Program Memorandum
Intermediaries/Carriers

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

Transmittal AB-03-007 **Date: JANUARY 24, 2003**

CHANGE REQUEST 2470

SUBJECT: Second Clarification of Medicare Policy Regarding the Implementation of the Ambulance Fee Schedule

A. Scope

This Program Memorandum (PM) is the second set of instructions to provide additional guidance on issues related to the implementation of the ambulance fee schedule.

B. Background

During the implementation of the ambulance fee schedule, issues concerning the interpretation of Medicare policy have arisen which require clarification. This PM provides additional guidance on these issues, and supplements previously issued instructions regarding the implementation of the ambulance fee schedule.

C. Policy

The following clarifications, organized by category, reflect Medicare's policy regarding the implementation of the ambulance fee schedule. If they have not already done so, intermediaries and carriers must implement these policies as specified in this PM.

D. Business Requirements

1. Issues Addressed in this PM:

    a. Change in Medicare Policy Concerning Bed-Confinement;
    b. Mandatory Assignment Rules;
    c. Claims Jurisdiction for Air Ambulance Suppliers During the Transition Period;
    d. Payment for Services Performed Under Standing Orders;
    e. Transport of Persons Other than the Beneficiary;
    f. Effect of Beneficiary Death on Medicare Payment for Ground and Air Ambulance Transports;
    g. Payment for Air Ambulance Transports Canceled Due to Weather or Other Circumstance Beyond the Pilot's Control;
    h. Payment when More than One Ambulance Arrives at the Scene;
    i. Billing for Ground-to-Air Ambulance Transports;
    j. Resident and Non-Resident Billing;
    k. Reasonable Charge Amount for Mileage During the Transition Period; and
    l. Physician Certification Statement (PCS) Requirements.

2. Policy Clarifications

    a. Change in Medicare Policy Concerning Bed-Confinement

    The final rule published in the **Federal Register** on February 27, 2002 (67 FR 9100) supersedes earlier Medicare policy on the issue of bed-confinement. The preamble of the final rule states that the beneficiary is bed-confined if he/she is: unable to get up from bed without assistance; unable to ambulate; and unable to sit in a chair or wheelchair. As defined in the preamble, the term "bed confined" is not synonymous with "bed rest" or "nonambulatory." Medicare's

current policy is that bed-confinement, by itself, is neither sufficient nor is it necessary to determine the coverage for Medicare ambulance benefits. It is simply one element of the beneficiary's condition that may be taken into account in the intermediary's/carrier's determination. Therefore, the current regulations (42 CFR §410.40(d)) provide that a Medicare ambulance transport may only be payable if other forms of transportation are contraindicated by the beneficiary's condition. This policy is effective with the implementation of the Medicare Fee Schedule on April 1, 2002.

b. Mandatory Assignment Rules

i. *Mandatory Assignment and Claim Submittal Requirements*

When an ambulance provider/supplier, or a third party under contract with the provider/supplier, furnishes a Medicare-covered ambulance service to a Medicare beneficiary and the service is not statutorily excluded under the particular circumstances, the provider/supplier must submit a claim to Medicare and accept assignment of the beneficiary's right to payment from Medicare.

ii. *Mandatory Assignment for Managed Care Providers/Suppliers*

Mandatory assignment for ambulance services, in effect with the implementation of the ambulance fee schedule on April 1, 2002, applies to ambulance providers/suppliers under managed care as well as under fee-for-service. (The ambulance fee schedule is effective for claims with a date of service on or after April 1, 2002.) During the fee schedule transition period, Medicare payment for ambulance services is a blend of the reasonable cost/charge and fee schedule amount (80 percent reasonable cost/charge amount, and 20 percent fee schedule amount for services furnished in 2002).

Per 42 CFR §422.214, any provider or supplier without a contract establishing payment amounts for services provided to a beneficiary enrolled in a Medicare + Choice (M+C) coordinated care plan or M+C private fee-for-service plan must accept, as payment in full, the amounts that they could collect if the beneficiary were enrolled in original Medicare. The provider or supplier can collect from the M+C plan enrollee the cost-sharing amount required under the M+C plan, and collect the remainder from the M+C organization.

iii. *Mandatory Assignment and 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 his/her 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 the ambulance items and services furnished. If, after seeing this bill, the beneficiary/representative decides to have Medicare pay for these items and services, then a beneficiary/representative signature is required and the ambulance provider/supplier must afford the beneficiary/representative this option within the claims filing period.

c. Claims Jurisdiction for Air Ambulance Suppliers During the Transition Period

During the transition period, air ambulance suppliers must continue to submit claims to the carrier that has jurisdiction for the locality in which its air ambulance is based (i.e., garaged or hangared), per MCM §§3102.C.1 and 2. Payment of a claim during the transition period is determined in part by the reasonable charge amount established in the carrier jurisdiction where the ambulance is based (i.e., garaged or hangared) and in part by the fee schedule amount in the jurisdiction of the point-of-pickup, as represented by its zip code.

