CMS Manual System

Pub. 100-02 Medicare Benefit Policy

Department of Health & Human Services (DHHS)
Centers for Medicare & Medicaid Services (CMS)

Transmittal 14 **Date: MAY 28, 2004**

CHANGE REQUEST 3225

I. SUMMARY OF CHANGES: Clarifications in portions of the ambulance benefit policy, Chapter 10 of the Medicare Benefit Policy Manual, including when payment for ambulance services is bundled into packaged prospective payment to hospitals, and when it is separately payable.

CLARIFICATION – EFFECTIVE DATE: April 1, 2002
IMPLEMENTATION DATE: July 1, 2004

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (*N/A if manual not updated.*)
(R = REVISED, N = NEW, D = DELETED – (*Only One Per Row.*)

R/N/D	CHAPTER/SECTION/SUBSECTION/TITLE
R	10/10.3/The Destination
R	10/10.3.2/Institution to Institution
R	10/10.3.3/Separately Payable Ambulance Transport Under Part B Versus Patient Transportation that is Covered Under a Packaged Institutional Service
R	10/10.3.4/ Transports to and from Medical Services for Beneficiaries who are not Inpatients
R	10/10.3.10/Multiple Patient Ambulance Transport

***III. FUNDING:**

These instructions shall be implemented within your current operating budget.

IV. ATTACHMENTS:

x	**Business Requirements**
x	**Manual Instruction**
	Confidential Requirements
	One-Time Notification
	Recurring Update Notification

***Medicare contractors only**

Attachment - Business Requirements

Pub. 100-02	Transmittal: 14	Date: May 28, 2004	Change Request 3225

SUBJECT: Changes in the Medicare Benefit Policy Manual—Chapter 10

I. GENERAL INFORMATION

The purpose of this Change Request is to make changes and clarifications to the ambulance policy section in Chapter 10 of the Medicare Benefit Policy Manual.

A. Background:

The Centers for Medicare and Medicaid Services (CMS) is responsible for the administration of the Medicare and Medicaid programs. CMS is required to provide accurate and consistent policy guidelines so that services may be rendered correctly and according to the law.

B. Policy:

Changes are made for informational clarification.

C. Provider Education:

None

II. BUSINESS REQUIREMENTS

“Shall" denotes a mandatory requirement
"Should" denotes an optional requirement

Requirement #	Requirements	Responsibility
3225.10.1	Medicare covers ambulance transports (that meet all other program requirements for coverage) only to the following destinations: • Hospital; • Critical Access Hospital (CAH); • Skilled Nursing Facility (SNF); • Beneficiary’s home; or • Dialysis facility for ESRD patient who requires dialysis. • 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. (See §10.3.7 below.) As a general rule, only **local** transportation by ambulance is covered and, therefore, only mileage to the nearest appropriate facility equipped to treat the patient is covered. However, if two or more facilities that meet the destination requirements can treat the patient appropriately and the locality (see §10.3.5 below) of each facility encompasses the place where the ambulance transportation of the patient began, then the full mileage to any one of the facilities to which the beneficiary is taken is covered. Because all duly licensed hospitals, and SNFs are presumed to be appropriate sources of health care, only in exceptional situations where the ambulance transportation originates beyond the locality of the institution to which the beneficiary was transported, may full payment for mileage be considered. And then, **only** if the evidence clearly establishes that the destination institution was the nearest one with appropriate facilities under the particular circumstances. (See §10.3.6 below.) The institution to which a patient is transported	Intermediaries and Local Part B Carrier

	need not be a participating institution but must meet at least the requirements of §1861(e)(1) or §1861(j)(1) of the Social Security Act (the Act). (See Medicare General Information, Eligibility, and Entitlement Manual, Chapter 5, "Definitions," for an explanation of these requirements.) See Claims Processing Manual, Chapter 15, "Ambulance," §20.9, for a description of multiple patient ambulance transport.	
3225.10.3.2	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 Section 10.3.3 below. 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.	Intermediaries and Local Part B Carrier
3225.10.3.3	Transportation of a beneficiary from his or her home, an accident scene, or any other point of origin is covered under Part B as an ambulance service only to the nearest hospital, critical access hospital (CAH), or skilled nursing facility (SNF) that is capable of furnishing the required level and type of care for the beneficiary's illness or injury, and only if medical necessity and other program coverage criteria are met. Medicare covered ambulance services are paid either as separately billed services, in which case the entity furnishing the ambulance service bills Part B of the program, or as a packaged service, in which case the entity furnishing the ambulance service must look to the provider who is responsible for the beneficiary's care. If either the origin or the destination of the ambulance transport is the beneficiary's home,	Intermediaries and Local Part B Carrier

