Introduction:

The Medicare Ambulance benefit is defined in Title XVIII of the Social Security Act. For Ambulance services to be covered it must be both medically necessary and reasonable.

Medical necessity is established when the patient's condition is such that the use of any other method of transportation is contraindicated. If some other means of transportation was available without endangering the health of the patient, then no payment can be made for ambulance services.

Claim tip: When submitting a claim for payment, it is advisable to provide information on the claim the patient's need to be transported by ambulance versus other forms of transportation.

The Medicare Ambulance benefit is a transportation benefit, and without a transport there is no payable service.

Ambulance services are separately reimbursable only under Part B. Once the patient is admitted if an Ambulance is used to transport the patient for specialized care, this service is considered part of the inpatient claim.

http://www.cms.gov/Center/Provider-Type/Ambulances-Services-Center.html

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Coverage criteria:

In addition to the Medical Necessity criteria described above in the Introduction of this document, the following coverage criteria must be met before a claim can be considered for processing.

Vehicle and Crew Requirements:

1. Any vehicle that is designated as an Ambulance is required to be designed and equipped to respond to medical emergencies and, in non-emergency situations, can transport beneficiaries with acute medical conditions.

2. The vehicle must comply with all State and local laws that govern the licensing and certification of the emergency vehicle.

3. The vehicle must contain a stretcher, linens, emergency medical supplies, oxygen equipment, and other lifesaving emergency medical equipment. The vehicle must have emergency warning lights, sirens, and telecommunications equipment as required by State and local laws.

4. The Ambulance must have customary patient care equipment and first aid supplies that include backboards and splinting supplies.

These are all considered part of the general ambulance service and payment for them is included in the payment rate for the transport.

Billing guidelines:

Independent ambulance suppliers may bill on CMS-1500 Form or the ANSI X12N 837P data set. These claims are processed using the Multi-Carrier System (MCS).

Institutional based ambulance providers may bill on CMS-1450/UB04 Form or the ANSI X 12N 837I. These claims are processed using the Fiscal Intermediary Shared System (FISS).

The Ambulance fee schedule has the following HCPCS coding logic:

- Seven categories of ground ambulance services
- Payment based on the condition of the patient, not the type of vehicle used
- Payment is determined by the point of pick up (reported on the claim by the 5-digit ZIP code)
- Increased payment for rural services
- Services and supplies included in base rate

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Modifiers specific to ambulance billing process:

Origin and Destination Modifiers

Any combination of these modifiers can be used to designate the point of pick up and the point of drop off for the patient transport.

The modifier combination is placed in box 24D of the CMS-1450 form (i.e., **RH** would interpret to the pickup point being the patient residence **(R)** and the drop off being the hospital **(H)**).

Modifier	Description
D	Diagnosis or therapeutic site other than P or H when these are used as origin codes
E	Residential, domiciliary, custodial facility (other than 1819 facility)
G	Hospital based ESRD facility
H	Hospital
I	Site of transfer (airport or helicopter pad) between modes of ambulance transport
J	Freestanding ESRD facility
N	Skilled nursing facility
P	Physician's Office
R	Residence
S	Scene of accident or acute event
X	Intermediate stop at physician's office on way to hospital (destination code only)

The modifiers below only apply to institutional providers. The modifiers must be reported with each HCPCS code to describe if the service was provided under contract arrangement or owned/in-house service:

Modifier	Description
QM	Ambulance service provided under arrangement by a provider of services
QN	Ambulance service furnished directly by a provider of services

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When both the Origin and Destination are Ambulance Providers:

The table below indicates the criterion and payment for ambulance services if both providers (i.e.; hospitals, CAH or SNF) are the same for origin and destination:

Criterion	Payment
Criterion 1: National Provider Identifier (NPI)	If the NPIs of the two providers are **different**: • The ambulance transport is separately billable If the NPIs of both providers are the **same**: • Follow criterion 2 that applies to Campus
Criterion 2: Campus*	If the campuses of the two providers **that share** the same NPI are the same: • The transport is not separately billable; and • The provider seeks payment If the campuses of the two providers are **different**: • See Criterion 3 that applies to Beneficiary Status – Inpatient vs Outpatient
Criterion 3: Beneficiary Status – Inpatient vs Outpatient	If the beneficiary is an inpatient at both providers (inpatient status at both the origin and the destination and the providers share the same NPI but are located on different campuses): • The transport is not separately billable; • The provider seeks payment; and • All other combinations (outpatient-to-inpatient, inpatient to outpatient, and outpatient-to-outpatient) are separately billable If the point of origin is not a provider: • The transport is not covered under Part A because the beneficiary is not an inpatient of any Part A provider at the time of transport; and • Ambulance transports are excluded from the 3-day preadmission payment window

*Campus is 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 to be part of the provider's campus by the CMS Regional Office.

The combinations of these items may duplicate other HCPCS modifiers, when billing with an ambulance transportation code the reported modifiers can only indicate origin/destination.

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Place of service codes that apply to ambulance transports

- Ambulance – Land is reported using code 41.
- Ambulance –Air or water is reported using code 42.

