

# Medicare Benefit Policy Manual

## Chapter 10 - Ambulance Services

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*(Rev. 130, 07-29-10)*

*(Rev. 133, 10-22-10)*

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## **10 - Ambulance Service**

**(Rev. 1, 10-01-03)**

**B3-2120, A3-3114, HO-236**

Ambulance services are separately payable only under Part B. There are certain circumstances in which the service is covered and payable as a beneficiary transportation service under Part A; however in this case the service cannot be classified and paid for as an ambulance service under Part B. (See §10.3.3 for a description of this exception. Also see §10.2.4 for the required documentation for ambulance services.)

Payment may be made for expenses incurred for ambulance service provided the conditions specified in the following subsections are met. (See the Medicare Claims Processing Manual, Chapter 15, "Ambulance," for instructions for processing ambulance service claims.)

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.

### **10.1 - Vehicle and Crew Requirement**

**(Rev. 1, 10-01-03)**

**B3-2120.1, A3-3114, HO-236.1**

#### **10.1.1 - The Vehicle**

**(Rev. 1, 10-01-03)**

**B3-2120.1.A, A3-3114.A, HO-236.1.A**

Any vehicle used as an ambulance must be designed and equipped to respond to medical emergencies and, in nonemergency situations, be capable of transporting beneficiaries with acute medical conditions. The vehicle must comply with State or local laws governing the licensing and certification of an emergency medical transportation vehicle. At a minimum, the ambulance must contain a stretcher, linens, emergency medical supplies, oxygen equipment, and other lifesaving emergency medical equipment and be equipped with emergency warning lights, sirens, and telecommunications equipment as required by State or local law. This should include, at a minimum, one 2-way voice radio or wireless telephone.

#### **10.1.2 - Vehicle Requirements for Basic Life Support and Advanced Life Support**

**(Rev. 1, 10-01-03)**

**A3-3114, B3-2120.1, HO-236.1**

Basic Life Support ambulances must be staffed by at least two people, at least one of whom must be certified as an emergency medical technician (EMT) by the State or local authority where the services are being furnished and be legally authorized to operate all

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 Hospital Service**

(Rev. 103; Issued: 02-20-09; Effective Date: 01-05-09; Implementation Date: 03-20-09)

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 seek payment from 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.

### **10.3.5 - Locality**

**(Rev. 1, 10-01-03)**

**A3-3114.C.5, HO-236.3.E, B3-2120.3.E**

The term "locality" with respect to ambulance service means the service area surrounding the institution to which individuals normally travel or are expected to travel to receive hospital or skilled nursing services.

**EXAMPLE:** Mr. A becomes ill at home and requires ambulance service to the hospital. The small community in which he lives has a 35-bed hospital. Two large metropolitan hospitals are located some distance from Mr. A's community and both regularly provide hospital services to the community's residents. The community is within the "locality" of both metropolitan hospitals and direct ambulance service to either of these (as well as to the local community hospital) is covered.

### **10.3.6 - Appropriate Facilities**

**(Rev. 1, 10-01-03)**

**A3-3114.C.6, HO-236.3.F**

The term "appropriate facilities" means that the institution is generally equipped to provide the needed hospital or skilled nursing care for the illness or injury involved. In the case of a hospital, it also means that a physician or a physician specialist is available to provide the necessary care required to treat the patient's condition. However, the fact that a particular physician does or does not have staff privileges in a hospital is not a consideration in determining whether the hospital has appropriate facilities. Thus, ambulance service to a more distant hospital solely to avail a patient of the service of a specific physician or physician specialist does not make the hospital in which the physician has staff privileges the nearest hospital with appropriate facilities.

The fact that a more distant institution is better equipped, either qualitatively or quantitatively, to care for the patient does not warrant a finding that a closer institution does not have "appropriate facilities." Such a finding is warranted, however, if the

-----Original Message-----

From: bwerfel@aol.com [mailto:bwerfel@aol.com]

Sent: Monday, April 21, 2014 12:13 PM

To: Matt Zavadsky

Subject: Re: RE: PGP Universal Secured Message

Matt,

The rule is that you are not permitted a payment under Part B if payment for the ambulance service has been made, directly or indirectly, under Part A. The hospital controls when a patient is admitted as an inpatient. Therefore, if the situation involves a free-standing ED operated by and affiliated with the main hospital system, the hospital's actions vis-a-vis admitting the patient determines whether your transport occurs at the time the patient was deemed an outpatient (separately payable by Part B) vs. an inpatient (payable by the hospital).

In other words, the key is that the hospital essentially has an option on whether it wants to take payment responsibility or not. If it does not want to take payment responsibility, then it must forebear admitting the patient as an inpatient until after the patient arrives at the main hospital campus. This was discussed on a recent ambulance open door forum with Medicare; however, to my knowledge, there is nothing in writing confirming this, other than the basic rule set out in the Medicare manual.

Best regards.

Brian

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On Sunday April 20, 2014 at 6:01 PM, Matt Zavadsky <mzavadsky@medstar911.org> wrote:

It seems we sought your counsel on a Part A, Part B billing question from one of our hospital systems. We presented the information about avoiding the Part A bill by NOT admitting the patient to the facility with the same NPI number, but instead doing as an interfacility transfer for higher level of care....

The compliance specialists at the hospital system are looking for additional explanation, and perhaps some documentation? We provided them the Medicare Manual covering ambulance services.

Thanks,

Matt