	then the ambulance transport is paid separately by Medicare Part B and the entity that furnishes the ambulance transport may bill its Medicare carrier or intermediary directly. If both the origin and destination of the ambulance transport are providers, e.g., a hospital, critical access hospital (CAH), skilled nursing facility (SNF), then responsibility for payment for the ambulance transport is determined in accordance with the following sequential criteria. **NOTE:** These criteria must be applied in sequence as a flow chart and not independently of one another. 1. Provider Numbers: If the Medicare-assigned provider numbers of the two providers are different, then the ambulance service is separately billable to the program. If the provider number of both providers is the same, then consider criterion 2, "campus". 2. Campus: Following criterion 1, if the campuses of the two providers (sharing the same provider numbers) are the same, then the transport is not separately billable to the program. In this case the provider is responsible for payment. If the campuses of the two providers are different, then consider criterion 3, "patient status". "Campus" means the physical area immediately adjacent to the provider's main buildings, other areas and structures that are not strictly contiguous to the main buildings, but are located within 250 yards of the main buildings, and any of the other areas determined on an individual case basis by the CMS regional office, to be part of the provider's campus.	

	3. Patient Status: Inpatient vs. Outpatient Following criteria 1 and 2, if the patient is an inpatient at both providers (i.e., inpatient status both at the origin and at the destination, providers sharing the same provider number, but located on different campuses), then the transport is not separately billable. In this case the provider is responsible for payment. All other combinations (i.e., outpatient-to-inpatient, inpatient-to-outpatient, outpatient-to-outpatient) are separately billable to the program. In the case where the point of origin is not a provider, Part A coverage is not available because, at the time the beneficiary is being transported, the beneficiary is not an inpatient of any provider paid under Part A of the program and ambulance services are excluded from the 3-day preadmission payment window. The transfer, i.e., the discharge of a beneficiary from one provider with a subsequent admission to another provider, is also payable as a Part B ambulance transport, provided all program coverage criteria are met, because at the time that the beneficiary is in transit, the beneficiary is not a patient of either provider and not subject to either the inpatient preadmission payment window or outpatient payment packaging requirements. This includes outpatient transfers from a remote, off-campus emergency department (ER) to becoming patients at the main campus hospital, even if the ER is owned and operated by the hospital. Once a beneficiary is admitted to a hospital, CAH, or SNF, it may be necessary to transport the beneficiary to another hospital or other site temporarily for specialized care while the beneficiary maintains inpatient status with the original provider. This movement of the patient is considered "patient transportation" and is covered as an inpatient hospital or CAH	

	service, and as a SNF service when the SNF is furnishing it as a covered SNF service and payment is made under Part A for that service. (If the beneficiary is a resident of a SNF and must be transported by ambulance to receive dialysis or certain other high-end outpatient hospital services, the ambulance transport may be separately payable under Part B.) Because the service is covered and payable as a beneficiary transportation service under Part A, the service cannot be classified and paid for as an ambulance service under Part B. This includes intra-campus transfers between different departments of the same hospital, even where the departments are located in separate buildings. Such intra-campus transfers are not separately payable under the Part B ambulance benefit. Such costs are accounted for in the same manner as the costs of such a transfer within a single building.	
3225.10.3.4	Ambulance transports to and from a destination (i.e., two 1-way trips) furnished to a beneficiary who is not an inpatient of a provider for the purpose of obtaining covered medical services are covered, if all program requirements for coverage are met. In addition, coverage of ambulance transports to and from a destination under these circumstances is limited to those cases where the transportation of the patient is less costly than bringing the service to the patient. For frequent transports of this kind, additional information may be required supporting the need for ambulance services relative to the option of admission to a treatment facility.	Intermediaries and Local Part B Carrier