Below are the HCPCS codes and definitions that are utilized for ambulance services, which can be found in the Calculator tab of the PARA Data Editor (PDE):

Select | Charge Quote | Charge Process | Claim/RA | Contracts | Pricing Data | Pricing | Rx / Supplies | Filters | CDM | Calculator | Advisor | Admin | RAC | CAT | PARA

Report Selection | 2013 Hospital Based HCPCS/CPT® Codes

2013 Hospital Based HCPCS/CPT - All Codes

Codes and/or Descriptions: **a042,a043** for selected Provider: **Regional Hospital (990001)**
Results Returned (below): 15
AWI: **1.2282**, DME: **CA**, Clinical Lab Fee Schedule: **CA1**, Physician Fee Schedule: **REST OF CALIFORNIA***
Check/Select codes and right click on page to auto-filter CDM Summary, Pricing Data Reports, or Refresh the HCPCS Query, with selected codes
Fullscreen popup window | Physician Supervision Definitions | Export to PDF | Export to Excel | Copy to Clipboard

HCPCS/CPT®	Status	Fee Schedule APC	Weight Payment Nat. Copay Min.Copay	Rev Codes OPPS	CCI Edit LCD/NCD	OCE QTY MUE - Units Of Service
A0420 - AMBULANCE WAITING TIME (ALS OR BLS), ONE HALF (1/2) HOUR INCREMENTS	A			0540	NO YES	0
A0422 - AMBULANCE (ALS OR BLS) OXYGEN AND OXYGEN SUPPLIES, LIFE SUSTAINING SITUATION	A			0540	NO YES	0
A0424 - EXTRA AMBULANCE ATTENDANT, GROUND (ALS OR BLS) OR AIR (FIXED OR ROTARY WINGED); (REQUIRES MEDICAL REVIEW)	A			0540	NO YES	0
A0425 - GROUND MILEAGE, PER STATUTE MILE	A			0540	NO YES	0
A0426 - AMBULANCE SERVICE, ADVANCED LIFE SUPPORT, NON-EMERGENCY TRANSPORT, LEVEL 1 (ALS 1)	A			0540	NO YES	0
A0427 - AMBULANCE SERVICE, ADVANCED LIFE SUPPORT, EMERGENCY TRANSPORT, LEVEL 1 (ALS1-EMERGENCY)	A			0540	NO YES	0
A0428 - AMBULANCE SERVICE, BASIC LIFE SUPPORT, NON-EMERGENCY TRANSPORT, (BLS)	A			0540	NO YES	0
A0429 - AMBULANCE SERVICE, BASIC LIFE SUPPORT, EMERGENCY TRANSPORT (BLS-EMERGENCY)	A			0540	NO YES	0
A0430 - AMBULANCE SERVICE, CONVENTIONAL AIR SERVICES, TRANSPORT, ONE WAY (FIXED WING)	A			0540	NO YES	0
A0431 - AMBULANCE SERVICE, CONVENTIONAL AIR SERVICES, TRANSPORT, ONE WAY (ROTARY WING)	A			0540	NO YES	0
A0432 - PARAMEDIC INTERCEPT (PI), RURAL AREA, TRANSPORT FURNISHED BY A VOLUNTEER AMBULANCE COMPANY WHICH IS PROHIBITED BY STATE LAW FROM BILLING THIRD PARTY PAYERS	A			0540	NO YES	0
A0433 - ADVANCED LIFE SUPPORT, LEVEL 2 (ALS 2)	A			0540	NO YES	0
A0434 - SPECIALTY CARE TRANSPORT (SCT)	A			0540	NO YES	0
A0435 - FIXED WING AIR MILEAGE, PER STATUTE MILE	A			0540	NO YES	0
A0436 - ROTARY WING AIR MILEAGE, PER STATUTE MILE	A			0540	NO YES	0

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Below is additional Detail on the codes:

HCPCS Code	Description
A0425	BLS mileage (per mile)
A0425	ALS mileage (per mile)
A0426	Ambulance service, Advanced Life Support (ALS), non-emergency transport, Level 1 **(see below definition for further information) **
A0427	Ambulance service, ALS, emergency transport, Level 1 **(see below definition for further information) **
A0428	Ambulance service, Basic Life Support (BLS), non-emergency transport **(see below definition for further information) **
A0429	Ambulance service, basic life support (BLS), emergency transport **(see below definition for further information) **
A0430	Ambulance service, conventional air services, transport, one way, fixed wing (FW)
A0431	Ambulance service, conventional air services, transport, one way, rotary wing (RW)
A0432	Paramedic ALS intercept (PI), rural area transport furnished by a volunteer ambulance company, which is prohibited by state law from billing third party payers. **(see below definition for further information) **
A0433	Ambulance service, advanced life support, level 2 (ALS2) **(see below definition for further information) **
A0434	Ambulance service, specialty care transport (SCT) **(see below definition for further information) **

****PI, ALS2, SCT, FW and RW assume an emergency condition and do not require an emergency designator to be reported on the claim.**

Covered categories for ground ambulance services:

There are seven categories of ground ambulance services. The definition of "ground" equates to both land and water transportation. As a reminder, medical necessity must be met for Medicare to reimburse for the services.

1. **Ambulance service, BLS, non-emergency transport, all inclusive (A0428)**

   Basic Life Support (BLS) Non-emergency is transportation by a ground ambulance vehicle and the provision of medically necessary supplies and services. The ambulance must be staffed by an individual who is qualified in accordance with State and local laws as an emergency medical

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technician-basic (EMT-basic). These laws may vary from State or within a State. **It is recommended providers check their State and local laws to assure compliance. In some jurisdictions is an EMT-basic allowed to operate limited equipment on board the ambulance, assist more qualified personnel in performing critical assessments and interventions, such as starting an IV line.**

2. **Ambulance service BLS, emergency transport, all inclusive (A0429)**

   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. **Ambulance service, ALS1, non-emergency transport, Level 1 (A0426)**

   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 <u>or</u> 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.

