

COVID-19 Frequently Asked Questions (FAQs) on Medicare Fee-for-Service (FFS) Billing

The FAQs in this document supplement the following previously released FAQs: 1135 Waiver FAQs, available at <https://www.cms.gov/About-CMS/Agency-Information/Emergency/Downloads/MedicareFFS-EmergencyQsAs1135Waiver.pdf>, and Without 1135 Waiver FAQs, available at [https://www.cms.gov/About-CMS/Agency-Information/Emergency/Downloads/Consolidated Medicare FFS Emergency QsAs.pdf](https://www.cms.gov/About-CMS/Agency-Information/Emergency/Downloads/Consolidated_Medicare_FFS_Emergency_QsAs.pdf).

We note that in many instances, the general statements of the FAQs referenced above have been superseded by COVID-19-specific legislation, emergency rules, and waivers granted under section 1135 of the Act specifically to address the COVID-19 public health emergency (PHE). The policies set out in this FAQ are effective for the duration of the PHE unless superseded by future legislation.

A few answers in this document explain provisions from the Coronavirus Aid, Relief, and Economic Security (CARES) Act, Public Law No. 116-136 (March 27, 2020). CMS is thoroughly assessing this new legislation and new and revised FAQs will be released as implementation plans are announced.

The interim final rule with comment period (IFC), CMS-1744-IFC, Medicare and Medicaid Programs; Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency, is available at the following link: <https://www.cms.gov/files/document/covid-final-ifc.pdf>

Ambulance Services

- 1. Question:** Can ground ambulance providers and suppliers transport beneficiaries with COVID-19 symptoms, or those who are confirmed to have COVID-19, to destination sites that are not a hospital, critical access hospital (CAH) or skilled nursing facility (SNF)?

Answer: To provide ground ambulance providers and suppliers the flexibility to furnish medically necessary emergency and non-emergency ambulance transports for beneficiaries during the PHE for the COVID-19 pandemic, we are temporarily expanding the list of allowable destinations for ground ambulance transports. During the COVID-19 PHE, a covered destination for a ground ambulance transport may include any destination that is equipped to treat the condition of the patient in a manner consistent with state and local Emergency Medical Services (EMS) protocols where the services will be furnished. These destinations may include, but are not limited to: any location that is an alternative site determined to be part of a hospital, CAH or SNF; community mental health centers; federally qualified health centers; rural health clinics; physician's offices; urgent care facilities; ambulatory surgical centers; any location furnishing dialysis services outside of the ESRD facility when an ESRD facility is not available; and the beneficiary's home. There must be a medically necessary ground ambulance transport of a patient in order for the ambulance service to be covered.

New: 4/9/20

- 2. Question:** How are Advanced Life Support (ALS) assessment, intervention, and ambulance transport defined?

Answer: Definitions for Ambulance Services are in 42 CFR §414.605. ALS assessment, intervention, and ambulance transport are defined as follows:

- Advanced life support (ALS) assessment is an assessment performed by an ALS crew as part of an emergency response that was necessary because the patient's reported condition at the time of dispatch was such that only an ALS crew was qualified to perform the assessment. An ALS assessment does not necessarily result in a determination that the patient requires an ALS level of service. ALS intervention means a procedure that is, in accordance with State and local laws, required to be furnished by ALS personnel. Advanced life support, level 1 (ALS1) means transportation by ground ambulance vehicle, medically necessary supplies and services and either an ALS assessment by ALS personnel or the provision of at least one ALS intervention.
- Advanced life support, level 2 (ALS2) means either transportation by ground ambulance vehicle, medically necessary supplies and services, and the administration of at least three medications by intravenous push/bolus or by continuous infusion, excluding crystalloid, hypotonic, isotonic, and hypertonic

solutions (Dextrose, Normal Saline, Ringer's Lactate); or transportation, medically necessary supplies and services, and the provision of at least one of the following ALS procedures: (1) Manual defibrillation/cardioversion, (2) Endotracheal intubation, (3) Central venous line, (4) Cardiac pacing, (5) Chest decompression, (6) Surgical airway, and (7) Intraosseous line.

