Program Memorandum
Intermediaries/Carriers

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

Transmittal AB-03-106 **Date: JULY 25, 2003**

CHANGE REQUEST 2770

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

NOTE: This Program Memorandum (PM) is a reminder of current Medicare policy regarding the Ambulance Fee Schedule, which was implemented on April 1, 2002. It is not intended to replace previously issued instructions and does not encompass all issues that have been addressed to date.

I. GENERAL INFORMATION

A. Background:

This PM is the third set of instructions to provide additional guidance on issues related to the implementation of the Ambulance Fee Schedule.

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.

B. 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.

1. Issues Addressed in this PM:

    a. Ambulance Fee Schedule Appeals
    b. Inherent Reasonable (IR) Adjustments
    c. Supplier Requests to Change Billing Methods During the Transition Period
    d. Advance Beneficiary Notice (ABN) Requirements
    e. Physician Certification Statement (PCS) Requirements
    f. Billing for Air Mileage
    g. Unsuccessful Advanced Life Support (ALS) Interventions
    h. ALS Assessment and Definition of "Emergency"
    i. Mandated ALS Response
    j. Intra-facility Transports
    k. Physician Services Provided During an Ambulance Transport
    l. Billing the Beneficiary for Non-covered Services

2. Policy Clarifications

    a. <u>Ambulance Fee Schedule Appeals</u>

    The ambulance final rule published on February 27, 2002, established a fee schedule for the payment of ambulance services under the Medicare program, thereby implementing §1834(l) of the Social Security Act. The Ambulance Fee Schedule is effective for claims with dates of service on or after April 1, 2002. The final rule established a 5-year transition period, during which time payment will be based on a blended amount, based in part on the Ambulance Fee Schedule and in part on reasonable cost or reasonable charge, as

applicable. In accordance with §1834(l)(5) of the Social Security Act and 42 CFR §414.625, ambulance providers/suppliers may not appeal the fee schedule amounts.

b. Inherent Reasonable (IR) Adjustments

The final rule implementing inherent reasonable (IR) adjustments to Medicare payment allowances was published in the **Federal Register** on December 13, 2002 (67 FR 76684). The criteria for applying IR, specified in the final rule, includes a threshold of 15 percent that must be met before IR adjustments may be made. That is, if a payment allowance is determined to be either deficient or excessive by an amount that is less than 15 percent, then no IR adjustment may be made. Prospective payment systems, including the Ambulance Fee Schedule, are exempt from IR. Therefore, IR applies only to the reasonable charge portion of the blended payment for ambulance services during the transition period.

The CMS has not yet developed contractor processes for applying IR. Until these processes are in place, contractors may not make any IR adjustments. Therefore, carriers that receive requests for IR adjustments to the reasonable charge portion of the blended payment for ambulance services may not make any such adjustments until CMS issues further guidance on how to implement IR. Carriers that receive requests for IR adjustments to the Ambulance Fee Schedule portion of the blended payment must deny any such requests.

c. Supplier Requests to Change Billing Methods During the Transition Period

A previous PM instructed Medicare carriers to ensure that all suppliers elect a single billing method by March 31, 2002. In the absence of any election, carriers were required to convert suppliers using multiple billing methods to billing Method 2. During the transition period, April 1, 2002 through December 31, 2005, a supplier may not change its billing method. Carriers must deny any such requests from a supplier. Effective with the full implementation of the Ambulance Fee Schedule beginning January 1, 2006, all ambulance suppliers will be converted to billing Method 2.

d. Advance Beneficiary Notice (ABN) Requirements

i. ABN Requirements for Non-Emergency Transports

The ABN (form CMS-R-131) is a written notice a physician or provider/supplier gives to a Medicare beneficiary before items or services are furnished when the physician or provider/supplier believes that Medicare probably or certainly will not pay for some or all of the items or services on the basis of certain Medicare statutory exclusions. See PM AB-02-168 and AB-02-114 for more information concerning ABN and beneficiary limitation of liability issues.

An ABN is rarely used for ambulance services, and may only be issued for non-emergency transports. An ABN may not be used when a beneficiary is under great duress. A beneficiary is considered to be under great duress when his or her medical condition requires emergency care. Intermediaries and carriers should use the following guidelines to determine when it is appropriate for an ambulance provider/supplier to issue an ABN for ambulance services.