   The determination to respond emergently with an ALS ambulance must be in accordance 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 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.

   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**) <u>or</u> **EMT-Paramedic**.

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EMT-Intermediate is an individual who is qualified, in accordance with State and local laws, as an EMT-Basic and who is also certified in accordance with State and local laws to perform essential advanced techniques and to administer a limited number of medications.

EMT-Paramedic possesses the qualifications of the EMT-Intermediate and, in accordance with State and local laws, has enhanced skills that include being able to administer additional interventions and medications.

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

4. **Ambulance service ALS1 Emergency Transports Level 1 (A0427)**

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. **Ambulance service ALS2 Advanced Life Support Level 2 (A0433)**

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/cardio version;
B. Endotracheal intubation**
C. Central venous line;
D. Cardiac pacing;
E. Chest decompression;
F. Surgical airway
G. Intraosseous line insertion

****The monitoring and maintenance of an endotracheal tube that was previously inserted prior to the transport also qualifies as an ALS2 procedure.**

The determination to respond emergently with an ALS ambulance must be in accordance 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

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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 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.

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

Emergency response is a BLS or ALS1 level of service that has been provided in immediate response to a 911 call or the equivalent. An immediate response is one in which the ambulance provider/supplier begins as quickly as possible to take the steps necessary to respond to the call.

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.

PARA has inserted a table at the end of this document that will reference Medical Conditions associated with BLS and ALS services.

6. **Specialty Care Transport (A0434)**

SCT is a hospital to hospital transport of a critically injured or ill patient by a ground ambulance vehicle at a level of service beyond the scope of the EMT-Paramedic. SCT is necessary when a patient's condition requires ongoing care that must be furnished by one or more health professionals in a specialty care area.

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7. **Paramedic Intercept (PI), rural area transport furnished by a volunteer ambulance company, which is prohibited by state law from billing third party payers. (A0432)**

   Paramedic Intercept services are considered ALS services provided by an entity that does not provide the ambulance transport**. Currently New York is the only state where these services are covered.**

Patient condition codes

This information is reported on a claim and is used to determine the medical appropriateness of ambulance services and the level of services utilized in the transport. This information can be reported in item 22 on CMS 1491 and in item 21 on CMS 1500.

The patient condition code list **(inserted at the end of this document for reference)** is a tool that is only intended to assist ambulance providers to best describe the patient condition to the dispatch center as observed by rescue personnel. Use of this list only assists in describing the medical condition of the patient, **it does not guarantee claim payment or payment for a certain level of service.**

As with all medical entities, ambulance providers are required to document all dispatch instructions, patient's condition, on-scene information, and details of the transport (i.e., medications administered, any changes in the patient condition en-route and miles traveled), all of which are subject to review by the Medicare contractor or any other oversight authority.

Important claim information below:

When a call for service is received at an Ambulance dispatch center and the condition necessitates the skilled assessment of ALS paramedic (based on the medical conditions list) then an ALS level ambulance should be dispatched to the scene. If on arrival, the actual patient condition corresponds to a BLS level situation, the claim would require two (2) separate condition codes from the medical condition list to be processed correctly. The first code would correspond to the "reason for transport" or the "on scene condition of patient" (ALS). Because this code corresponds to a BLS condition, a second code would correspond to the dispatch information to support the payment at the ALS level.

In addition to reporting the diagnosis related to the **Medical Conditions Code List** that best describes the patient condition and the medical necessity for the transport, one of the transport indicators should

be listed. **This indicator will define why it was necessary to transport the patient in this specific level ALS/BLS. This indicator should also be reported in the "narrative" or "remarks" section of the claim.**

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Transport Indicators:

Indicators	Descriptors
C1	Inter-facility transport (higher level of care) determined necessary by the originating facility based on EMTALA regulations and guidelines. **This indicator can be used by Air or Ground transport.**
C2	Transport from one facility to another because the patient requires services not available to treat patient. The services that are not available to treat the patient should be included in the "remarks" on the claim. **This indicator can be used by Air or Ground transport.**
C3	This indicator may be used on claims as a secondary code where a response was made to a **major incident** or mechanism of injury. This indicator is intended to indicate the highest level of service available response was medically justified. Use of this indicator indicates the types of patients found are appropriate for ALS response. **This indicator can be used by Air or Ground transport.**
C4	Ambulance response was medically necessary but the miles reported on the claim were excessive. This indicator should be used only if a facility is on divert status or a particular service is not available at the time of transport only. The provider may include this information in the "remarks" field on the claim. **This indicator can be used by Air or Ground transport.**
C5	This indicator is used in transport scenarios where a patient with an ALS level is encountered, treated and transported by a BLS level ambulance with no ALS level involvement at all. This scenario would occur when ALS resources are not available to respond to the patient, but the ambulance provider is indicating the patient was transported had an ALS level condition and the actual service was rendered by a BLS level ambulance**. When this indicator is present on a claim, the claim should be paid at a BLS level. This indicator is restricted to reporting on Ground transport only.**
C6	This indicator is used to report situations when an ALS level ambulance is always appropriate to dispatch based on medical dispatch protocols. If the crew arrives on the scene and the patient condition is a BLS level, this indicator should be reported on the claim to indicate the ALS level response was based on the operator's dispatch center information**. Claims reporting this indicator should include 2 primary codes – the first will indicate the BLS level corresponding to the patient condition found on scene and during transport. The second will indicate the ALS level condition that corresponds with the dispatch center information that indicated the need for the ALS response. This indicator is restricted to reporting on Ground transport only.**
C7	This indicator is used where IV medications were started en-route. This indictor is appropriate to use to report patients requiring ALS level transport in non-emergent situations because the patient condition requires monitoring of ongoing IV medications that have been administered. **This does not apply to self-administered medications. This does not apply to administration of crystalloid intravenous fluids (Normal Saline, Lactate Ringers, 5% Dextrose in Water). This indicator is restricted to reporting on Ground Transport only.**