For suppliers that provide services in multiple states, no additional enrollment is necessary for claims submission until the end of the transition period unless the supplier has established a base in another state. (Only if the supplier has established a base/hangar in another state, must it then also enroll with the carrier for the other state.) The carrier with jurisdiction for the claim has the supplier's reasonable charge amount and also the fee schedule amounts for all states in which the ambulance supplier provides services to determine the blended payment.

d. Payment for Services Performed Under Standing Orders

Under the Medicare Ambulance Fee Schedule, payment for the transport includes payment for all medically necessary services and supplies. However, during the transition period, a supplier that had previously billed separately for medically necessary services may continue to do so. In situations where a supplier provides a service under a standing order (e.g., a standing order for performing a rhythm strip, placing oxygen, and starting an intravenous line when an Advanced Life Support [ALS] ambulance is called), Medicare payment for such a service depends on whether it is medically necessary.

Under Medicare rules, whether a particular separately-billable service is medically necessary is dependent on the particular circumstances of the beneficiary's condition at the time of the transport. For the purpose of Medicare payment, services furnished pursuant to a standing order requiring that something be done regardless of the patient's needs are not recognized as being medically necessary on the basis of such an order. Services furnished by licensed personnel based on recognition of patient need and authorized by standing order, such as in an algorithm, or that are consistent with EMT protocols established in that state, can be paid for, provided the services are reasonable and necessary based on the patient's condition at the time they are furnished.

e. Transport of Persons Other than the Beneficiary

Medicare payment policy remains unchanged with respect to the transport of persons other than the beneficiary. That is, no payment may be made for the transport of ambulance staff or other personnel when the beneficiary is not onboard the ambulance (e.g., an ambulance transport to pick up a specialty care unit from one hospital to provide services to a beneficiary at another hospital). This policy applies to both ground and air ambulance transports.

f. Effect of Beneficiary Death on Medicare Payment for Ground and Air Ambulance Transports

Because the Medicare ambulance benefit is a transport benefit, if no transport of a Medicare beneficiary occurs, then there is no Medicare-covered service. In general, if the beneficiary dies before being transported, then no Medicare payment may be made. Thus, in a situation where the beneficiary dies, whether any payment under the Medicare ambulance benefit may be made depends on the time at which the beneficiary is pronounced dead by an individual authorized by the State to make such pronouncements.

The chart below shows the Medicare payment determination for various ground ambulance scenarios in which the beneficiary dies. In each case, the assumption is that the ambulance transport would have otherwise been medically necessary.

Ground Ambulance Scenarios: Beneficiary Death	
Time of Death Pronouncement	**Medicare Payment Determination**
Before dispatch.	None.
After dispatch, before beneficiary is loaded onboard ambulance (before or after arrival at the point-of-pickup).	The provider's/supplier's BLS base rate, no mileage or rural adjustment; use the QL modifier when submitting the claim.
After pickup, prior to or upon arrival at the receiving facility.	Medically necessary level of service furnished.

The chart below shows the Medicare payment determination for various air ambulance scenarios in which the beneficiary dies. In each case, the assumption is that the ambulance transport would have otherwise been medically necessary. If the flight is aborted for other reasons, such as bad weather, the Medicare payment determination is based on whether the beneficiary was onboard the air ambulance. (See item g. below.)

Air Ambulance Scenarios: Beneficiary Death	
Time of Death Pronouncement	**Medicare Payment Determination**
Prior to takeoff to point-of-pickup with notice to dispatcher and time to abort the flight.	None. **NOTE:** This scenario includes situations in which the air ambulance has taxied to the runway, and/or has been cleared for takeoff, but has not actually taken off.)
After takeoff to point-of-pickup, but before the beneficiary is loaded.	Appropriate air base rate with no mileage or rural adjustment; use the QL modifier when submitting the claim.
After the beneficiary is loaded onboard, but prior to or upon arrival at the receiving facility.	As if the beneficiary had not died.

g. Payment for Air Ambulance Transports Canceled Due to Weather or Other Circumstance Beyond the Pilot's Control

The chart below shows the Medicare payment determination for various air ambulance scenarios in which the flight is aborted due to bad weather, or other circumstance beyond the pilot's control.