An ABN may be needed and may be used for *non-emergency* transports in the following situations:

a. A transport by air ambulance when the transporting entity has a reasonable basis to believe that the transport can be done safely and effectively by ground ambulance transportation.

b. A level of care downgrade, e.g., from ALS-2 to ALS-1, or from ALS to Basic Life Support (BLS), when the transport at the lower level of care is a covered transport.

An ABN is not needed, and should not be used, in the following situations:

a. Any denial where the patient could be transported safely by other means (these are denials under §1861(s)(7) of the Social Security Act (the Act)).

b. Any denial that is based on not meeting an origin or destination requirement (these denials are based on 42 CFR 410.40 and generally also constitute §1861(s)(7) denials).

c. A denial for mileage that is beyond the nearest appropriate facility (for the same reason as "b" above).

d. A denial where the PCS or accepted alternative (e.g., certified mail) is not obtained (for the same reason as "b" above).

e. A convenience discharge, e.g., where the patient is an inpatient at one hospital that can care for their needs, but wants to be transferred to a second hospital to be closer to family (for the same reason as "b" above).

The Notice of Exclusions from Medicare Benefits (NEMB, form CMS-20007) is an optional form that CMS developed to assist suppliers and providers in informing beneficiaries that the services they are receiving are excluded from Medicare benefits. When an ABN is not appropriate to use because medical necessity is not the basis for the expected denial, an NEMB may be used. Ambulance providers/suppliers may develop their own process to communicate to beneficiaries that they will be billed for excluded services, for which the ABN is not appropriate.

The NEMB form CMS-20007 is available in English and Spanish online and can be accessed at the CMS Beneficiary Notices Initiative webpage at http://www.cms.hhs.gov/medicare/bni/.

In the case of the denials listed above for which an ABN is not appropriate, on the NEMB, check Box #1 and write the relevant reason in the "Medicare will not pay for" space (above check Box #1), for example: "ambulance transports that do not meet an origin or destination requirement" or "ambulance transports where the patient could be transported safely by other means" or "personal convenience transports."

The following table summarizes situations when an ABN is applicable regarding ambulance services:

Situation	Statutory Provision	ABN Applicable	Limitation On Liability Applicable	Responsible for Payment
Other means of transportation not contraindicated	1861(s)(7) - Benefit Category	NO. An NEMB may be used.	NO	BENEFICIARY
Air to Ground Downcoding	1862(a)(1)(A) Reasonable & Necessary	YES **	YES	SUPPLIER/PROVIDER or BENEFICIARY if ABN is signed
ALS to BLS Downcoding	1862(a)(1)(A) Reasonable & Necessary	YES**	YES	SUPPLIER/PROVIDER or BENEFICIARY if ABN is signed
Mileage Partial Denial	1861(s)(7) - Benefit Category	NO. An NEMB may be used.	NO	BENEFICIARY

**Indicates that an ABN is applicable. However, if it is an emergency transport, ABNs cannot be used*, since beneficiaries are considered under great duress in such situations. (See PM-AB-02-168, section I.2.B.2.).*

ii. ABN Requirements for International Flights

Absent the rare circumstance of coverage of an ambulance service under §1814(f) of the Act, services outside the United States furnished to a Medicare beneficiary are statutorily excluded from Medicare coverage under §1862(a)(4) of the Act. Thus, when the point of pickup is outside the United States, including a point of pickup outside of the U.S. territories, then the transport from the point of pickup to the nearest U.S. point of entry is statutorily excluded. The use of an ABN is not indicated but the beneficiary should be informed that Medicare will not pay for the international portion of the flight. An NEMB may be used, in which case, on the NEMB, check Box #2 and the sixth box in the left column ("Health care received outside of the USA") and write the relevant reason in the "Medicare will not pay for" space (above check Box #1), for example: "ambulance transports outside of the USA." If the beneficiary (or his/her representative) desires a formal Medicare determination on a claim for a transport originating outside the U.S., then the transporting entity must file a claim to Medicare.