III. SUPPORTING INFORMATION AND POSSIBLE DESIGN CONSIDERATIONS

A. Other Instructions: N/A

X-Ref Requirement #	Instructions

B. Design Considerations: N\A

X-Ref Requirement #	Recommendation for Medicare System Requirements

C. Interfaces: N/A

D. Contractor Financial Reporting /Workload Impact: N/A

E. Dependencies: N/A

F. Testing Considerations: N/A

IV. SCHEDULE, CONTACTS, AND FUNDING

Effective Date: April 1, 2004 **Implementation Date:** July 1, 2004 **Pre-Implementation Contact(s):** Glenn McGuirk (410) 786-5723 **Post-Implementation Contact(s):** Glenn McGuirk (410) 786-5723	These instructions shall be implemented within your current operating budget.

Medicare Benefit Policy Manual

Chapter 10 - Ambulance Services

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(Rev. 14, 05-28-04)

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10.3 - The Destination

(Rev. 14, 05-28-04)

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

Medicare covers ambulance transports *(that meet all other program requirements for coverage)* only to the following destinations*:*

- Hospital*;*
- *Critical Access Hospital (*CAH*);*
- *Skilled Nursing Facility (*SNF*)*;
- Beneficiary's home; *or*
- Dialysis facility for ESRD patient who requires dialysis; or
- A physician's office is not a covered destination*. However,* under special circumstances an ambulance transport may temporarily stop at a physician's office without affecting the coverage status of the transport.

As a general rule, only **local** transportation by ambulance is covered*, and therefore, only mileage to the nearest appropriate facility equipped to treat the patient is covered. However, if two or more facilities that meet the destination requirements can treat the patient appropriately and the* locality (see §10.3.*5* below) *of each facility* encompasses the place where the ambulance transportation of the patient began*, then the full mileage to any one of the facilities to which the beneficiary is taken is covered*. *Because all duly licensed hospitals and SNFs are presumed to be appropriate sources of health care, only in* exceptional situations where the ambulance transportation originates beyond the locality of the institution to which the beneficiary was transported, *may* full payment *for mileage* be *considered. And then,* **only** if the evidence clearly establishes that *the destination* institution *was* the nearest one with appropriate facilities *under the particular circumstances*. (See §10.3.6 below.) The institution to which a patient is transported need not be a participating institution but must meet at least the requirements of §1861(e)(1) or §1861(j)(1) of the Social Security Act (the Act.) (See Medicare General Information, Eligibility, and Entitlement Manual, Chapter 5, "Definitions," for an explanation of these requirements.) See Claims Processing Manual, Chapter 15, "Ambulance," §20.9, for a description of multiple patient ambulance transport.

10.3.2 - Institution to Institution

(Rev. 14, 05-28-04)

A3-3114.C.2, HO-236.3.B

Occasionally, the institution to which the patient is initially taken is found to have inadequate *or unavailable* facilities to provide the required care, and the patient is then transported to a second institution having appropriate facilities. In such cases, transportation by ambulance to both institutions would be covered *to the extent of the mileage* to be the nearest *institution* with appropriate facilities. *Responsibility for payment would follow the rules in § 10.3.3.* In these cases, transportation from such second institution to the patient's home could be covered if the home is within the locality served by that institution, or the locality served by the first institution to which the patient was taken.\

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

(Rev. 14, 05-28-04)

Transportation of a beneficiary from his or her home, an accident scene, or any other point of origin is covered under Part B as an ambulance service only to the nearest hospital, critical access hospital (CAH), or skilled nursing facility (SNF) that is capable of furnishing the required level and type of care for the beneficiary's illness or injury and only if medical necessity and other program coverage criteria are met.

Medicare-covered ambulance services are paid either as separately billed services, in which case the entity furnishing the ambulance service bills Part B of the program, or as a packaged service, in which case the entity furnishing the ambulance service must look to the provider who is responsible for the beneficiary's care. If either the origin or the destination of the ambulance transport is the beneficiary's home, then the ambulance transport is paid separately by Medicare Part B, and the entity that furnishes the ambulance transport may bill its Medicare carrier or intermediary directly. If both the origin and destination of the ambulance transport are providers, e.g., a hospital, critical access hospital (CAH), skilled nursing facility (SNF), then responsibility for payment for the ambulance transport is determined in accordance with the following sequential criteria.

