

National Coverage Provision

Subject:
Ambulance Services

Subject Number:
AMB-001

Description:

Medicare covers ambulance services, including fixed wing and rotary wing ambulance services, only if they are furnished to a beneficiary whose medical condition is such that other means of transportation are contraindicated. The beneficiary's condition must require the ambulance transportation itself and the level of service provided in order for the billed service to be considered medically necessary. Ambulance services are divided into different levels of ground (including water) and air ambulance services based on the medically necessary treatment during transport.

Mandatory Assignment. Effective with implementation of the ambulance fee schedule for services furnished on or after April 1, 2002, all payments made for ambulance services are made only on an assignment-related basis.

Ambulance Fee Schedule. The fee schedule was implemented beginning on April 1, 2002. We will phase-in implementation of the ambulance fee schedule under a 5-year transition. Payment under the fee schedule for ambulance services: Comprises a base rate payment plus a payment for mileage; Covers both the transport of the beneficiary to the nearest facility and all items and services associated with such transport; and Precludes a separate payment for items and services furnished under the ambulance benefit.

Jurisdiction. During the transition period of the Ambulance Fee Schedule, the jurisdiction of ambulance claims remains with the contractor that serves the locality where the vehicle is garaged or hangared. (This is significant when vehicles cross-state lines to pick up a patient.) In air ambulance claims, where multiple vehicles (air and ground) are involved, the air portion should be processed by the contractor serving the locality where the plane or helicopter is garaged. Once the transition is completed, the jurisdiction will transfer to the point of pick-up, as identified by the zip code.

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, a representative payee, relative, friend, representative of the institution providing care or a government agency providing assistance may sign on her/his 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. (Per 42 CFR §424.44, there is a 15 to 27 month period for filing a Medicare claim.)

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 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 with the claims filing period.

Resident and Non-Resident Billing. The ambulance fee schedule has no effect on Medicare's long standing policy concerning resident versus non-resident billing. In areas that distinguish between residents and non-residents, Medicare beneficiaries must be charged the same rate as all others in the same category. That is, all residents of a particular jurisdiction must be charged the same "resident rate" and all non-residents of that city and state must be charged the same "non-resident" rate.

Procedure Codes CPT or HCPCS:

A0425	Ground mileage, per statute mile
A0426	Ambulance service, advanced life support, non-emergency transport, level 1 (ALS1)
A0427	Ambulance service, advanced life support, emergency transport, level 1 (ALS1-Emergency)
A0428	Ambulance service, basic life support, non-emergency transport (BLS)
A0429	Ambulance service, basic life support, emergency transport (BLS-Emergency)
A0430	Ambulance service, conventional air services, transport, one way (fixed wing)(FW)
A0431	Ambulance service, conventional air services, transport, one way (rotary wing)(RW)
A0433	Advanced life support, level 2 (ALS2)
A0434	Specialty care transport (SCT)
A0435	Fixed wing air mileage, per statute mile
A0436	Rotary wing air mileage, per statute mile
A0888	Non-covered ambulance mileage, per mile (e.g., for miles traveled beyond closest appropriate facility)

Modifiers

Modifiers identify place of origin and destination of the ambulance trip. The modifier is to be placed next to the HCPCS code billed. The following is a list of current ambulance modifiers. Each of the modifiers may be utilized to make up the first and/or second half of a two-letter modifier. The first letter must describe the origin of the transport, and the second letter must describe the destination (Example: if a patient is picked up at his/her home and transported to the hospital, the modifier to describe the origin and destination would be – RH).

<u>Code</u>	<u>Description</u>
D	Diagnostic or therapeutic site other than “P” or “H”
E	Residential, domiciliary, custodial facility, nursing home other than SNF (other than 1819 facility)
G	Hospital-based dialysis facility (hospital or hospital-related) which includes:
-	Hospital administered/Hospital located
-	Non-Hospital administered/Hospital located
H	Hospital
I	Site of transfer (e.g., airport, ferry, or helicopter pad) between modes of ambulance transport
J	Non-hospital-based dialysis facility
-	Non-Hospital administered/Non-Hospital located
-	Hospital administered/Non-Hospital located
N	Skilled Nursing Facility (SNF) (1819 Facility)
P	Physician’s Office (includes HMO non-hospital facility, clinic, etc.)

R	Residence
S	Scene of Accident or Acute Event
X	Destination Code Only) Intermediate stop at physician's office enroute to the hospital (includes HMO non-hospital facility, clinic, etc.)

Indications and Limitations of Coverage

A. Nearest Appropriate Facility

Medicare pays for a medically necessary transportation to the nearest appropriate facility. The current AHA guide for each state determines the nearest appropriate facility.

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.