Air Ambulance Scenarios: Aborted Flights	
Aborted Flight Scenario	**Medicare Payment Determination**
Any time before the beneficiary is loaded onboard (i.e., prior to or after take-off to point-of-pickup.)	None.
Transport after the beneficiary is loaded onboard.	Appropriate air base rate, mileage, and rural adjustment.

h. Payment When More than One Ambulance Arrives at the Scene

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. Ambulance providers/suppliers that arrive on the scene but do not furnish a transport are not due payment from Medicare.

i. Billing for Ground-to-Air Ambulance Transports

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. Each provider/supplier must submit a claim for its respective services/mileage to the intermediary/carrier that has jurisdiction for the locality in which its ambulance is based. (See item c. above.)

j. Resident and Non-Resident Billing

The ambulance fee schedule has no effect on Medicare's longstanding policy concerning resident versus non-resident billing. In areas that distinguish between residents and nonresidents, 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.

k. Reasonable Charge Amount for ALS Mileage During the Transition Period

During the transition period, the HCPCS ground mileage code A0425 reasonable charge amount for the blended payment is calculated using a simple average (not a weighted average) of the 2001 reasonable charge allowances for HCPCS codes A0380 and A0390, updated by the Ambulance Inflation Factor. (HCPCS codes A0380 and A0390 are invalid for dates of service on or after April 1, 2002).

If a supplier has established a customary charge for only ALS mileage or only BLS mileage, then that customary charge, subject to the inflation indexed charge (IIC) rules, is used to establish the supplier-specific customary charge amount for the reasonable charge portion of the blended payment for A0425 during the transition period. However, the program's payment allowance for the reasonable charge portion of the blended transition rate for A0425 is based on the lower of the supplier's customary charge (subject to the IIC rules), the prevailing charge, or the prevailing IIC. Therefore, the payment allowance under the reasonable charge portion of the blended payment for A0425 during the transition period will not exceed the prevailing charge or prevailing IIC that includes both BLS mileage and ALS mileage charge data for the locality in which the charge data was accumulated. The program's payment allowance

for A0425 is then based on the lower of the blended rate and the actual charge on the claim.

l. Physician Certification Statement (PCS) Requirements

The current regulations governing PCS requirements are specified at 42 CFR §410.40(d). A PCS is required for the following ambulance services:

- Nonemergency, scheduled, repetitive ambulance services; and
- Unscheduled, nonemergency ambulance services or nonemergency ambulance services scheduled on a nonrepetitive basis for a resident of a facility who is under the care of a physician.

NOTE: For nonemergency, scheduled, repetitive ambulance services, the physician's order must be dated no earlier than 60 days before the date that the service is furnished.

A PCS is not required for the following ambulance services:

- Emergency; and
- Nonemergency, unscheduled ambulance services for a beneficiary who, at the time of the transport, was residing either at home or in a facility and who was not under the direct care of a physician.

If unable to obtain the physician's signature, it is acceptable to obtain a signed certification statement from the physician assistant, nurse practitioner, registered nurse, clinical nurse specialist (where all applicable State licensure or certification requirements are met), or discharge planner, who has personal knowledge of the beneficiary's condition at the time that the ambulance transport is ordered or the service is furnished. This individual must be employed by the beneficiary's attending physician or by the hospital or facility where the beneficiary is being treated and from which the beneficiary is transported. (See the Medicare Ambulance Fee Schedule Final Rule published in the **Federal Register** on February 27, 2002.)

For nonemergency ambulance services that are either unscheduled or that are scheduled on a nonrepetitive basis, providers/suppliers must obtain a written order from the beneficiary's attending physician, within 48 hours after the transport, per 42 CFR §410.40(d)(3). If unable to obtain a written order from the attending physician within 48 hours, providers/suppliers may submit a claim for the service if a PCS or certification from an acceptable alternative person as described in 42 CFR §410.40(d)(3)(iii) has been obtained, or after 21 days if acceptable documentation of attempts to obtain the certification has been obtained. This policy also applies in a situation where a provider/supplier responds to a nonemergency call and, upon arrival at the point-of-pickup, the condition of the beneficiary requires emergency care. (**NOTE:** Although the condition of the beneficiary in this scenario would require the provider/supplier to concentrate on the emergent treatment of the patient upon arrival at the scene, the claim for this service would not qualify as an "emergency transport," as defined in program memorandum AB-02-130.)

When a PCS cannot be obtained in accordance with §410.40(d)(3)(iv), a provider/supplier may send a letter via U.S. Postal Service (USPS) Certified Mail with a return receipt proof of mailing or other similar commercial service demonstrating delivery of the letter as evidence of the attempt to obtain the PCS.

Until the 2002 compilation of Title 42 of the CFR is published (it is updated each October 1st and usually becomes available in January of the following

year), intermediaries and carriers should consult the final rule published in the **Federal Register** on February 27, 2002 for additional guidance on PCS requirements. (See 67 **Federal Register** 9100.)

F. Provider Education

Notify providers and suppliers of these policy clarifications in your next scheduled newsletter and update your Web site with this information within two weeks of receipt of this PM.

The *effective date* for this PM is January 24, 2003.

The *implementation date* for this PM is February 24, 2003.

These instructions should be implemented within your current operating budget.

This PM may be discarded after December 31, 2003.

Contact the appropriate regional office for additional guidance.