***NOTE**: These criteria must be applied in sequence as a flow chart and not independently of one another.*

1. *Provider Numbers:*

   If the Medicare-assigned provider numbers of the two providers are different, then the ambulance service is separately billable to the program. If the provider number of both providers is the same, then consider criterion 2, "campus".

2. *Campus:*

   Following criterion 1, if the campuses of the two providers (sharing the same provider numbers) are the same, then the transport is not separately billable to the program. In this case the provider is responsible for payment. If the campuses of the two providers are different, then consider criterion 3, "patient status." "Campus" means the physical area immediately adjacent to the provider's main buildings, other areas and structures that are not strictly contiguous to the main buildings, but are located within 250 yards of the main buildings, and any of the other areas determined on an individual case basis by the CMS regional office to be part of the provider's campus.

3. *Patient Status: Inpatient vs. Outpatient*

   Following criteria 1 and 2, if the patient is an inpatient at both providers (i.e., inpatient status both at the origin and at the destination, providers sharing the same provider number but located on different campuses), then the transport is not separately billable. In this case the provider is responsible for payment. All other combinations (i.e., outpatient-to-inpatient, inpatient-to-outpatient, outpatient-to-outpatient) are separately billable to the program.

In the case where the point of origin is not a provider, Part A coverage is not available because, at the time the beneficiary is being transported, the beneficiary is not an inpatient of any provider paid under Part A of the program and ambulance services are excluded from the 3-day preadmission payment window.

The transfer, i.e., the discharge of a beneficiary from one provider with a subsequent admission to another provider, is also *payable* as a Part B ambulance transport, provided all program coverage criteria are met, because, at the time that the beneficiary is in transit, the beneficiary is not a patient of either provider and not subject to either the inpatient preadmission payment window or outpatient payment packaging requirements. This includes *an* outpatient transfer from a remote, off-campus emergency department (ER) to becoming *an inpatient or outpatient* at the main campus hospital, even if the ER is owned and operated by the hospital.

Once a beneficiary is admitted to a hospital, CAH, or SNF, it may be necessary to transport the beneficiary to another hospital or other site temporarily for specialized care while the beneficiary maintains inpatient status with the original provider. This movement of the patient is considered "patient transportation" and is covered as an inpatient hospital or CAH service and as a SNF service when the SNF is furnishing it as a covered SNF service and payment is made under Part A for that service. (If the beneficiary is a resident of a SNF and must be transported by ambulance to receive dialysis or certain other high-end outpatient hospital services, the ambulance transport may be separately payable under Part B.) Because the service is covered and payable as a beneficiary transportation service under Part A, the service cannot be classified and paid for as an ambulance service under Part B. This includes intra-campus transfers

between different departments of the same hospital, even where the departments are located in separate buildings. Such intra-campus transfers are not separately payable under the Part B ambulance benefit. Such costs are accounted for in the same manner as the costs of such a transfer within a single building.

10.3.4 – *Transports to and from Medical* Services *for Beneficiaries who are not Inpatients*

(Rev. 14, 05-28-04)

A3-3114.C.3, HO-236.3.C, AB-00-127, B3-2120.3C

Ambulance transports to and from a covered destination (i.e., two 1-way trips) furnished to a beneficiary who is not an inpatient of a provider for the purpose of obtaining covered medical services are covered*, if all program requirements for coverage are met*.

In addition, coverage of ambulance *transports to and from a destination under these circumstances* is limited to those cases where the transportation of the patient is less costly than bringing the service to the patient. *For frequent transports of this kind subject to the contractor's discretion, additional information may be required supporting the need for ambulance services relative to the option of admission to a treatment facility.*

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

10.3.*10*- Multiple Patient Ambulance Transport

(Rev. 14, 05-28-04)

Effective April 1, 2002, if two patients are transported to the same destination simultaneously, for each Medicare beneficiary, Medicare will allow 75 percent of the payment allowance for the base rate applicable to the level of care furnished to that beneficiary plus 50 percent of the total mileage payment allowance for the entire trip. If three or more patients are transported to the same destination simultaneously, then the payment allowance for the Medicare beneficiary (or each of them) is equal to 60 percent of the base rate applicable to the level of care furnished to the beneficiary. However, a single payment allowance for mileage will be prorated by the number of patients onboard.

This policy applies to both ground and air transports.

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