B. Vehicle and Crew Requirements

- 1. 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 minimum, one two-way voice radio or wireless telephone.*
- 2. Basic Life Support (BLS) ambulances must be staffed by at least two people, one of whom must be certified as an emergency medical technician (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.*
- 3. Advanced Life Support (ALS) vehicles must be staffed by two people with one of the two staff members certified as paramedic or an EMT-intermediate who is trained and certified, by the State or local authority where services are being furnished, to perform one or more ALS service. The EMT-intermediate is defined as an individual who is qualified, in accordance with State and local laws, as an EMT and who is also qualified in accordance with State and local laws to perform essential advanced techniques and to administer a limited number of medications. The EMT-Paramedic is defined as possessing the qualification of the EMT-Intermediate and also, in accordance with State and local laws, as having enhanced skills that includes being able to administer interventions and medications.*

C. Mileage

- 1. Charges for mileage must be based on loaded mileage only, i.e., from the pickup of a patient to his/her arrival at the destination.*
- 2. Loaded mileage means the number of miles the Medicare beneficiary is transported in the ambulance.*

3. *Payment is allowed for all medically necessary mileage. That is, Medicare allows payment for mileage incurred transporting the beneficiary to the nearest appropriate facility (or transfer point in the case of air to ground or ground to air transfer).*
4. *If mileage is billed, the miles must be in whole numbers. If a trip has a fraction of a mile, round up to the nearest whole number. Code "1" as the mileage for trips of less than a mile.*
5. *The Medicare program covers mileage only to the nearest facility equipped to treat the beneficiary. Any additional mileage is not covered by Medicare. However, the beneficiary may arrange with the ambulance supplier to pay the difference.*
6. *HCPCS code A0888 is the code for non-covered ambulance mileage (for example, mileage traveled beyond the closest appropriate facility). This code has not been deleted and may continue to be used as it was previously.*

D. Definitions of Ambulance Services

The following definitions apply to both land and water (hereafter collectively referred to as "ground") ambulance services unless otherwise specified as applying to air ambulance services:

1. *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 condition at the time of dispatch was such that only an ALS crew was qualified to perform the assessment. An ALS assessment does not necessarily result in a determination that the patient requires an ALS level of service.*

Application: The determination to respond emergently with an ALS ambulance must be in accord with the local 911 or equivalent service dispatch protocol. If the call came in directly to the ambulance provider/supplier, then the provider's/supplier's dispatch protocol must meet, at a minimum, the standards of the dispatch protocol of the local 911 or equivalent service. In areas that do not have a local 911 or equivalent service, then the protocol must meet, at a minimum, the standards of a dispatch protocol in another similar jurisdiction within the State or, if there is no similar jurisdiction within the State, then the standards of any other dispatch protocol with 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.

2. *Advanced Life Support Intervention is a procedure that is, in accordance with State and local laws, beyond the scope of practice of an emergency medical technician – basic (EMT-Basic).*

Application: An ALS intervention must be medically necessary to qualify as an intervention for payment of an ALS level of service. An ALS intervention applies only to ground transports.

3. *Advanced Life Support, Level 1 (ASL1) 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**.*

4. Advanced Life Support, Level 2 (ALS2) is the transportation by ground ambulance vehicle and the provision of medically necessary supplies and services including:
- a. At least three separate administrations of one or more medications by intravenous push/bolus or by continuous infusion (excluding crystalloid fluids) or
 - b. Ground ambulance transport and the provision of at least one of the ALS2 procedures listed below.

Application: Crystalloid fluids include fluids such as 5 percent Dextrose in water, Saline and Lactated Ringer's. Medications that are administered by other means, for example: intramuscular/subcutaneous injection, oral, sublingually or nebulized, do not qualify to determine whether the ALS2 level rate is payable. However, this is not an all-inclusive list. Likewise, a single dose of medication administered fractionally (i.e., one-third of a single dose quantity) on three separate occasions does not qualify for the ALS2 payment rate. The criterion of multiple administrations of the same drug requires a suitable quantity and amount of time between administrations that is in accordance with standard medical practice guidelines. The fractional administration of a single dose (for this purpose meaning a standard or protocol dose) on three separate occasions does not qualify for ALS2 payment. In other words, the administration of 1/3rd of a qualifying dose 3 times does not equate to three qualifying doses for purposes of indicating ALS2 care. One-third of X given 3 times might = X (where X is a standard/protocol drug amount), but the same sequence does not equal 3 times X. Thus, if 3 administrations of the same drug are required to show that ALS2 care was given, each of those administrations must be in accord with local protocols. The run will not qualify on the basis of drug administration if that administration was not according to protocol. An example of a single dose of medication administered fractionally on three separate occasions that would not qualify for the ALS2 payment rate would be the use of Intravenous (IV) Epinephrine in the treatment of pulseless Ventricular Tachycardia/Ventricular Fibrillation (VF/VT) in the adult patient. Administering this medication in increments of 0.25 mg, 0.25mg, and 0.50 mg would not qualify for the ALS2 level of payment. This medication, according to 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, in order to receive payment for an ALS2 level of service, three separate administrations of Epinephrine in 1 mg increments must be administered for the treatment of pulseless VF/VT. A second example that would not qualify for the ALS2 payment level is the use of Adenosine in increments of 2 mg, 2 mg, and 2 mg for a total of 6 mg in the treatment of an adult patient with Paroxysmal Supraventricular Tachycardia (PSVT). According to ACLS guidelines, 6 mg of Adenosine should be given by rapid intravenous push (IVP) over 1 to 2 seconds. If the first dose does not result in the elimination of the supraventricular tachycardia within 1 to 2 minutes, 12 mg of Adenosine should be administered IVP. If the supraventricular tachycardia persists, a second 12 mg dose of Adenosine can be administered for a total of 30 mg of Adenosine. Three separate administrations of the drug Adenosine in the dosage amounts outlined in the later case would qualify for ALS2 payment.