Physician Certification Statement (PCS) Requirements

A physician certification statement (PCS) is a written order that certifies the medical necessity or need for the ambulance transport. This signed certification is not however a guarantee of claim payment for

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the transport. Non-emergency ambulance transports are categorized as scheduled and non-scheduled. A physician certification statement (PCS) is required for all. Included in these are:

- Non-emergency **repetitive** scheduled transports (the PCS must be signed by the patient's MD)
- Non-emergency, non-repetitive scheduled transports
- Certain non-emergency, non-scheduled ambulance services

A repetitive ambulance service is defined by CMS as a medically necessary transport that is furnished **three or more times during a 10-day period or at least once per week for at least 3 weeks.** An example of these transport types would be Dialysis and Respiratory Therapy patients. The requirement for submitting the PCS form for non-emergency repetitive, scheduled, ambulance services is based on the quantitative standard as described above.

- **Scheduled** is defined as transports that are arranged more than 24 hours prior to the transport
- **Non-scheduled** is defined as transports scheduled less than 24 hours in advance

It is important to note: Patients residing in a facility not under the active care of a physician or those beneficiaries residing at home would not require physician certification statements for non-emergency, non-scheduled ambulance services.

CMS does not require a particular form or format for the certification. Suppliers and physicians have the choice of developing their own certification form. The forms may be computer generated and contain computerized physician signatures as long as they both meet PCS requirements. Regardless, the written order must be completed by the attending Physician or any of the specific professionals on the list below:

- The patient's attending physician (MD or DO)
- Physician Assistant (PA)
- Nurse Practitioner (NP)
- Clinical Nurse Specialist (CNS)
- Register Nurse (RN)
- A discharge planner employed by the hospital or facility where the beneficiary is treated. The discharge planner must have knowledge of the beneficiary's condition at the time the transport was ordered or when the services were rendered.

The physician certification statement may include the expected length of time the ambulance transport would be required. The following chart describes when the certification is required.

Nature of Transport	PCS Required	Time Frame
Non-Emergency Repetitive Scheduled	Yes	No earlier than 60 days
Non-Emergency Non-Repetitive Scheduled	Yes	Within 48 hours
Non- Emergency Services –Non-Scheduled –Under direct care of a Physician	Yes	Within 48 hours
Non-Emergency Services – Non-Scheduled-not under direct care of a Physician	No	Not required

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ABN requirements for ambulance transports:

In making the determination if an ABN is required, the ambulance provider must first make a clinical decision to determine if the patient is not in a medical emergency or under similar duress. If the patient has either, then no ABN is given at the time of transport.
Next ambulance providers must take into consideration the three questions listed below and be able to answer “yes” to all three (3) of the questions. If the answer to all three is yes, then an ABN is required to be obtained prior to transport.

(1) Is this service a covered ambulance benefit? **AND**
(2) Will payment for part or all of this service be denied because it is not reasonable and medical necessary? **AND**
(3) Is the patient stable and is this transport non-emergent? (The patient is not showing any signs or symptoms of duress)

An ABN could be needed for the following reasons:

- ✓ A transport by air ambulance when the transporting agency believes the transport could have been done safely by ground ambulance
- ✓ A level of care downgrade, e.g. from ALS-2 to ALS-1 or ALS to BLS
- ✓ Transport from a residence to hospital for a service that can be performed within the home
- ✓ Transport of a skilled nursing resident to a hospital or another SNF for a service that can be performed within the first SNF

Medical Condition List:

Symptoms for BLS response -Emergency Non-Traumatic

- ✓ Abdominal Pain
- ✓ Allergic Reactions
- ✓ Cold Exposure
- ✓ Eye Symptoms, non- traumatic

- ✓ Heat Exposure
- ✓ Infectious diseases requiring Isolation procedures, public health risk
- ✓ Medical Device Failure
- ✓ Alcohol Intoxication or drug overdoses (suspected)
- ✓ Post-operative procedure complications
- ✓ Psychiatric/Behavioral
- ✓ Sick Person - fever

Symptoms for BLS response - Emergency Trauma

- ✓ Suspected facture/dislocation requiring splinting/immobilization for transport
- ✓ Penetrating extremity injuries
- ✓ Amputation - digits

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- ✓ Burns - minor per ABA
- ✓ Animal bites/stings/envenomation
- ✓ Eye injuries, acute vision loss or blurring, severe pain or chemical exposures, penetrating, severe lid lacerations
- ✓ Sexual Assault with minor or no injuries

Symptoms for BLS response - Non-Emergency

- ✓ Suctioning required en route, need for titrated O2 therapy or IV fluid management
- ✓ Airway control/positioning required en route
- ✓ Third party assistance/attendant required to apply, administer, or regulate or adjust oxygen en route
- ✓ Patient safety, danger to self or others, en route
- ✓ Patient safety, danger to self or others, monitoring
- ✓ Patient safety - Risk of falling off wheelchair or stretcher while in motion (not related to obesity)
- ✓ Special handling en route- isolation
- ✓ Special handling en route to reduce pain - orthopedic device
- ✓ Special handling en route - positioning requires specialized handling

