

FACT SHEET

Definition of Ambulance Services

There are several categories of ground ambulance services and two categories of air ambulance services under the fee schedule. (Note that “ground” refers to both land and water transportation.) *All ground and air ambulance transportation services must meet all requirements regarding medical reasonableness and necessity as outlined in the applicable statute, regulations, and manual provisions.*

Medical Necessity

- 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.

Reasonableness

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

Vehicle Requirement for Basic Life Support and Advanced Life Support

- Basic Life Support (BLS) ambulances must be staffed by at least two people, *who meet the requirements of state and local laws where the services are being furnished and where*, at least one of whom must
 1. Be certified at a minimum as an emergency medical technician-basic (EMT-basic) by the state or local authority where the services are being furnished and
 2. Be legally authorized to operate all lifesaving and life-sustaining equipment on board the vehicle.

The ambulance benefit is defined in title XVIII of the Social Security Act in §1861(s) (7) which establishes coverage for “medical and other health services” named in the statute, including: “ambulance service where the use of other methods of transportation is contraindicated by the individuals’ condition, but only to the extent provided in regulations.” http://www.ssa.gov/OP_Home/ssact/title18/1861.htm

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.

This Fact Sheet is for informational purposes only and is not intended to guarantee payment for services, all services submitted to Medicare must meet Medical Necessity guidelines. The definition of “medically necessary” for Medicare purposes can be found in Section 1862(a)(1)(A) of the Social Security Act – Medical Necessity (http://www.ssa.gov/OP_Home/ssact/title18/1862.htm).

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- Advanced Life Support (ALS) vehicles must be staffed by at least two people, *who meet the requirements of state and local laws where the services are being furnished and where at least one of whom must:*
 1. *Meet the vehicle staff requirements above for BLS vehicles and*
 2. *Be certified as an EMT-Intermediate or an EMT-Paramedic by the state or local authority where the services are being furnished to perform one or more ALS services.*

Beneficiary's Condition

Beneficiary was suffering from an illness or injury which contraindicated transportation by other means. Examples include:

- Transported in an emergency situation (i.e., result of accident, injury or acute illness)
- Needed to be restrained to prevent injury to the beneficiary or others
- Was unconscious or in shock
- Required oxygen or other emergency treatment during transport to nearest facility
- Exhibits signs and symptoms of acute respiratory distress or cardiac distress such as shortness of breath or chest pain
- Exhibits signs and symptoms that indicated the possibility of acute stroke
- Had to remain immobile because of a fracture that had not been set or the possibility of a fracture
- Is experiencing severe hemorrhage
- Could be moved only by stretcher
- Was bed-confined before and after the ambulance trip

In the absence of any of the conditions listed above, additional documentation should be obtained to establish medical need.

Beneficiary Signature Requirements

Medicare requires the signature of the beneficiary, or that of his or her representative, for both the purpose of accepting assignment and submitting a claim to Medicare. If the beneficiary is unable to sign because of a mental or physical condition, the following individuals may sign the claim form on behalf of the beneficiary:

- The beneficiary's legal guardian.
- A relative or other person who receives social security or other governmental benefits on behalf of the beneficiary.
- A relative or other person who arranges for the beneficiary's treatment or exercises other responsibility for his or her affairs.
- A representative of an agency or institution that did not furnish the services for which payment is claimed, but furnished other care, services, or assistance to the beneficiary.
- A representative of the provider or of the nonparticipating hospital claiming payment for services it has furnished, if the provider or nonparticipating hospital is unable to have the claim signed in accordance with 42 CFR 424.36(b) (1 – 4).

Bed Confinement

A beneficiary is considered 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 CGS's (or another Medicare contractor's) determination of whether means of transport other than an ambulance were contraindicated.

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- A representative of the ambulance provider or supplier who is present during an emergency and/or nonemergency transport, provided that the ambulance provider or supplier maintains certain documentation in its records for at least 4 years from the date of service. A provider/supplier (or his/her employee) cannot request payment for services furnished except under circumstances fully documented to show that the beneficiary is unable to sign and that there is no other person who could sign.