- c. For purposes of this definition, the ALS2 procedures are:
 - i. Manual defibrillation/cardioversion.
 - ii. Endotracheal intubation.
 - iii. Central venous line.

- iv. Cardiac pacing.
 - v. Chest decompression.
 - vi. Surgical airway.
 - vii. Intraosseous line.
- d. Endotracheal intubation is one of the services that qualifies for the ALS2 level of payment; therefore, it is not necessary to consider medications administered by endotracheal intubation for the purpose of determining whether ALS2 rate is payable. The monitoring and maintenance of an endotracheal tube that was previously inserted prior to the transport also qualifies as an ALS2 procedure.
5. Advanced Life Support (ALS) Personnel are individuals trained to the level of the emergency medical technician-intermediate (**EMT-Intermediate**) or paramedic.
 6. 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 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.
 7. Emergency Response is a BLS or ALS1 level of service has been provided in immediate response to a 911 call or equivalent. An immediate response is one in which the ambulance provider/supplier begins as quickly as possible to take the steps necessary to respond to the call.

Application: The phrase “911 call or equivalent” is intended to establish the standard that the nature of the call at the time of dispatch is the determining factor. Regardless of the medium by which the call is made (e.g., a radio call could be appropriate) the call is of an emergent nature when, based on the information available to the dispatcher at the time of the call, it is reasonable for the dispatcher to issue an emergency dispatch in light of accepted, standard dispatch protocol. An emergency call need not come through 911 even in areas where a 911-call system exists. However, the determination to respond emergently must be in accord with the local 911 or equivalent service dispatch protocol. If the call came in directly to the ambulance provider/supplier, then the provider’s/supplier’s dispatch protocol and the dispatcher’s actions must meet, at a minimum, the standards of the dispatch protocol of the local 911 or equivalent service. In areas that do not have a local 911 or equivalent service, then both the protocol and the dispatcher’s actions must meet, at a minimum, the standards of the dispatch protocol in another similar jurisdiction within the State, or if there is no similar jurisdiction, then the standards of any other dispatch protocol within the State. Where the dispatch was inconsistent with this standard of protocol, including where no protocol was used, the beneficiary’s condition (for example, symptoms) at the scene determines the appropriate level of payment.

8. 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.

9. EMT-Paramedic possesses the qualification 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.
10. Fixed Wing (FW) Air Ambulance is the transportation by a fixed wing aircraft that is certified by the Federal Aviation Administration (FAA) as a **fixed wing air ambulance** and the provision of medically necessary services and supplies.
11. Point of Pick-up is the location of the beneficiary at the time he or she is placed on board the ambulance.

*Application: The zip code of the **point of pick-up** must be reported on each claim for ambulance services.*

12. Rotary Wing (RW) Air Ambulance is the transportation by helicopter that is certified by the FAA as a rotary wing ambulance, including the provision of medically necessary supplies and services.
- *13. Specialty Care Transport (SCT) is *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.

E. Origin and Destination

1. Medicare can cover the following transportation:
 - a. From any point of origin to the nearest hospital, Critical Access Hospital (CAH) or SNF that is capable of furnishing the required level and type of care for the beneficiary's condition. The Hospital or CAH must have available the type of physician or physician specialist needed to treat the beneficiary's condition.
 - b. From a hospital, CAH, or SNF to the beneficiary's home