Following the international portion of a flight, if the beneficiary is then transported from the nearest point of entry by ambulance, including the same aircraft used to transport the beneficiary on the international flight, then standard Medicare rules apply. If the beneficiary is transported from the nearest point of entry to the nearest appropriate facility, then, assuming all other Medicare rules are met, the transport would be covered and payable. If the transporting entity has a reasonable basis to believe that the domestic portion of a non-emergency flight would not be covered because it is not reasonable and necessary under Medicare rules, then use of an ABN is indicated for non-emergency ambulance transports.

e. <u>PCS Requirements</u>

i. PCS Requirements for Emergency Transports

The regulations governing PCS requirements are specified at 42 CFR §410.40(d). As stated in previously issued instructions, a PCS is not

required if the transport is an emergency transport. This instruction applies to providers submitting ambulance claims to intermediaries as well as suppliers submitting ambulance claims to carriers. In accordance with PM AB-02-130, an emergency response is defined as a BLS or ALS-1 level of service provided in immediate response to a 911 call or the equivalent. The patient's diagnosis, and whether the transport is documented as an "emergency" due to the patient's condition, is not relevant to this determination. See item h. for more information concerning the Medicare definition of "emergency."

ii. PCS Requirements for Repetitive Ambulance Services

The regulations governing PCS requirements for repetitive, scheduled, non-emergency ambulance services are specified at 42 CFR §410.40(d)(2). A repetitive ambulance service is defined as medically necessary ambulance transportation that is furnished three or more times during a 10-day period or at least once per week for at least three weeks. Dialysis and respiratory therapy are types of treatments for which repetitive ambulance services are often necessary. However, the requirement for submitting the PCS form for repetitive, scheduled, non-emergency ambulance services is based on the quantitative standard (three or more times during a ten-day period or at least once per week for at least three weeks). Similarly, regularly scheduled ambulance services for follow-up visits, whether routine or unexpected, are not "repetitive" for purposes of this requirement unless one of the quantitative standards is met. PCS requirements for other types of ambulance transports are specified in PM AB-03-007.

iii. Computer Generated PCS Forms and Electronic Signatures

Providers/suppliers may use computer-generated PCS forms and computerized physician signatures to meet the PCS requirements of 42 CFR §410.40(d).

iv. Proof of Mailing When a PCS Cannot be Obtained

As stated in PM AB-03-007, 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. Providers/suppliers may also use the U.S. Postal Service Certificate of Mailing, Form 3817 as an acceptable alternative to certified mail.

f. Billing for Air Mileage

Claims for air transports may account for all mileage from the point of pickup, including where applicable: ramp to taxiway, taxiway to runway, takeoff run, air miles, roll out upon landing, and taxiing after landing.

g. Unsuccessful ALS Interventions

An ALS intervention is a procedure that is, in accordance with State and local laws, beyond the scope of practice of an emergency medical technician-basic (EMT-Basic). An unsuccessful attempt to perform an ALS intervention (e.g., endotracheal intubation was attempted, but was unsuccessful) may qualify the transport for billing at the appropriate ALS level provided that the intervention would have been reasonable and necessary had it been successful.

h. Establishing an ALS Transport Based on an ALS Assessment

When a BLS ambulance is dispatched and an ALS assessment is performed, the transport may be billed as ALS only for emergency transports. Medicare pays the BLS-level rate for non-emergency transports regardless of whether an ALS assessment is performed.

For Medicare program purposes, an emergency level of ambulance services depends upon how the ambulance was dispatched and how it responded. Emergency status does not depend upon whether an assessment was furnished after the ambulance arrived. PM AB-02-130 defines "emergency response" as a BLS or ALS-1 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. An emergency is determined based on the information available to the dispatcher at the time of the call, based on standard dispatch protocols. PM AB-02-130 also specifies that an ALS assessment is relevant only with respect to payment for an ALS emergency transport. That is, the ALS assessment may be relevant to determine whether an emergency transport is payable at the BLS or ALS level. However, an ALS assessment has no bearing on whether the transport qualifies for emergency-level payment. Furthermore, identifying a service as an emergency response has no bearing on its status under SSA 1861(s)(7), i.e., whether transportation by other means is feasible.

i. Mandated ALS Response

During the transition period, Medicare allows the ALS-level payment for emergency and non-emergency transports when an ALS vehicle is used but no ALS service is furnished in areas where an ALS-only response is mandated. As stated in previously issued instructions, two temporary Healthcare Common Procedure Coding System (HCPCS) codes have been established to allow billing for these services during the transition period. HCPCS code Q3019 applies when an ALS vehicle is used for an emergency transport, but no ALS-level service is furnished. HCPCS code Q3020 applies when an ALS vehicle is used for a non-emergency transport, but no ALS level service is furnished. The fee schedule portion of the blended payment is based on the emergency or non-emergency BLS level, as applicable, and the reasonable charge portion of the blended payment is the ALS emergency/non-emergency rate. (See PM AB-02-036.)