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

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

Air Ambulance Services

Medically appropriate air ambulance transportation is a covered service regardless of the State or region in which it is rendered. However, contractors approve claims only if the beneficiary's medical condition is such that transportation by either basic or advanced life support ground ambulance is not appropriate.

There are two categories of air ambulance services: fixed wing (airplane) and rotary wing (helicopter) aircraft. The higher operational costs of the two types of aircraft are recognized with two distinct payment amounts for air ambulance mileage. The air ambulance mileage rate is calculated per actual loaded (patient onboard) miles flown and is expressed in statute miles (not nautical miles).

- **Fixed Wing (FW):** 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.
- **Rotary Wing (RW):** Furnished when the beneficiary 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.

Ambulance Service to Physician's Office

These trips are covered only under the following circumstances:

- The ambulance transport is en route 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.

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Advanced Life Support (ALS)

An 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. *In the case of an appropriately dispatched ALS Emergency service, if the ALS crew completes an ALS Assessment, the services provided by the ambulance transportation service provider or supplier may 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,*
- Level 1 (ALS1) is the transportation by ground ambulance vehicle and the provision of medically necessary supplies and services including the provision of an ALS assessment or at least one ALS intervention.
- Advanced Life Support Intervention: 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.
- 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.
- 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 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:
 - Manual Defibrillation/cardioversion
 - Endotracheal intubation
 - Central venous line
 - Cardiac pacing
 - Chest decompression
 - Surgical airway, or
 - Intraosseous line
- 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*

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.

- BLS Emergency; when medically necessary, 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.

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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.

ALS Personnel are individuals trained to the level of the emergency medical technician-intermediate (EMT – Intermediate) or paramedic.

For additional information please see References section at the end of this document.

Specialty Care Transport (SCT)

Specialty Care Transport (SCT) is considered medically necessary when the following parameters are met:

- Involves an inter-facility transportation of a critically injured or ill beneficiary by ground ambulance at a level of service beyond the scope of the EMT-Paramedic. 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.
- 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.
- "Additional training" such as:
 - Emergency care
 - Critical care nursing
 - Emergency medicine
 - Respiratory care
 - Cardiovascular care
 - A paramedic with additional training.
- One or more body systems are abnormal and rapidly deteriorating in association with an acute illness or injury

Certifications

- 42 CFR 410.40(d)(2) Medicare covers medically necessary nonemergency, scheduled, repetitive ambulance services if the ambulance provider or supplier, before furnishing the service to the beneficiary, obtains a written order from the beneficiary's attending physician certifying that the medically necessary requirements of paragraph (d)(1) of this section are met. The physician's order must be dated no earlier than 60 days before the date the service is furnished.
- 410.40(d)(3) Medicare covers medically necessary nonemergency ambulance services that are either unscheduled or that are scheduled on a nonrepetitive basis under one of the following circumstances:
 - Resident of a facility who is under the care of a physician if the ambulance provider obtains a written order from the beneficiary's attending physician within 48 hours after the transport; the order must certify that the medical necessity requirements of paragraph (d)(1) of this section are met.
 - Beneficiary residing at home or in a facility who is not under the direct care of a physician. A physician certification is not required
 - • If the ambulance provider or supplier is unable to obtain a signed physician certification statement from the bene's attending physician, the following are acceptable:
 - » Review contractors shall accept a non-physician certification statement from other authorized staff for nonemergency ambulance transportations that are unscheduled or non-repetitive when the attending physician is unavailable.
 - » Review contractors shall accept documentation signed and dated from other authorized staff when the attending physician is unavailable and there is no prescribed form or format for the non-physician certification statement.
 - » For non-physician certification statements, review contractors shall accept documentation signed and dated by physician assistants, nurse practitioners, clinical nurse specialists, registered nurses, licensed practical nurses/licensed vocational nurses (LPNs/LVNs), social workers, discharge planners and case managers. Note that for purposes of medical review, the term LVN is deemed synonymous with LPN.
 - If unable to obtain required certification within 21 calendar days following the Date of Service the ambulance supplier must document its attempts to obtain requested certification; this includes but is not limited to a signed return receipt from the US Postal Service.