4. *If three or more patients are transported at the same time in one ambulance to the same destination,*
 - a. *The adjusted payment for each Medicare beneficiary would equal 60 percent of the single-patient allowed amount applicable to the level of service furnished that beneficiary,*
 - b. *Plus a proportional mileage allowed, i.e., the total mileage allowed amount divided by the number of patients onboard.*
5. *The fact that the level of medically necessary service among the patients may be different is not relevant to this payment policy. The percentage is applied to the allowed amount applicable to the level of service that is medically necessary for each beneficiary.*
6. *If a multi-patient transport includes multiple destinations, then the Medicare allowed amount for mileage depends upon whether it is for an emergency versus non-emergency ground transport.*
 - a. *For an emergency ground transportation, which includes BLS-E, ALS1-E, ALS2, and SCT, the mileage payment shall be based on the number of miles to the nearest appropriate facility for each patient, divided by the number of patients on board when the vehicle arrives at the facility. This formula applies cumulatively for beneficiaries who are the 2nd or 3rd patient to be delivered. Absent evidence to the contrary, it will be assumed that the sequence of deliveries was predicated on the medical needs of each patient.*
 - b. *For a non-emergency ground transport, which includes BLS and ALS1, the mileage payment shall be based on the number of miles from the point of pickup to the nearest appropriate facility for each beneficiary, divided by the number of beneficiaries on board at the point of pick-up. This formula applies cumulatively for beneficiaries for multiple points of pick-up. Mileage other than the mileage that would be incurred by transporting the beneficiary directly from the point of pick-up to the nearest appropriate facility is not covered. Thus, for non-emergency transports, the extra mileage that may be incurred by having multi-destinations shall not be taken into account.*
 - c. *For air transports the policy is the same as for emergency ground transports.*
7. *If a Medicare beneficiary is furnished medically necessary supplies, and the supplier bills supplies separately, then the allowed amount of the supplies is not subject to an apportionment for multiple patients. The allowed amount for supplies should be determined in the same manner as if the beneficiary was the only patient onboard the vehicle.*
8. *Use modifier “-GM” to identify a multiple transport.*
9. *Suppliers must submit documentation to specify the particulars of a multiple transport.*

I. Pronouncement of Death

The pronouncement of death is recognized only when made by an individual who is licensed or otherwise authorized under state law to pronounce death in the State where such pronouncement is made.

1. *The beneficiary is pronounced dead after the ambulance is called but before the ambulance arrives at the scene: payment is made for a BLS service if a ground vehicle is dispatched. Neither mileage nor a rural adjustment would be paid. The blended rate amount will otherwise apply. Suppliers continue to use the QL modifier.*
2. *The beneficiary is pronounced dead after being loaded into the ambulance (regardless of whether the pronouncement is made during or subsequent to the transport): payment is made following the usual rules of payment as if the beneficiary had not died. The scenario includes a determination of “dead on arrival” at the facility at which the beneficiary was transported.*
3. *No payment will be made if the beneficiary was pronounced dead prior to the time the ambulance is called.*
4. *In each case, the assumption is that the ambulance transport would have otherwise been medically necessary.*

J. The Destination

1. *Medicare covers ambulance transports (that meet all other program requirements for coverage) only to the following destinations.*
 - a. *Hospital;*
 - b. *Critical Access Hospital (CAH);*
 - c. *Skilled Nursing Facility (SNF);*
 - d. *Beneficiary's home; or*
 - e. *Dialysis facility for ESRD patient who requires dialysis; or*
 - f. *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.*
2. *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 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. 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.*
3. *Institution to Beneficiary's Home - 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.*

4. *Institution or Institution - 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 "Separately Payable Ambulance Transport Under Part B Versus Patient Transportation that is Covered Under a Packaged Institutional Service".*

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.

5. *Separately Payable Ambulance Transport Under Part B Versus Patient Transportation that is Covered Under a Packaged Institutional Service.*
- a. *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.*
- b. *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.*

- a. *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".*
- b. *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.

- c. 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 transfer within a single building.

- 6. Transports to and from Medical Services for Beneficiaries who are not Inpatients.*
 - a. 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.*
 - b. 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 bring 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.

- c. Specialized services are covered services that are not available at the facility in which the beneficiary is a patient.*

7. Transfer for Renal Dialysis

- a. Ambulance Transportation to Renal Dialysis Facility Located on Premises of Hospital. A renal dialysis facility may be approved to participate in the end-stage renal disease program as a part of a hospital or as a non-provider. Where the facility has been approved as a part of a hospital, it meets the destination requirements of an institution. Even where the facility has been approved as a non-provider, it may be determined to meet the destination requirements for purposes of ambulance service coverage under the following circumstances.*

- i. The facility is located on or adjacent to the premises of a hospital;*
- ii. The facility furnishes services to patients of the hospital, e.g., on an outpatient or emergency basis, even though the facility is primarily in operation to furnish dialysis services to its own patients; and*
- iii. There is an ongoing professional relationship between the two facilities. For example, the hospital and the facility have an agreement that provides for physician staff of the facility to abide by the bylaws and regulations of the hospital medical staff.*

- b. Reimbursement for Ambulance Services to Nonhospital-Based Dialysis Facilities. Claims for end-stage renal disease (ESRD) patients with a destination of nonhospital-based dialysis facility are covered in accordance with 42 CFR §410.40, for claims with dates of service after February 23, 1999.*

- 8. Locality -** *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.