The use of an ALS vehicle to furnish only BLS-level services would most often occur in local jurisdictions that mandate all ambulances to be ALS. However, a contract with a government agency to furnish general ambulance services in one or more specific political jurisdictions may also qualify as a "mandated ALS response" if the terms of the contract require an ALS-only response for all requests for service. For example, in a locality where there is no ordinance requiring an "ALS only" EMS response, but there is a contract with a supplier for 911 services that requires an ALS response to all requests for services, the contractual requirement to provide such services may qualify as a "mandated ALS response". The intermediary or carrier must determine whether, in the totality of the circumstances, any particular contractual requirement is tantamount to a "mandated ALS response". However, a contractual requirement for ALS-only service in a contract either with a private entity, or with a government agency for less than general, jurisdiction-wide ambulance services, would not qualify as a "mandated ALS response". Note that the ALS vehicle must meet the crew requirements specified in 42 CFR §410.41.

The policy of paying according to the medically necessary services actually furnished continues under the Ambulance Fee Schedule. That is, payment is based on the level of service provided, not on the vehicle used. Even if a local

government requires an ALS response for all calls, Medicare pays only for the level of service provided, and then only when the service is medically necessary. The use of Q3019 and Q3020 described in this instruction, and in PM AB-02-036, is effective only during the transition period.

j. Intra-facility Transports

An intra-facility transport, i.e., a transport within the certified campus of a facility, is not within the scope of the Medicare ambulance benefit because it fails to meet Medicare origin and destination requirements. (See CFR §413.65(a)(2) for a definition of "certified campus.") Medicare payment to a facility for the cost of facility-based treatment includes an allowance for intra-facility movement of the beneficiary. No separate Medicare payment may be made for such a transport. Moreover, it is improper for a provider to bill Medicare for an intra-facility transport to receive a Medicare denial since the Medicare facility payment constitutes payment in full for all medically necessary, Medicare-covered services furnished to the beneficiary while undergoing treatment at the facility. As such, billing the beneficiary or another insurer for such included services would be similarly improper.

k. Physician Services Provided During an Ambulance Transport

Under the Ambulance Fee Schedule, payment for all ambulance-related items and services (including ambulance services that happen to be furnished by a physician) is included in the base payment for the ambulance transport. Therefore, under the Ambulance Fee Schedule, there is no separate payment for these services. However, if, during an ambulance transport, a physician furnishes a service(s) that is covered as a physician's service, and not covered under the Medicare ambulance benefit, then the physician may bill and be paid separately from the Ambulance Fee Schedule payment for such a service.

l. Billing the Beneficiary for Non-covered Services

When a provider/supplier issues an ABN because the service is not reasonable and necessary, it may only collect upfront the coinsurance amount and deductible from the beneficiary. If a transport is clearly statutorily excluded for another reason (e.g., it originates outside the United States), or if there is no benefit category for the service, the provider/supplier may charge the individual its full fee and collect the fee at a time of its choosing. In this situation, the provider/supplier may wish to advise the beneficiary, in advance of furnishing the service, that such transportation is not covered under Medicare. (An NEMB may be used, since an ABN is not appropriate.)

II. BUSINESS REQUIREMENTS

Requirement #	Requirements	Responsibility
2770.1	Intermediaries and carriers shall deny provider/supplier requests to appeal the Ambulance Fee Schedule amounts, in accordance with 1834(1)(5) of the Act and 42 CFR §414.625.	Intermediaries/ Carriers
2770.2	Carriers shall deny supplier requests to make IR adjustments to the fee schedule portion of the Ambulance Fee Schedule blended payment.	Carriers
2770.3	Carriers shall not make IR adjustments to the reasonable charge portion of the Ambulance Fee Schedule blended payment until CMS issues further guidance on how to implement IR.	Carriers
2770.4	Carriers shall deny requests from suppliers to change billing methods during the transition period, April 1, 2002 through December 31, 2005.	Carriers