Of Note: The presence of the signed certification statement or signed return receipt does NOT alone demonstrate that the ambulance transport was medically necessary. All other program criteria must be met in order for payment to be made.

https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AmbulanceFeeSchedule/downloads/cfr410_40.pdf

Extended Care Services: If ambulance service is furnished by a skilled nursing facility an additional certification is required. It may be furnished by any physician who has sufficient knowledge of the patient's case, including the physician who requested the ambulance or the physician who examined the patient upon his arrival at the facility. The physician must certify that the ambulance service was medically required.

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 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.

Payment for Non-Emergency Trips to/from ESRD Facilities

- Section 637 of the American Taxpayer Relief Act of 2012 requires that, effective for transports occurring on and after October 1, 2013, fee schedule payments for non-emergency basic life support (BLS) transports of individuals with end-stage renal disease (ESRD) to and from renal dialysis treatment be reduced by 10%. The payment reduction affects transports (base rate and mileage) to and from hospital-based and freestanding renal dialysis treatment facilities for dialysis services provided on a non-emergency basis. Non-emergency BLS ground transports are identified by Healthcare Common Procedure Code System (HCPCS) code A0428. Ambulance transports to and from renal dialysis treatment are identified by modifier codes “G” (hospital-based ESRD) and “J” (freestanding ESRD facility) in either the first position (origin code) or second position (destination code) within the two-digit ambulance modifier. (See Section 30 (A) for information regarding modifiers specific to ambulance.)
- Effective for claims with dates of service on and after October 1, 2013, the 10% reduction will be calculated and applied to HCPCS code A0428 when billed with modifier code “G” or “J”. The reduction will also be applied to any mileage billed in association with a non-emergency transport of a beneficiary with ESRD to and from renal dialysis treatment. BLS mileage is identified by HCPCS code A0425.
- The 10% reduction will be taken after calculation of the normal fee schedule payment amount, including any add-on or bonus payments, and will apply to transports in rural and urban areas as well as areas designated as “super rural”.
- Payment for emergency transports is not affected by this reduction. Payment for non-emergency BLS transports to other destinations is also not affected. This reduction does not affect or change the Ambulance Fee Schedule.

Note: The 10% reduction applies to beneficiaries with ESRD that are receiving non-emergency BLS transport to and from renal dialysis treatment. While it is possible that a beneficiary who is not diagnosed with ESRD will require routine transport to and from renal dialysis treatment, it is highly unlikely. However, contractors have discretion to override or reverse the reduction on appeal if they deem it appropriate based on supporting documentation.

Additional Information

- Date of Service is the date/time the loaded vehicle departs the point of pickup
 - If the beneficiary is pronounced dead after dispatch but before loaded into the vehicle the dispatch date/time is used
- Please note that ALL services ordered or rendered to Medicare beneficiaries MUST be signed. Signatures may be handwritten or electronically signed; exceptions for stamped signatures are described in MLN Matters article MM8219 (<http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8219.pdf>). You should NOT add late signatures to a medical record but instead make use of the signature authentication process outlined in MLN Matters article MM6698 (<http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM6698.pdf>). A sample attestation statement is available on the CGS website (http://www.cgsmedicare.com/partb/cert/attestation_form.pdf). Guidelines regarding signature requirements are located in the CMS Program Integrity Manual (Pub. 100-08), chapter 3, section 3.3.2.4 (<http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/pim83c03.pdf>).

References:

- The Medicare Ambulance Benefit & Statutory Bases for Denial of Claims: <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AmbulanceFeeSchedule/downloads/ambabn71603.pdf>
- CMS Medicare Benefit Policy Manual (Pub. 100-02), chapter 10, Ambulance Services: <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c10.pdf>
- CMS Medicare Claims Processing Manual (Pub 100-04), Chapter 15, Ambulance: <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c15.pdf>
- CMS Medicare Program Integrity Manual (Pub. 100-08), chapter 6, section 604, Medical Review of Rural Air Ambulance Services: <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/pim83c06.pdf>
- MLN Medicare Ambulance Services: http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/medicare_ambulance_services_icn903194.pdf
- Ambulance Fee Schedule and Medicare Transports: <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Medicare-Ambulance-Transports-Booklet-ICN903194.pdf>