K. Skilled Nursing Facility Consolidated Billing - Clarification of Ambulance Services

- 1. Except for specific exclusions, consolidated billing includes those medically necessary ambulance trips that are furnished during the course of a covered Part A stay.*
- 2. In most cases, ambulance trips are excluded from consolidated billing when resident status has ended. The ambulance company then must bill the carrier directly for payment.*

3. *Listed below are a number of specific circumstances under which a beneficiary may receive ambulance services that are covered by Medicare, but excluded from consolidated billing.*
 - a. *A medically necessary trip to a Medicare participating hospital or critical access hospital for the specific purpose of receiving emergency or other excluded outpatient hospital services.*
 - b. *Medically necessary ambulance trips after a formal discharge or other departure from the SNF, **unless** the beneficiary is readmitted or returns to that or another SNF before midnight of the same day.*
 - c. *An ambulance trip to receive dialysis-related services.*
 - d. *A trip for an inpatient admission to a Medicare participating hospital or critical access hospital.*
 - e. *After a discharge from the SNF, a medically necessary trip to the beneficiary's home where the beneficiary will receive services from a Medicare participating home health agency under a plan of care.*
4. *A beneficiary's transfer from one SNF to another before midnight of the same day is not excluded from consolidated billing. When a medically necessary transport from one SNF to another SNF occurs when the beneficiary is discharged from the first SNF and admitted to the second, this transport is included in consolidated billing. The first SNF is responsible for the ambulance service and the cost is included in the Part A rate. It is not separately billable.*

L. Distinguishing Between Part A and Part B Ambulance Services

1. *Distinguishing between ambulance services, which are covered under Part B, and transportation services, which are covered under Part A.*
2. *The movement of a beneficiary from his or her home, an accident scene, or any other point of origin to the nearest hospital, critical care 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 is covered, assuming medical necessity and other coverage criteria are met, only under Part B as an ambulance service. No Part A coverage is available because at the time the beneficiary is transported, he or she is not an inpatient of any provider of Part A of the program.*
3. *The transfer of a beneficiary from one provider to another (for example, from an acute care hospital to a long-term care hospital or to a SNF) is also not covered as a Part A provider service because at the time the person is in transit, he or she is not a patient of either provider. This service may be covered under Part B.*
4. *However, once a beneficiary has been admitted to a hospital, CAH, or SNF, it may be necessary to transport the beneficiary to another hospital or other site for specialized care. In this instance, the specialized services are furnished under arrangement made by the hospital, CAH or SNF. Following that treatment, the beneficiary is returned to the hospital, CAH, or SNF to complete the inpatient stay. This movement of the beneficiary is considered "patient transportation" and is covered as an inpatient hospital or CAH service under Part A of the program and as a SNF service when the SNF is furnishing it as a covered SNF service, and Part A payment is made for that service.*

M. Physician Certification Statement (PCS)

1. *The attending physician must sign the Physician Certification Statement (PCS). If the ambulance supplier is unable to obtain a signed physician certification statement from the attending physician, a signed physician certification must be obtained from either the physician, physician assistant, nurse practitioner, clinical nurse specialist, registered nurse, or discharge planner who is employed by the attending physician or by the hospital or facility where the beneficiary is being treated and who has personal knowledge of the beneficiary's condition at the time the transport is ordered or the service was furnished.*
2. *If the supplier is unable to obtain the required statement as described above within 21 calendar days following the date of service, the ambulance suppliers must document its attempts to obtain the physician certification statement and may then submit the claim. Acceptable documentation must include a signed return receipt form the US Postal Service or similar delivery service. A signed return receipt will serve as documentation that the ambulance supplier attempted to obtain the required physician certification statement.*
3. *In all cases, the provider or supplier must keep the appropriate documentation on file and, upon request, present it to the contractor. 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.*
4. *In addition to the physician's signature it is acceptable to obtain signed certification statements when physician assistants, nurse practitioners, or clinical nurse specialists furnish professional services (where all applicable State licensure or certification requirements are met).*
5. *The following situations require PCS:*
 - a. *Non-emergency, scheduled, repetitive ambulance services. The physician's order must be dated no earlier than 60 days before the date the service is furnished.*
 - b. *Non-emergency, unscheduled or scheduled on a non-repetitive basis. For a resident of a facility who is under the care of a physician if the ambulance provider or supplier obtains a written order (PCS) from the beneficiary's attending physician, within 48 hours after the transport, certifying that the medical necessity has been met.*
 - c. *For a beneficiary residing at home or in a facility who is not under the direct care of a physician, a physician certification is not required.*
6. *A PCS is not required for the following ambulance services:*
 - a. *Emergency; and*
 - b. *Nonemergency, unscheduled, ambulance services for a beneficiary who, at the time of transport time of transport, was residing either at home or in a facility and who was not under the direct care of a physician.*

N. Ground to Air Transports

1. *When a beneficiary is transported by ground ambulance and transferred to an air ambulance, the ground ambulance may bill Medicare for the level of service provided and mileage from the point-of-pickup to the point-of-transfer to the air ambulance.*
2. *For situations in which a beneficiary is transported by ground ambulance to or from an air ambulance, the ground and air ambulance providers/suppliers providing the transports must bill Medicare independently. Under these circumstances, Medicare pays each provider/supplier individually for its respective services and mileage.*
3. *Each provider/supplier must submit a claim for its respective services/mileage to the carrier that has jurisdiction for the locality in which its ambulance is based.*

