary covered items and services (such as oxygen, drugs, extra attendants, and electrocardiogram testing) associated with the transport; and

Third – Precludes a separate payment for items and services furnished under the ambulance benefit.

Each year, an update is applied to the payment limits for ambulance transports that is equal to the percentage increase in the Consumer Price Index. The resulting update percentage is called the Ambulance Inflation Factor. Please see page four (4) of the "Ambulance Fee Schedule" Fact Sheet for more information.

Now, let's discuss how payment rates are set. There are two types of transports – ground and air. First, we will discuss ground ambulance transport. Effective January 1, 2006, the total payment amount to ground ambulance providers and suppliers is based on 100 percent of the national Ambulance F-S. Payments for ground ambulance transports under the Ambulance F-S include the following six (6) elements:

First – A nationally uniform base rate or conversion factor for all ground ambulance transports;

Second – A relative value unit, which is a numeric value for ambulance transports relative to the value of a base level ambulance transport is assigned to each type of ground ambulance transport;

Third – A geographic adjustment factor, or G-A-F, equal to the practice expense, or P-E, portion of the geographic practice cost index, or G-P-C-I for the Medicare Physician Fee Schedule, for each Ambulance F-S locality area;

Fourth – A nationally uniform loaded mileage rate;

Fifth – An additional amount for certain mileage for a rural point-of-pickup, or P-O-P; and

Sixth – Additional payments to the base rate and/or mileage rate for certain specified temporary periods.

Next, we will discuss air ambulance transports. Effective January 1, 2006, the total payment amount for air ambulance providers and suppliers is based on 100 percent of the national Ambulance F-S. Payments for air ambulance transports under the Ambulance F-S include the following four (4) elements:

First – A nationally uniform base rate for fixed wing and a nationally uniform base rate for rotary wing;

Second – A G-A-F equal to the P-E portion of the G-P-C-I for each Ambulance F-S locality area;

Third – A nationally uniform loaded mileage rate for each type of air transport; and

Fourth – A rural adjustment to the base rate and mileage for transports furnished for a rural P-O-P.

Last, we will discuss updates to the ambulance F-S. For more information about the Ambulance F-S payment update, refer to the "Policy and Payment Changes to the Medicare Physician Fee Schedule for 2015" Fact Sheet, as well as the "Revisions to Payment Policies under the Physician Fee Schedule, Clinical Laboratory Fee Schedule, Access to Identifiable Data for the Center for Medicare and Medicaid Innovation Models & Other Revisions to Part B for C-Y 2015" Final Rule. The locations for these resources can be found on page five (5) of the "Ambulance Fee Schedule" Fact Sheet.

There are additional resources to help you with your ambulance fee schedules questions and concerns on page five (5) of the "Ambulance Fee Schedule" Fact Sheet.

More questions? To learn more about the ambulance fee schedule contact your Medicare Administrative Contractor or visit our website at www.cms.gov to download the Fact Sheet. At the top of the page in the search bar, type "Ambulance Fee Schedule Fact Sheet."

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