Medicare Benefit Policy Manual
Chapter 10 - Ambulance Services

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(Rev. 68, 03-30-07)

Transmittals for Chapter 10

Crosswalk to Old Manual

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

Basic Life Support ambulances must be staffed by at least two people, at least one of whom must be certified as an emergency medical technician (EMT) 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. Advanced Life Support (ALS) vehicles must be staffed by at least two people, at least one of whom must be certified by the State or local authority as an EMT-Intermediate or an EMT-Paramedic.

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, carriers 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 carrier 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 carrier 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), carriers 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 Part A intermediary 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 Part A intermediary may ask the carrier 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 intermediary contacts the Part B carrier to ascertain whether it has already determined whether the crew and ambulance requirements are met. In such a situation, the intermediary should accept the carrier'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 carrier/intermediary. 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. 1, 10-01-03)
B3-2120.2.B, A3-3114.B, HO-236.2

Under the FS payment is made according to the 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.

During the ambulance fee schedule transition period, Medicare allows the ALS-level payment for the reasonable charge portion of the blended rate for emergency and nonemergency transports when an ALS vehicle is used but no ALS service is furnished, if no BLS vehicle was available at the time. Two temporary HCPCS codes, Q3019 and Q3020, may be used in accordance with the following rules.

A. ALS Vehicle Used, Emergency Transport, No ALS Service Furnished

During the ambulance fee schedule (FS) transition period, if an ALS vehicle is used for an emergency transport, but no ALS level service is furnished, the FS portion of the blended payment is based on the emergency BLS level. The amount on the FS for HCPCS Q3019 is the same fee as BLS-Emergency (BLS-E), FS HCPCS A0429. The reasonable charge portion of the blended payment is based on the ALS emergency rate (A0427).

B. ALS Vehicle Used, Non-Emergency Transport, No ALS Service Furnished

During the ambulance fee schedule (FS) transition period, if an ALS vehicle is used for a non-emergency transport, but no ALS level service is furnished, the FS portion of the blended payment is based on the non-emergency Basic Life Support (BLS) level. The amount displayed on the FS for HCPCS Q3020 is the same fee displayed for BLS non-emergency, FS HCPCS A0428. The reasonable charge portion of the blended payment is based on the ALS non-emergency rate (A0426).

C. Transport for Specialized Services

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.

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. Contractors 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 intermediary's/carrier'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 carrier. 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. 1, 10-01-03)
A3-3114.C.9, HO-236.3.I, B3-2130.3.I

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.

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.

10.3 - The Destination

(Rev. 14, 05-28-04)

B3-2120.3, B3-2120.3E, A3-3114.C, HO-236.3

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 Medicare General Information, Eligibility, and Entitlement Manual, Chapter 5, "Definitions," for an explanation of these requirements.) See Claims Processing Manual, Chapter 15, "Ambulance," §20.9, for a description of multiple patient ambulance transport.

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 Hospital Service

(Rev. 14, 05-28-04)

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 look to 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.

10.3.4 – 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 contractor'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. 1, 10-01-03)
A3-3114.C.5, HO-236.3.E, B3-2120.3.E

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.

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 contractor, 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. 14, 05-28-04)

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.

For a complete description of claims processing payment policy for multiple patient transport, refer to the Medicare Claims Processing Manual, Chapter 15, "Ambulance," §10.4.1.

10.4 - Air Ambulance Services

(Rev. 1, 10-01-03)
B3-2120.4, A3-3114.C.11, HO-236.3.J
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.

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 Appropriateness
(Rev. 1, 10-01-03)
A3-3114.C.11.B

Medical appropriateness 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, contractors 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. 1, 10-01-03)
A3-3114.11.G - H

If a determination is made that transport by air ambulance was necessary, but ground ambulance service would have sufficed, payment for the air ambulance service is based on the amount payable for ground transport, if less costly.

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 nearer hospital 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. 1, 10-01-03)
B3-2120.4.H

In order to determine the medical appropriateness of air ambulance services the contractor will 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. 1, 10-01-03)

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. (See item g. below.)

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. 1, 10-01-03)

B3-2125

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 supplier is listed in the table of approved ambulance companies (§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. (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 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 code 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 code 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 §10.3.7 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:	(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:	(a) From the pickup point to the nearest appropriate facility, or (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. 1, 10-01-03)

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 + Choice (M+C) coordinated care plan or M+C 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+C plan enrollee the cost-sharing amount required under the M+C plan, and collect the remainder from the M+C organization.

20.1.2 - Beneficiary Signature Requirements
(Rev. 1, 10-01-03)

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, a representative payee, relative, friend, representative of the institution providing care, or a government agency providing assistance may sign on his/her behalf. 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. 1, 10-01-03)

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 will be phased in over a 5-year period. When fully implemented, the fee schedule will replace the current retrospective reasonable cost reimbursement system for providers and the reasonable charge system for ambulance suppliers. During the transition period, payment is 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 - Categories of Ambulance Services
(Rev. 1, 10-01-03)

There are seven 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. 68; Issued: 03-30-07; Effective: 01-01-07; Implementation: 04-30-07)

Refer to the Medicare Claims Processing Manual, Chapter 15, "Ambulance," §10.3, for additional definitions and their applications.

1. Basic Life Support (BLS)

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.

2. Basic Life Support (BLS) - Emergency

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.

3. Advanced Life Support, Level 1 (ALS1)

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**.**

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.

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.

4. Advanced Life Support, Level 1 (ALS1) - Emergency

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.

5. Advanced Life Support, Level 2 (ALS2)

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. Surgical airway; or

g. Intraosseous line.

6. Specialty Care Transport (SCT)

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.

The EMT-Paramedic level of care is set by each State. 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.

7. Paramedic Intercept (PI)

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," for payment of paramedic intercept services.

30.1.2 - Air Ambulance Services
(Rev. 1, 10-01-03)

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#
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