O. Air Ambulance

1. *Medical appropriateness is only established when the beneficiary's condition is such that the time needed to transport a beneficiary by land, or the instability of transportation by land, 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.*
 - a. *Intracranial bleeding – requiring neurosurgical intervention.*
 - b. *Cardiogenic shock.*
 - c. *Burns requiring treatment in a Burn Center;*
 - d. *Conditions requiring treatment in a Hyperbaric Oxygen Unit;*
 - e. *Multiple severe injuries; or*
 - f. *Life-threatening trauma.*
2. *Time Needed for Land Transport. Differing Statewide Emergency Medical Services (EMS) system determine the amount and level of basic and advanced life support land transportation available. However, there are very limited emergency cases where land transportation is available but the time required to transport the patient by land as opposed to air endangers the beneficiary's life or health. As a general guideline, when it would take a land ambulance 30-60 minutes or more to transport an emergency patient, consider air transportation appropriate.*
3. *Appropriate Facility. -- It is required that the beneficiary be transported to the nearest hospital with appropriate facilities for treatment. The term " appropriate facilities" refers to units or components of a hospital that are capable of providing the required level and type of care for the patient's illness and that have available the type of physician specialist needed to treat the beneficiary's condition. In determining whether a particular hospital has appropriate facilities, take into account whether there are beds or a specialized treatment unit immediately available and whether the necessary physicians and other relevant medical personnel are available in the hospital at the time the patient is being transported. The fact that a more distant hospital is better equipped does not in and of itself warrant a finding that a closer hospital 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.*

4. *Hospital to Hospital Transport.* -- 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 services include burn units, cardiac care units, and trauma units. 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 his or her family prefers a specific hospital or physician.
5. *Special Coverage Rule.* -- 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.
6. *Special Payment Limitations.* --If a determination is made that transport by ambulance was necessary, but land ambulance service would have sufficed, payment for the air ambulance service is based on the amount payable for land transport, if less costly. If the air transport was medically appropriate (that is, land 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 he or she was transported, the air transport payment is limited to the rate for the distance from the point of pickup to that nearer hospital.
7. *Air mileage is based on loaded miles flown, as expressed in statute miles.*
8. *For air ambulance, the point of origin includes the beneficiary loading point and runway taxiing until the beneficiary is offloaded from the air ambulance.*
9. *Additional air mileage may be allowed in situations where additional mileage is incurred, due to circumstances beyond the pilot's control. These circumstances include but are not limited to, the following:*
 - a. *Military base and other restricted zones, air-defense zones, and similar FAA restrictions and prohibitions.*
 - b. *Hazardous weather.*
 - c. *Variations in departure patterns and clearance routes required by an air traffic controller.*
10. *Air ambulance transports canceled due to weather or other circumstances beyond the pilot's control.*
 - a. *There will not be any Medicare payment for an aborted flight any time before the beneficiary is loaded on board (i.e., prior to or after take-off to point-of-pick-up.)*
 - b. *If the flight is aborted after the beneficiary is loaded on board, the appropriate air base rate, mileage and rural adjustment will be made.*
11. *Air ambulance transportation of deceased beneficiary. 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).*

- a. *This is provided the air ambulance service would otherwise have been medically necessary.*
- b. *A pronouncement of death is effective only when made by an individual authorized under State law to make such pronouncements.*
- c. *The allowed amount is the appropriate air based rate, i.e. fixed wing or rotary wing.*
- d. *No amount shall be allowed for mileage or for a rural adjustment.*
- e. *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.*
- f. *Suppliers must use the modifier “QL” (Patient pronounced dead after ambulance called) to indicate the circumstances when an air ambulance takes off to pick up a beneficiary but the beneficiary pronounced dead before the pickup can be made.*
- g. *The supplier must submit documentation with the claim sufficient to show that:*
 - i. *The air ambulance was dispatched to pick up a Medicare beneficiary.*
 - ii. *The aircraft actually took off to make the pickup;*
 - iii. *The beneficiary to whom the dispatch relates was pronounced dead before being loaded onto the ambulance for transport.*
 - iv. *The pronouncement of death was made by an individual authorized by State law to make such pronouncements; and*
 - v. *The dispatcher did not receive notice of such pronouncement in sufficient time to permit the flight to be aborted before take off.*

