

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-02 Medicare Benefit Policy	Centers for Medicare & Medicaid Services (CMS)
Transmittal 13459	Date: November 26, 2025
	Change Request 14036

Transmittal 13169 issued April 17, 2025, is being rescinded and replaced by Transmittal 13459, dated November 26, 2025, to replace the IOM instructions; the previous file did not include all the other definitions listed in section 30.1.1 that should be cited. All other information remains the same.

SUBJECT: Update to the List of Advanced Life Support, Level 2 (ALS2) Procedures in Chapter 10, Ambulance Services, Section 30.1.1, Definition of Ground Ambulance Services

I. SUMMARY OF CHANGES: The purpose of this Change Request (CR) is to revise the Medicare Benefit Policy Manual, Chapter 10, Section 30.1.1 to include changes that were finalized in the Calendar Year (CY) 2025 Physician Fee Schedule (PFS) final rule (89 FR 98333) to the list of Advanced Life Support, Level 2 (ALS2) procedures.

EFFECTIVE DATE: January 1, 2025

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

IMPLEMENTATION DATE: July 17, 2025

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-Only One Per Row.

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	10/30.1.1/Definition of Ground Ambulance Services

III. FUNDING:

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**

Attachment - Business Requirements

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II. GENERAL INFORMATION

A. Background: This transmittal provides an update to the list of ALS2 procedures that were finalized in the CY 2025 PFS final rule (89 FR 98333).

B. Policy: At 42 Code of Federal Regulations (CFR) § 414.605, ALS2 is defined as either transportation by ground ambulance vehicle, medically necessary supplies and services, and the administration of at least three medications by intravenous push/bolus or by continuous infusion, excluding crystalloid, hypotonic, isotonic, and hypertonic solutions (Dextrose, Normal Saline, Ringer's Lactate); or transportation, medically necessary supplies and services, and the provision of at least one of the following ALS procedures: (1) Manual defibrillation/cardioversion; (2) Endotracheal intubation; (3) Central venous line; (4) Cardiac pacing; (5) Chest decompression; (6) Surgical airway; (7) Intraosseous line. These procedures must be performed by ALS personnel trained to the level of the emergency medical technician-intermediate (EMT-Intermediate) or paramedic (§ 414.605).

CMS proposed in the CY 2025 PFS proposed rule (89 FR 62002 through 62004) to modify the definition of ALS2 at § 414.605 by adding the administration of low titer O+ whole blood transfusion (WBT) to the current list of seven ALS2 procedures as a new number 8. We also stated that we would reflect this change in the Medicare Benefit Policy Manual, Chapter 10, Ambulance Services, section 30.1.1, Definition of Ground Ambulance Services. Under this proposal, a ground ambulance transport that provides WBT would itself constitute an ALS2-level transport.

After consideration of public comments and upon further review, we modified our proposed policy to add the administration of low titer O+ whole blood to the list of procedures that independently qualify as an ALS2 procedure and finalized a policy to change the definition of ALS2 at § 414.605 by including all prehospital blood transfusions (PHBTs) in the list of procedures that independently qualify as an ALS2 procedure. Specifically, we modified the definition of ALS2 at § 414.605 so that the list of ALS2 procedures now includes, as a new number 8, prehospital blood transfusion, which includes the administration of low titer O+ and O- whole blood; the administration of packed red blood cells; the administration of plasma; or the administration of a combination of packed red blood cells and plasma.

III. BUSINESS REQUIREMENTS TABLE

"Shall" denotes a mandatory requirement, and "should" denotes an optional requirement.

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
14036.1	Contractors shall be aware of the changes to the Medicare Benefit Policy Manual, Chapter 10, Section 30.1.1.	X	X							

IV. PROVIDER EDUCATION

Medicare Learning Network® (MLN): CMS will develop and release national provider education content and market it through the MLN Connects® newsletter shortly after we issue the CR. MACs shall link to relevant information on your website and follow IOM Pub. No. 100-09 Chapter 6, Section 50.2.4.1 for distributing the newsletter to providers. When you follow this manual section, you don't need to separately track and report MLN content releases. You may supplement with your local educational content after we release the newsletter.

Impacted Contractors: A/B MAC Part A, A/B MAC Part B

V. SUPPORTING INFORMATION

Section A: Recommendations and supporting information associated with listed requirements: N/A

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:
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Section B: All other recommendations and supporting information: N/A

VI. CONTACTS

Pre-Implementation Contact(s): Amy Gruber, amy.gruber@cms.hhs.gov

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR).

VII. FUNDING

Section A: 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.

ATTACHMENTS: 0

30.1.1 - Ground Ambulance Services

(Rev. 13459; Issued: 11-26-25; Implementation: 01-01-25; Effective: 07-17-25)

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; *or*

h. Prehospital blood transfusion which includes:

- (i) Administration of low titer O+ and O- whole blood (WBT);*
- (ii) Administration of packed red blood cells (PRBCs);*
- (iii) Administration of plasma; or*
- (iv) Administration of a combination of PRBCs and plasma.*

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.

The administration of PHBTs requires an individual trained to the level of the emergency medical technician -intermediate [EMT-Intermediate] or paramedic. Medical monitoring of WBT by an EMT-Intermediate or paramedic with additional training to administer WBT during a ground ambulance transport would qualify for ALS2 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: 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.