Program Memorandum Carriers

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

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CHANGE REQUEST 1945

SUBJECT: Payment Policy When More Than One Patient Is Onboard An Ambulance

Scope

This Program Memorandum (PM) for carriers states the payment policy and claims processing instructions for ambulance services when multiple patients are transported simultaneously in the same ambulance.

Background

The final regulation to establish an ambulance fee schedule contained an additional provision that clarified the payment policy for pricing a single ambulance vehicle transport of a Medicare beneficiary where more than one patient is onboard the ambulance.

1. When more than one patient is transported in an ambulance, the Medicare allowed charge for each beneficiary is a percentage of the allowed charge for a single beneficiary transport (the "allowed charge" for a single beneficiary transport is the lower of the submitted charge and the fee schedule amount for the service – which, during the fee schedule transition period, is a blended amount.) The applicable percentage is based on the total number of patients transported, including both Medicare beneficiaries and non-Medicare patients.

2. This policy applies to both ground and air transports. For purposes of this PM, the term "ground transport" includes transports by water ambulance.

3. If two patients are transported at the same time in one ambulance to the same destination, the adjusted payment allowance for each Medicare beneficiary would equal 75 percent of the single-patient allowed amount applicable to the level of service furnished a beneficiary, plus 50 percent of the total mileage payment allowance for the entire trip.

   If three or more patients are transported at the same time in one ambulance to the same destination, 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 plus a proportional mileage allowed amount, i.e., the total mileage allowed amount divided by the number of all the patients onboard.

4. 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.

5. 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 transport, 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, carriers should assume 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 pick-up 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.

6. 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.

Implementation

1. Carriers must accept and instruct their suppliers to use modifier "GM" to identify a multiple transport.
2. Require suppliers to submit documentation 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.
3. Require suppliers to submit the charge applicable to the appropriate service rendered to each beneficiary and the total mileage for the trip.
4. Require suppliers to submit all associated Medicare claims for that multiple transport within a reasonable number of days of submitting the first claim.
5. If there is only one Medicare beneficiary in the multiple patient transport, process the claims using the necessary information from the supplier's documentation.
6. If more than one Medicare beneficiary is transported in a multiple patient transport, then the carrier must associate all ambulance claims for Medicare beneficiaries for the one transport.
7. The carrier must process the claims and apply the correct percentages to the allowed amount applicable to the level of service furnished and mileage.

    a. When two patients are transported, for each beneficiary:

    i) Allow 75 percent of the allowed amount for a single-person transport (excluding separately billable mileage).

    ii) For mileage to a single destination, allow half of the total mileage.

iii) For mileage for both emergency ground transports and all air transports to multiple destinations, the allowed amount for the first leg is the amount for the mileage divided by 2. The allowed amount for the second leg is the full mileage. Thus, payment on behalf of a beneficiary whose transport is to the first nearest appropriate facility is based on half the mileage amount to that facility, whereas payment on behalf of the second beneficiary, whose transport was to the next nearest appropriate facility, would be based on half of the mileage to the first facility plus all of the mileage from the first facility to the second facility.

iv) For mileage for non-emergency ground transports, allow only the mileage from the point of pickup to the nearest appropriate facility and then divide that amount by the number of beneficiaries loaded on board at the point 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.

b. When three or more patients are transported, for each beneficiary:

i) Allow 60 percent of the allowed amount for a single-person transport (excluding separately billable mileage).

ii) For mileage to a single destination, allow a pro rata share of the total mileage.

iii) For mileage for both emergency ground transports and all air transports to multiple destinations, the allowed amount for each leg of the transport is a pro rata share of the total mileage based on the number of patients on board upon arrival at each destination.

iv) For mileage for non-emergency ground transports, the allowed amount for each beneficiary is based on the mileage to the nearest appropriate facility divided by the number of beneficiaries loaded on board at the point of pick-up (including any intermediate points of pickup). Do not take into account any mileage other than the mileage that would be incurred from transporting each beneficiary directly from the point of pick-up to the nearest appropriate facility.

8. Use the appropriate message to indicate that there is a reduction. Use message codes M16 and N45.

Provider Education

Inform your suppliers about this policy in the next scheduled newsletter; repeat annually.

Update your Web site upon receipt of this PM or at the time they would update for this implementation date.

The *effective date* for this PM is April 1, 2002.

The *implementation date* for this PM is October 30, 2002.

These instructions should be implemented within your current operating budget.

This PM may be discarded after April 1, 2003.

If you have any questions concerning the payment policy, contact your CMS regional office.