P. BLS/ALS Joint Responses

- 1. *In situations where a BLS entity provides the transport of the beneficiary and an ALS entity provides a service that meets the fee schedule definition of an ALS intervention (e.g., ALS assessment), the BLS supplier may bill Medicare the ALS rate provided that a written agreement between the BLS and ALS entities exists.*
- 2. *Provider/suppliers must provide a copy of the agreement or other such evidence (e.g., signed attestation) as determined by their carrier upon request.*
- 3. *If there is no such agreement between the BLS supplier and the ALS entity furnishing the service, then only BLS level of payment may be made.*
- 4. *Under current policy, Medicare payment may be made for these services only when the ambulance provider (that is, actual transporting ambulance unit) submits the claim.*
- 5. *Payment rules for combined Basic Life Support (BLS) and Advanced Life Support (ALS) Services*
 - a. *With the exception of those circumstances in which a single episode of ambulance service is comprised of air and ground ambulance transportation, Medicare only recognizes one supplier per trip.*
 - b. *When a patient is transferred from a BLS vehicle to an ALS ambulance, the ALS service may be billed. However, only one supplier can submit a claim for the ambulance service.*

- c. *ALS service may be billed when the placement of ALS personnel and equipment on board a BLS vehicle qualifies the BLS vehicle as an ALS ambulance. Section 1861 (s)(7) of the Social Security Act provides coverage for ambulance services, which is defined in Medicare regulations as transportation by means of ambulance. Therefore, only the ambulance provider that transported the patient may bill Medicare.*
 - i. *This could occur when a BLS ambulance transports a Medicare patient to a rendezvous with an ALS ambulance and ALS personnel and equipment join the patient in the BLS ambulance for the rest of the trip to the hospital.*
 - ii. *This may also be the case when a BLS ambulance transports a Medicare patient to a rendezvous with a non-ambulance vehicle, which is staffed by ALS personnel and carries ALS equipment and ALS personnel and equipment join the patient in the BLS ambulance for the rest of the trip to the hospital.*

Q. More Than One Ambulance Arrives at the Scene

- 1. *The general Medicare program rule is that 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.*
- 2. *Ambulance providers/supplier that arrive on the scene but do not furnish a transport are not due payment from Medicare.*

Covered ICD-9 Codes:

N/A

Coding Guidelines

*As of April 2, 2007, suppliers are no longer permitted to submit paper claims on the CMS-1491 form.

A. General Claims Submission:

- *1. All claims must be submitted as assigned.
- *2. For paper claims processed after April 2, 2007, you may only use the CMS-1500 form.
- *3. The claim must state the conditions and/or symptom(s), which would indicate why a transport by cot is necessary, e.g. the patient's vital signs at the time of transport. List this information in Item 19 or Item 21 (CMS-1500) or HA0 record.
- 4. Use the appropriate HCPCS code plus the HCPCS origin/destination modifier.
- *5. The transporting supplier's name, complete address and provider number should be listed in Item 33 (CMS-1500).
- *6. The zip code for the origin must be in Item 23 (CMS-1500). If billing for multiple trips and the zip code for each origin is the same, services can be submitted on the same claim. If the zip codes are different, a separate claim must be submitted for each trip.

B. When submitting a claim for a payable ambulance transport to a facility that is not the nearest facility, include the following:

- 1. Name of the facility that was bypassed because services were not available there (electronically: this should be given following the reason for transport).

2. The specific service(s) or physician specialty that was not available at the nearest facility and what the patient needed (electronically: this should be entered in the reason for the transport).
3. The name, complete address, and type of facility where the transport started and ended.
4. The mileage of the trip.

C. When submitting a claim for payable hospital transfers include the following on the claim:

1. The diagnosis or condition, which requires hospitalization;
2. Any treatment needed enroute;
3. Specific services needed which are not available at the first hospital (electronically: this should be entered in the reason for transport);
4. Specify the physician specialty and/or staff/tests not available (electronically: this should be placed in the reason for transport);
- *5. The name and complete addresses of both hospitals and the date of discharge from the hospital must be kept on file and available upon request.

***D. Specialty Care Transport (SCT) - at a level of service beyond the scope of the EMT-Paramedic - HCPCS A0434**

- *1. Providers must submit the following required documentation when submitting the claim:
 - *a. The patient's condition that requires on-going care during transport
 - *b. The reason for the transport
 - *c. Specific treatment given to the patient en route
 - *d. The level of the health professional's training, beyond the scope of the EMT/Paramedic, who furnished the care. List training qualifications
 - *e. Credentials of trained personnel (e.g., RT, RN, MD)
 - *f. Please submit the documentation in the narrative record or on a run sheet.