2770.5	Intermediaries and carriers shall not require providers/suppliers to routinely issue either ABNs or NEMBs to beneficiaries for ambulance services.	Intermediaries/ Carriers
2770.6	Intermediaries and carriers shall allow providers and suppliers to use computer-generated PCS forms to meet the PCS requirements of 42 CFR §410.40(d).	Intermediaries/ Carriers
2770.7	Intermediaries and carriers shall allow providers and suppliers to use computerized physician signatures to meet the PCS requirements of 42 CFR §410.40(d).	Intermediaries/ Carriers
2770.8	Intermediaries and carriers shall accept the following items as evidence of the provider/supplier's attempt to obtain a PCS when a PCS cannot be obtained in accordance with 42 CFR §410.40(d)(3)(iv): • A U.S. Postal Service Certified Mail Return Receipt, or other similar commercial service demonstrating delivery of the letter. • A U.S. Postal Service Certificate of Mailing (Form 3817).	Intermediaries/ Carriers
2770.9	Intermediaries and carriers shall allow payment for all necessary mileage from the point of pickup, including where applicable: ramp to taxiway, taxiway to runway, takeoff run, air miles, roll out upon landing and taxiing after landing.	Intermediaries/ Carriers
2770.10	Intermediaries and carriers shall determine whether, in the totality of the circumstances, a contract with a government agency to furnish general ambulance services in one or more specific political jurisdictions, the terms of which require an ALS-only response for all requests for services, may qualify as a "mandated ALS response".	Intermediaries/ Carriers
2770.11	Intermediaries shall deny claims for intra-facility transports.	Intermediaries
2770.12	Intermediaries and carriers shall deny separate payment for physician services furnished as part of an ambulance transport when these services are covered under the Medicare ambulance benefit.	Intermediaries/ Carriers
2770.13	Intermediaries and carriers shall notify providers and suppliers on their Web sites, through any listserv(s), and in their regularly scheduled bulletins that Ambulance Fee Schedule amounts may not be appealed.	Intermediaries/ Carriers
2770.14	Carrier shall notify suppliers on their Web sites, through any listserv(s), and in their regularly scheduled bulletin of the following information concerning IR adjustments: • Prospective payment systems, including the Ambulance Fee Schedule, are exempt from IR. Therefore, IR applies only to the reasonable charge portion of the blended payment for ambulance services during the transition period. • The criteria for applying IR, specified in the final rule, includes a threshold of 15 percent that must be met before IR adjustments may be made. That is, if a payment allowance is determined to be either deficient or excessive by an amount that is less than 15 percent, then no IR adjustment may be made. • The CMS has not yet developed contractor processes for applying IR. Until these processes are in place, contractors may not make any IR adjustments.	Carriers
2770.15	Carriers shall notify suppliers on their Web sites, through any listserv(s), and in their regularly scheduled bulletin that suppliers may not change their billing methods during the transition period, April 1, 2002 through December 31, 2005.	Carriers

2770.16	Intermediaries and carriers shall notify providers/suppliers on their Web sites, through any listserv(s), and in their regularly scheduled bulletin of the following information concerning the issuance of ABNs: • Providers/suppliers may not routinely issue ABNs to beneficiaries for ambulance services. • ABNs should be issued to beneficiaries for non-emergency transports in the following situations: a. A transport by air ambulance when the transporting entity has a reasonable basis to believe that the transport can be done safely and effectively by ground ambulance transportation. b. A level of care downgrade, e.g., from ALS-2 to ALS-1, or from ALS to BLS, when the transport at the lower level of care is a covered transport. • ABNs should not be issued, but NEMBs may be issued, to beneficiaries in the following situations to beneficiaries in the following situations: a. Any denial where the patient could be transported safely by other means (these are denials under §1861(s)(7) of the Act. b. Any denial that is based on not meeting an origin or destination requirement (these denials are inconsistent with 42 CFR §410.40 and generally also constitute §1861(s)(7) denials). c. A denial for mileage that is beyond the nearest appropriate facility (for the same reason as "b" above). d. A denial where the PCS or accepted alternative (e.g., certified mail) is not obtained (these denials are inconsistent with 42 CFR §410.40 and generally also constitute §1861(s)(7) denials). e. A convenience discharge, e.g., where the patient is an inpatient at one hospital that can care for their needs, but wants to be transferred to a second hospital to be closer to family (these denials are inconsistent with 42 CFR §410.40 and generally also constitute §1861(s)(7) denials). • ABNs should not be issued, but NEMBs may be issued, to beneficiaries when the point of pickup of the ambulance transport is outside of the United States, including a point of pickup outside of the U.S. territories. • Providers/suppliers should issue ABNs to beneficiaries for non-emergency international flights when the provider/supplier has a reasonable basis to believe that the domestic portion of the flight would not be covered because it is not reasonable and necessary under Medicare rules.	Intermediaries/ Carriers