Symptoms for ALS response -Emergency Non-Traumatic

- ✓ Severe abdominal pain, Nausea, vomiting, fainting, pulsatile mass, distention, rigid, tenderness on exam, guarding
- ✓ Abnormal cardiac rhythm/Cardiac dysrhythmia, potentially life-threatening, Bradycardia junctional and ventricular blocks, non-sinus tachycardia, PVC's >6, bi and trigemini, ventricular tachycardia, ventricular fibrillation, atrial flutter, PEA, asystole, AICD/AED fired
- ✓ Abnormal skin signs, Diaphoresis, cyanosis, delayed cap refill, poor turgor, mottled
- ✓ Abnormal vital signs with or without symptoms - this includes abnormal pulse oximetry
- ✓ Allergic reaction Potentially life threatening, rapid progression of symptoms, prior history of anaphylaxis, wheezing, difficulty swallowing
- ✓ Blood Glucose Abnormal <80 or >250, with symptoms - Altered mental status, vomiting, signs of dehydration
- ✓ Respiratory arrest -Apnea, hypoventilation requiring ventilator assistance and airway management
- ✓ Difficulty breathing
- ✓ Cardiac arrest - resuscitation in progress
- ✓ Chest pain (non-traumatic) Dull, Severe, crushing substernal, epigastric, left sided chest pain associated with pain of the jaw, left arm, neck, back, and nausea, vomiting, palpitations, pallor, diaphoresis, decreased LOC
- ✓ Chocking episode, airway obstructed or partially obstructed
- ✓ Cold exposure -potentially life or limb threatening, temperature <95F, deep frost bite, other emergency conditions
- ✓ Altered level of consciousness (non- traumatic) Acute condition with Glasgow Coma Scale <15
- ✓ Convulsions, seizures, seizing immediate post seizure, postictal or at risk or seizure and requires medical monitoring/observation
- ✓ Non-traumatic headache, with neurologic distress conditions or sudden severe onset

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- ✓ Cardiac Symptoms other than chest pain, palpitations, skipped beats
- ✓ Cardiac Symptoms other than chest pain, Persistent nausea and vomiting, weakness, hiccups, pleuritic pain, feeling of impending doom and other emergency conditions
- ✓ Heat exposure -Potentially life threatening -Hot and dry skin Temp 105, neurologic distress, signs of heat stroke or heat exhaustion, orthostatic vitals, other emergency conditions
- ✓ Hemorrhage - Severe (quantity) and potentially life threatening -Uncontrolled or significant signs of shock or other emergency conditions. Severe, active vaginal, rectal bleeding, hematemesis
- ✓ Hazmat exposure - Toxic fume or liquid exposure via inhalation, absorption, oral, radiation, smoke inhalation
- ✓ Medical device failure - Life or limb threatening malfunction, failure or complication-ventilator, internal pacemaker, internal defibrillator, implanted drug delivery system
- ✓ Neurologic distress - facial drooping, loss of vision, aphasia, difficulty swallowing, numbness, tingling extremity, stupor, delirium, confusion, hallucination, paralysis, paresis (focal weakness) abnormal movements, vertigo, unsteady gait or balance, slurred speech, unable to speak
- ✓ Pain, severe, acute onset, unable to ambulate or sit due to intensity of pain - pain is the reason for transport, use severity scale (7-10) or patient receiving pharmacologic intervention
- ✓ Back pain - non-traumatic (T/or LS)
- ✓ Poisons-ingested, injected, inhaled, absorbed
- ✓ Alcohol intoxication or drug overdose (suspected) Unable to care for self and unable to ambulate, no airway compromised
- ✓ Pregnancy complications, childbirth or Labor
- ✓ Psychiatric/Behavioral, abnormal mental status/drug withdrawal
- ✓ Severe dehydration - Nausea/vomiting/diarrhea, severe and incapacitating resulting in severe side effects of dehydration
- ✓ Unconscious, fainting, syncope or near syncope, weakness or dizziness, Transient unconscious episode or found unconscious, Acute episode or exacerbation

Symptoms for ALS response - Emergency Trauma

- ✓ Major Trauma - as defined by ACS Field Triage Decision Scheme
- ✓ Need to monitor or maintain airway; Decreased LOC, bleeding into airway, trauma to head, face or neck
- ✓ Major bleeding; uncontrolled or significant bleeding
- ✓ Amputation - all other
- ✓ Suspected internal head, chest or abdominal injuries, signs of closed or open head injury, pneumothorax, hemo-thorax, abdominal bruising, positive abdominal signs on exam, internal bleeding criteria, evisceration
- ✓ Major burns (per ABA) partial thickness burns >10% total body, surface area (TBSA) involving face, hands, feet, genitalia, perineum, or major joints, third degree burns, electrical, chemical, inhalation, burns with preexisting medical disorders; burns and trauma
- ✓ Animal bites, stings, envenomation, potentially life or limb threatening
- ✓ Lightning
- ✓ Electrocution
- ✓ Near drowning; Airway compromised during near drowning event
- ✓ Sexual assault with major injuries

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Symptoms for ALS response - Non-Emergency

- ✓ Cardiac/hemodynamic monitoring required en route, Expectation monitoring is needed before and after transport
- ✓ Advanced airway management; Ventilator dependent, apnea monitor, possible intubation needed deep suctioning
- ✓ Chemical restraint

Provider specific Medicare ambulance transports coverage and billing guidelines:

Acute Care Hospitals: The definition of an acute care hospital is a facility that provides acute hospital inpatient care to the beneficiary. A "hospital inpatient" is defined as a beneficiary who has been formally admitted to a hospital. It does not include a beneficiary who is in the process of being transferred from one hospital to another hospital.