***E. How to bill for BLS/ALS Joint Responses:**

1. The ambulance provider transporting the patient and arriving at the final destination must bill. The bill should be for the entire trip including the original point of pick up.
- *2. Indicate the service is a joint response. List this in Item 19 (CMS-1500) or narrative record for electronic claims (2410E/2310E/2420D)
- *3. List the name of the joint response Ambulance Company in Item 19 (CMS-1500) or narrative record for electronic claims (2410E/2310E/2420D).
 - *a. If the BLS provider bills, indicate the BLS provider name and number in Item 33 (CMS-1500) or the electronic equivalent; AND
 - *b. The ALS provider name - State if they are a Medicare Part A or Part B provider/supplier in Item 19 (CMS-1500) Electronically: place this after the reason for the transport.
 - b. Claims not verifying certification of the ambulance provider as a Medicare Part A or Part B provider will be assumed to be a Part B supplier.
4. The run sheets or documentation on the claim or in the narrative record should contain the following information:
 - a. Name of both ambulance companies. Both ambulance companies must be approved Medicare suppliers/providers.
 - b. Reason for the intercept. The documentation should clearly indicate why the services of an ALS vehicle were needed.
 - c. Treatment given and the patient's condition enroute. This should include information from both vehicles (BLS and ALS)

***F. When submitting claims when more than one patient is onboard:**

1. Use origin/destination modifiers in first positions.
2. Use modifier “-GM” to identify a multiple transport.
3. Submit documentation with the claim to specify the particulars of a multiple transport. The documentation must include the total number of patients transported in the vehicle at the same time and the health insurance claim numbers for each Medicare beneficiary.
4. Submit the charge applicable to the appropriate service rendered to each beneficiary and the total mileage for each trip.
5. Submit all associated Medicare claims for that multiple transport within a reasonable number of days of submitting the first claim.

***History**

Final Rule as published in the *Federal Register* on January 25, 1999, Final Rule as published in the *Federal Register* on November 30, 2001, Final Rule as published in the *Federal Register* on February 27, 2002, 42 CFR §410.40, PM-AB-99-83/99-53, PM-AB-00-88/01-185, PM-AB-01-165, PM-AB-02-031, PM-B-02-060, PM-B-02-060.1, PM-AB-02-130, PM-AB-02-131, PM-AB-03-007. MCM 2120.3, MCM 2120.4, MCM 4168.4, MCM 4210.5, MCM 4210.7, MCM 5116.3. MCM-3-REV-1796, 05/16/2003. CMS Manual System Pub. 100-2 Medicare Benefit Policy, *Transmittal 1144, CR 5390, December 29, 2006, *Transmittal 68 CR 5533, March 30, 2007, Transmittal 14 CR 3225, May 28, 2004. CMS Manual System Pub 100-2, Chapter 10 and Pub. 100-4, Chapter 15. Identical Letter C05/B2120, Identical Letter C05/B5116, CORR-02-10-600. Formerly WI policies: AMB-001, AMB-005, AMB-006, AMB-007, AMB-009, AMB-010, AMB-015, AMB-016, AMB-017, AMB-018, AMB-019, AMB-020, AMB-021, AMB-027. Formerly IL/MI policies: AMB-006, AMB-007, AMB-009, Formerly MN policy: AMB-99-11. Merge 08/01/2002.

***Dates and Revision History:**

Wisconsin, Illinois, Michigan, and Minnesota

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Revision Date & #: *05/01/2007, eleven, Revised SCT definition from hospital-to-hospital to "interfacility," Removed CMS-1491 claim form. 01/01/2006, ten, Revised-Ambulance Fee Schedule, HCPCS; Removed-Billing Methods, Q3019 and Q3020; Removed Coding Guidelines-Rhythm ECG, Waiting time, Oxygen, Extra Attendant, Drugs. 10/01/2004, nine (Revised Coding Guidelines, I) and added Life Pack EKG to supply list, 07/01/2004, eight (New/Revised §K. Destination), 02/01/2004, seven (removed G0240/G0241 and instructions relating to use), 09/01/2003, six (Revised Coding Guidelines, General A.6.) 07/01/2003, five (New/Revised §K. Destination; New §L. Skilled Nursing Facility Consolidated Billing - Clarification of Ambulance Services; New §M. Distinguishing Between Part A and Part B Ambulance Services; New Coding Guidelines [A.7.] Round trip ambulance trips must be billed on separate claims.) Revision Date & #: 03/01/2003, four, (New-Beneficiary Signature Requirements; New-Resident and Non-Resident Billing; New-§G. Transport of Persons Other Than Beneficiary; Revised-§J. Pronouncement of Death; Revised §N. Physician Certification Statement; Revised §O. Ground to Air Transports; Revised-§P. Air Ambulance; New §S. More than One Ambulance Arrives at the Scene.) 12/01/2002, three (Revise and clarify

More Than One Patient Onboard, Point of pick-up.) 11/01/2002, two, (New-Jurisdiction; Revised-§D. Mileage; Deleted-§E. Levels of Ambulance Service, New-§D. Definitions of Ambulance Services; New-§G. No Transport; New-§H. More Than One Patient Onboard; New-§N. Ground to Air; Revised-§O. Air Ambulance; Revised-§P. ALS/BLS). 09/01/2002, one (Corrected Effective Date)

Comments

Italicized text is wording of Centers for Medicare & Medicaid Service (CMS). This text is published from CMS documentation and is subject to the CMS implementation date.

Asterisked (*) text indicates changes made since the last publication date.

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