2770.17	Intermediaries and carriers shall notify providers/suppliers on their Web sites, through any listserv(s), and in their regularly scheduled bulletin of the following information concerning PCS requirements: • Providers and suppliers may use computer-generated PCS forms, as well as computer-generated physician signatures to meet the PCS requirements of 42 CFR §410.40(d). • When a PCS cannot be obtained in accordance with 42 CFR §410.40(d)(3)(iv), provider/supplier's may use the following items as evidence of the attempt to obtain the PCS: a. A U.S. Postal Service Certified Mail Return Receipt, or other similar commercial service demonstrating delivery of the letter. b. A U.S. Postal Service Certificate of Mailing (Form 3817).	Intermediaries/ Carriers
2770.18	Intermediaries and carriers shall notify providers/suppliers on their Web sites, through any listserv(s), and in their regularly scheduled bulletin that Medicare allows payment for all necessary mileage from the point of pickup, including where applicable: ramp to taxiway, taxiway to runway, takeoff run, air miles, roll out upon landing and taxiing after landing.	Intermediaries/ Carriers
2770.19	Intermediaries and carriers shall notify providers/suppliers on their Web sites, through any listserv(s), and in their regularly scheduled bulletin of the following information concerning mandated ALS responses: • During the transition period, Medicare allows the ALS-level payment for emergency and non-emergency transports when an ALS vehicle is used but no ALS service is furnished in areas where an ALS-only response is mandated. • The use of an ALS vehicle to furnish only BLS-level services would most often occur in local jurisdictions that mandate all ambulances to be ALS. • A contract with a government agency to furnish general ambulance services in one or more specific political jurisdictions, the terms of which require an ALS-only response for all requests for service may qualify as a "mandated ALS response". • Intermediaries and carriers have discretion in determining whether, in the totality of the circumstances, any particular contractual requirement is tantamount to a "mandated ALS response". However, a contractual requirement for ALS-only service in a contract either with a private entity, or with a government agency for less than general, jurisdiction-wide ambulance services, would not qualify as a "mandated ALS response". • The ALS vehicle must meet the crew requirements specified in 42 CFR § 410.41. • The policy of paying according to the medically necessary services actually furnished continues under the Ambulance Fee Schedule. That is, payment is based on the level of service provided, not on the vehicle used. Even if a local government requires an ALS response for all calls, Medicare pays only for the level of service provided, and then only when the service is medically necessary. • The temporary HCPCS established for billing these services, Q3019 and Q3020, are effective only during the transition period.	Intermediaries/ Carriers

2770.20	Intermediaries shall notify providers on their Web sites, through any listserv(s), and in their regularly scheduled bulletin that it is improper to bill Medicare for an intra-facility transport to receive a Medicare denial.	Intermediaries
2770.21	Intermediaries shall notify providers that it is improper to bill the beneficiary for an intra-facility transport.	Intermediaries
2770.22	Intermediaries and carriers shall notify providers/suppliers on their Web sites, through any listserv(s), and in their regularly scheduled bulletin that it is improper to bill Medicare for physician services furnished as part of an ambulance transport when these services are covered under the Medicare ambulance benefit. The costs of such services are bundled into the base rate amount for the ambulance transport.	Intermediaries/ Carriers

III. SUPPORTING INFORMATION AND POSSIBLE DESIGN CONSIDERATIONS

A. Other Instructions: N/A

B. Design Considerations: N/A

C. Interfaces: N/A

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

E. Dependencies: N/A

F. Testing Considerations: N/A

IV. ATTACHMENT(S): None

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