Covered Transports	Billing Guidelines
Beneficiary is transported by ground ambulance to nearest hospital equipped to provide needed hospital or skilled nursing care on admission or discharge date or within occurrence span code 74 "From" and "Through" dates plus 1 day	Hospital bills MAC separately under Part B
Beneficiary who is inpatient of hospital is transported by ground ambulance to or from nearest appropriate Long Term Care Facility (LTCH), Inpatient Psychiatric Facility (IPF), or Inpatient Rehabilitation Facility (IRF) for specialized services that are not available at the first hospital. Inpatient status is maintained at first hospital.	First hospital bills MAC under Part A
Beneficiary who is inpatient of hospital or freestanding facility (such as a LTCH, IPF or IRF) is transported by ground ambulance to or from nearest appropriate hospital to receive specialized services that are not available at first hospital. Inpatient status is maintained at first hospital.	First hospital, LTCH, IPF or IRF bills MAC under appropriate Prospective Payment System (PPS)
Beneficiary who is inpatient of hospital is transported by ground ambulance to transfer him/her to nearest appropriate hospital equipped to provide needed hospital or skilled nursing services that are not available at first hospital. Beneficiary is admitted as an inpatient to the second hospital.	Second hospital or ambulance supplier bills MAC separately under Part B
Beneficiary under a home health plan of care (POC) is transported by ground ambulance to or from home to nearest appropriate hospital to obtain needed medical services that are not otherwise available. Place of origin requirements must be met.	HHA bills MAC separately under Part B
Beneficiary under a hospice POC is transported by ground ambulance to or from home to nearest appropriate hospital for services related to terminal illness and/or related conditions	Ambulance transports are included in hospice per diem payment. Ambulance transports related to the terminal illness or related conditions should be arranged by the hospice. Payment to ambulance supplier is the responsibility of the hospice.

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Provider specific Medicare ambulance transports coverage and billing guidelines (continued):

Covered Transports	Billing Guidelines
Beneficiary under hospice POC is transported by ground ambulance to or from home to nearest appropriate hospital for services that are not related to terminal illness and/or related conditions	Follow usual ambulance billing procedures as if the beneficiary is not under a hospice election
Beneficiary is transported by ground ambulance to hospital in connection with a covered foreign hospitalization	Hospital or beneficiary submits bill to MAC separately under Part B
Railroad Retirement beneficiary in Canada is transported by ground ambulance to hospital in connection with covered hospital services	Hospital bills Railroad Retirement Board separately under Part B
Beneficiary who is a SNF resident is transported by ground ambulance to or from nearest appropriate hospital for the following exceptionally intensive outpatient hospital services: • Cardiac Catheterization • Computerized axial tomography scans • Magnetic resonance imaging services • Ambulatory surgery that involves use of an operating room or comparable setting • Emergency services • Radiation therapy services • Angiography • Certain lymphatic and venous procedures	SNF or ambulance supplier bills MAC separately under Part B
Beneficiary who is a hospital inpatient is transported by air ambulance to transfer him/her to another hospital. The following requirements must be met: • A ground ambulance transport endangers the beneficiary's health • The first hospital does not have needed hospital or skilled nursing care for the beneficiary's illness or injury (such as burn care, cardiac care, trauma care and critical care) • The second hospital is the nearest appropriate facility	Second hospital or ambulance supplier bills MAC under Part A
Beneficiary is transported from the scene of an accident by air ambulance to acute care hospital	Ambulance supplier bills MAC under Part B
Non-Covered Transports for Acute Care Hospitals	
Transports that do not meet coverage guidelines discussed in the Coverage Requirements	
Transports in which some other means of transportation could be used without endangering the beneficiary's health, regardless of whether the other means or transportation are actually available	
Transports to a more distant hospital solely to avail the beneficiary of the services of a specific physician or physician specialist. Medicare will pay the base rate and mileage for a medically necessary ambulance transport to the nearest appropriate facility. If the transport is to a facility that is not the nearest appropriate facility, the beneficiary is only responsible for additional mileage to his/her preferred facility	
Transports from hospital in connection with a covered foreign hospitalization	

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Beneficiaries' Homes: The definition of home is where the beneficiary makes his/her home and dwells permanently. It does not include a hospital or other facility. The home must be:

- Within the locality of the institution. "Locality" is the service area surrounding the institution to which individuals normally travel or are expected to travel to receive hospital or skilled nursing services; or
- Outside the locality of the institution but in relation to the beneficiary's home, it is the nearest appropriate facility.

Covered Transports	Billing Guidelines
Beneficiary is transported by ground ambulance to or from and nearest appropriate hospital, CAH or SNF	See billing guidelines for hospitals, CAHs and SNFs
Beneficiary is transported by ground ambulance from home to SNF after being discharged as resident of SNF. He/she is re-admitted or returned to that or another SNF before midnight of the same day	SNF bills MAC under Part A. Ambulance supplier looks to SNF for payment
Beneficiary is transported by ground ambulance from home to SNF after being discharged as resident of SNF. He/she is returned to that or another SNF after day discharge from first SNF	Second SNF bills MAC separately under Part B
Beneficiary under home health plan of care (POC) is transported by ground ambulance to or from home to nearest appropriate hospital or SNF to obtain needed medical services that are not otherwise available. Place of origin requirements must be met.	HHA bills MAC separately under Part B
Beneficiary under a hospice POC is transported by ground ambulance to or from home to nearest appropriate hospital or CAH for services related to terminal illness and/or related conditions	Ambulance transports are included in hospice per diem payment. Ambulance transports related to the terminal illness or related conditions should be arranged by the hospice. Payment to ambulance supplier is the responsibility of the hospice
Beneficiary under a hospice POC is transported by ground ambulance to or from home to nearest appropriate hospital or CAH for services NOT related to terminal illness and/or related conditions	Follow usual ambulance billing procedures as if the beneficiary is not under a hospice election
Non-Covered Transports – Beneficiaries' Homes	
Transports that do not meet coverage guidelines discussed in the Coverage Requirements Section	
Transports in which some other means of transportation could be used without endangering the beneficiary's health, regardless of whether the other means or transportation are actually available	
Transports to a more distant hospital solely to avail the beneficiary of the services of a specific physician or physician specialist. Medicare will pay the base rate and mileage for a medically necessary ambulance transport to the nearest appropriate facility. If the transport is to a facility that is not the nearest appropriate facility, the beneficiary is only responsible for additional mileage to his/her preferred facility	
Air ambulance transports	

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ESRD Facilities: The definition of an ESRD facility (other than a hospital) provides dialysis treatment, maintenance, and/or training to beneficiaries with ESRD.

Covered Transports	Billing Guidelines
Beneficiary who is a SNF resident under SNF Prospective Payment System Consolidated Billing, has ESRD, and requires Part B dialysis services is transported by ground ambulance to or from nearest appropriate hospital-based or freestanding Renal Dialysis Facility in a non-emergency Basic Life Support level of service	SNF or ambulance supplier bills MAC separately under Part B
Beneficiary under a hospice plan of care (POC) is transported by ground ambulance to or from home to nearest appropriate ESRD facility for services related to terminal illness and/or related conditions	Ambulance transports are included in hospice per diem payment. Ambulance transports related to the terminal illness or related conditions should be arranged by the hospice. Payment to ambulance supplier is the responsibility of the hospice.
Beneficiary under a hospice plan of care (POC) is transported by ground ambulance to or from home to nearest appropriate ESRD facility for services that are NOT related to terminal illness and/or related conditions	Follow usual ambulance billing procedures as if the beneficiary is not under a hospice election.
Non-covered Transports	
Transports that do not meet coverage guidelines discussed in the Coverage Requirements Section	
Transports in which some other means of transportation could be used without endangering the beneficiary’s health, regardless of whether the other means or transportation are actually available	
Transports to a more distant hospital solely to avail the beneficiary of the services of a specific physician or physician specialist. Medicare will pay the base rate and mileage for a medically necessary ambulance transport to the nearest appropriate facility. If the transport is to a facility that is not the nearest appropriate facility, the beneficiary is only responsible for additional mileage to his/her preferred facility	
Air ambulance transports	

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Physicians' Office: The physicians' office is defined as a doctor of medicine or osteopathy, a doctor of dental surgery or dental medicine, a doctor of podiatry or surgical chiropody, a doctor of optometry or a chiropractor.

<table>
<tr><th>Covered Transports</th><th>Billing Guidelines</th></tr>
<tr><td>Beneficiary who is a SNF resident under SNF Prospective Payment System Consolidated Billing is transported by ground ambulance to physicians' office</td><td>SNF bills MAC under Part A, Ambulance supplier looks to the SNF for payment</td></tr>
<tr><td>Other ground ambulance transports to physicians' office only as follows:
• When transport is en route to a Medicare-covered destination;
• Ambulance stops because of beneficiary's dire need for professional attention, and
• Immediately thereafter, ambulance continues to covered destination.</td><td>Ambulance provider or supplier bills MAC separately under Part B</td></tr>
<tr><th colspan="2">Non-Covered Transports for Physicians' Offices</th></tr>
<tr><td colspan="2">Transports that do not meet coverage guidelines discussed in the Coverage Requirements Section</td></tr>
<tr><td colspan="2">Transports in which some other means of transportation could be used without endangering the beneficiary's health, regardless of whether the other means or transportation are actually available</td></tr>
<tr><td colspan="2">Transports to a more distant hospital solely to avail the beneficiary of the services of a specific physician or physician specialist. Medicare will pay the base rate and mileage for a medically necessary ambulance transport to the nearest appropriate facility. If the transport is to a facility that is not the nearest appropriate facility, the beneficiary is only responsible for additional mileage to his/her preferred facility</td></tr>
<tr><td colspan="2">Air ambulance transports</td></tr>
</table>

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SNFs: A SNF can be defined as a facility that primarily provides inpatient skilled nursing care and related services to residents who require medical, nursing or rehabilitative services.

Covered Transports Under SNF PPS/CB	Billing Guidelines
Beneficiary who is a SNF resident is transported by ground ambulance from one SNF to another SNF before midnight of the same day	SNF bills MAC under Part A, Ambulance supplier looks to SNF for payment
Beneficiary is transported by ground ambulance from home to SNF after being discharged as resident of SNF. He/she is re-admitted or returned to that or another SNF before midnight of the same day	SNF bills MAC under Part A, Ambulance supplier looks to SNF for payment
Beneficiary who is a SNF resident, has ESRD and requires Part B dialysis services is transported by ground ambulance to or from nearest appropriate hospital-based of free standing Renal Dialysis Facility as a non-emergency BLS level of service	SNF or ambulance supplier bills MAC separately under Part B
Beneficiary who is a SNF resident is transported by ground ambulance to a physician's office	SNF bills MAC under Part A, Ambulance supplier looks to SNF for payment
Beneficiary is transported by ground ambulance to SNF for initial admission or from SNF following final discharge, unless the resident is re-admitted or returns to that or another SNF before midnight of the same day	SNF or ambulance supplier bills MAC separately under Part B
Beneficiary who is a SNF resident is transported by ground ambulance to or from nearest appropriate hospital or CAH to obtain needed medical services that are not otherwise available	SNF or ambulance supplier bills MAC separately under Part B
Beneficiary who is a SNF resident is transported by ground ambulance to nearest appropriate Medicare-participating hospital or CAH to obtain needed medical services that are not otherwise available. Beneficiary is admitted as an inpatient to the hospital	SNF or ambulance supplier bills MAC separately under Part B
Beneficiary who is a SNF resident is transported by ground ambulance to and from nearest appropriate Ambulatory Surgical Center/non-hospital facility to obtain needed medical services that are not otherwise available	SNF or ambulance supplier bills MAC separately under Part B
Beneficiary who is a SNF resident, has ESRD, and requires Part B dialysis services is transported by ground ambulance to or from nearest appropriate hospital-based or free standing Renal Dialysis Facility in a non-emergency BLS level of service	SNF or ambulance supplier bills MAC separately under Part B
Beneficiary under a home health plan of care (POC) is transported by ground ambulance to or from SNF to home. Place of service requirements must be met	HHA bills MAC separately under Part B
Beneficiary under hospice POC is transported by ground ambulance to or from SNF to nearest appropriate hospital for services that are not related to terminal illness and/or related conditions	Follow usual ambulance billing procedures as if the beneficiary is not under a hospice election
Beneficiary who is a SNF resident is transported by ground ambulance to and from nearest appropriate hospital for the following exceptionally intensive outpatient hospital services: • Cardiac catheterization • Computerized axial tomography scans (CT) • Magnetic resonance imaging services (MRI)	SNF or ambulance supplier bills MAC separately under Part B

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- Ambulatory surgery that involves use of an operating room or comparable setting - Emergency services - Radiation therapy services - Angiography, and - Certain lymphatic and venous procedures	
Non-Covered Transports – SNFs	
Transports that do not meet coverage guidelines discussed in the Coverage Requirements	
Transports in which some other means of transportation could be used without endangering the beneficiary's health, regardless of whether the other means or transportation are actually available	
Transports to a more distant hospital solely to avail the beneficiary of the services of a specific physician or physician specialist. Medicare will pay the base rate and mileage for a medically necessary ambulance transport to the nearest appropriate facility. If the transport is to a facility that is not the nearest appropriate facility, the beneficiary is only responsible for additional mileage to his/her preferred facility	
Air ambulance transports	

The Ambulance Fee Schedule applies to all ambulance transports. The fee schedule amounts are Medicare allowed amounts for all transports meeting Medicare criteria and payments are represented as paid in full amounts. Ambulance suppliers can only bill or collect from Medicare beneficiaries any deductible or co-insurance amounts that are unmet under Part B.

The following are ground and air ambulance case scenarios that reference when a patient expires:

Ground Ambulance Payment When the Beneficiary Expires	
Time of Death Pronouncement	**Payment**
Before dispatch	None
After dispatch and before the beneficiary is loaded on board the ambulance (before or after arrival at the place of pick-up) POP	Your BLS base rate, and No mileage or rural adjustment, and Use modifier QL to indicate "Patient pronounced dead after ambulance called" on claim
After pickup and prior to or upon arrival at the receiving facility	Appropriate air base rate mileage, and rural adjustment, if applicable

Air Ambulance Payment When the Beneficiary Expires	
Time of Death Pronouncement	**Payment**
Before the beneficiary is loaded on board the ambulance: - The dispatcher receives the pronouncement of death and has reasonable opportunity to notify the pilot to abort the flight; and - The aircraft has taxied but has not taken off or at the controlled airport, the aircraft has been cleared for take-off but has not actually taken-off	None
After take-off to the POP and before the beneficiary is loaded on board the air ambulance	Appropriate air base rate with no mileage or rural adjustment, and Use QL modifier on the claim

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Air Ambulance Payment When the Beneficiary Expires (continued)

Air Ambulance Payment When the Beneficiary Expires	
Time of Death Pronouncement	**Payment**
After the beneficiary is loaded on board the air ambulance and before or upon arrival at the receiving facility	Appropriate air base rate, mileage, and rural adjustment, if applicable
Air Ambulance Aborted Flight Scenarios	
Aborted Flight Scenario	**Payment**
Before the beneficiary is loaded on board the air ambulance (prior to or after take-off to the POP	None
After the beneficiary is loaded on board the air ambulance	Appropriate air base rate, mileage and rural adjustment

References:

http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c15.pdf

Medicare Claims Processing Manual
Chapter 15 - Ambulance

Table of Contents
(Rev. 2620, 12-21-12)

Transmittals for Chapter 15

http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AmbulanceFeeSchedule/Ambulance-Services-Transmittals.html

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Ambulance Fee Schedule
- Ambulance Fee Schedule Public Use Files
- Ambulance Reasonable Charge Public Use Files
- Code of Federal Regulations
- AFS Regulations and Notices
- Ambulance Services Transmittals

Ambulance Services Transmittals

The list below shows the transmittals that are directed to the Ambulance provider community, but the list may not include all instructions for which Ambulance providers are responsible. For a list of all instructions, view the Transmittals web page under Regulations and Guidance.

Show entries: 10

Filter On:

CR #	Release Date	Subject	Article #
5394	2006-12-08	Instructions for Downloading the Medicare Zip Code File	N/A
5419	2006-12-22	Provider Migration	N/A

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