New: 4/9/20

3. Question: How is an ALS assessment determined?

Answer: Medicare ambulance coverage policy provides that an ALS assessment is an assessment performed by an ALS crew as part of an emergency response that was necessary because the patient's reported condition at the time of dispatch was such that only an ALS crew was qualified to perform the assessment. An ALS assessment does not necessarily result in a determination that the patient requires an ALS level of service. In the case of an appropriately dispatched ALS emergency service if the ALS crew completes an ALS assessment, the services provided by the ambulance transportation service provider or supplier is covered at the ALS emergency level, regardless of whether the patient required ALS intervention services during the transport, provided that ambulance transportation itself was medically reasonable and necessary and all other coverage requirements are met (see Medicare Benefit Policy Manual, Chapter 10, Section 30.1.1.).

New: 4/9/20

4. Question: Will all transports of COVID-19 patients or patients suspected to have COVID-19 be designated as Advanced Life Support (ALS) transports?

Answer: No. Payment for an ambulance transport is based on the level of service provided.

New: 4/9/20

5. Question: Will CMS allow ground ambulance providers and suppliers to treat COVID-19 patients in their home or designated residence and allow for reimbursement at the ALS reimbursement base rate?

Answer: Section 1861(s)(7) of the Act describes the ambulance services benefit under Medicare as a transportation benefit, and thus an ambulance transport of a beneficiary is required in order for the ambulance to be paid under Medicare.

New: 4/9/20

6. Question: Should HCPCS code A0998 (ambulance response and no transport) be reported for treatment in place?

Answer: No, HCPCS code A0998 (ambulance response and no transport) is not covered under the ambulance services benefit (defined in section 1861(s)(7) of the Act), and thus is not payable under Medicare's Ambulance Fee Schedule.

New: 4/9/20

7. Question: Will CMS allow all responses, including Basic Life Support (BLS), related to COVID-19 to be billed at the ALS rate, regardless if ALS interventions were performed?

Answer: We recognize that COVID-19 transports require following infectious disease protocols, such as decontamination procedures, professional protective equipment (PPE), and the required engagement of paramedics which may increase the cost of transports involving suspected or diagnosed COVID-19 patients. However, ground ambulance transports must be billed according to the level of service furnished. Only transports that meet the requirements for billing at the ALS level of service can be billed at the ALS rate.

New: 4/9/20

- 8. Question:** Can ground ambulance providers and suppliers report other services they provide to PUI or COVID-19 patients?

Answer: Under § 414.610(d), payment under the ambulance fee schedule represents payment in full (subject to applicable Medicare Part B deductible and coinsurance requirements) for all services, supplies, and other costs for an ambulance transport service furnished to a Medicare beneficiary.

New: 4/9/20

- 9. Question:** Can I consider any COVID-19 positive patient to meet the medical necessity requirements for ambulance transport?

Answer: The medical necessity requirements for coverage of ambulance services have not been changed. For both emergency and non-emergency ambulance transportation, Medicare pays for ground (land and water) and air ambulance transport services only if they are furnished to a Medicare beneficiary whose medical condition is such that other forms of transportation are contraindicated. The beneficiary's condition must require both the ambulance transportation itself and the level of service provided for the billed services to be considered medically necessary.

New: 4/9/20

- 10. Question:** If the ambulance crew provides treatment but does not transport anyone, can the company bill Medicare for the services provided?

Answer: No. Medicare law prohibits payment for an ambulance service unless a medically necessary transport of a Medicare beneficiary has taken place. However, when an enrolled physician or other qualified health professional furnishes services from an ambulance, he or she may bill for those services under the Medicare Physician Fee Schedule, assuming that the services furnished were in accordance with applicable state law and services are within his or her scope of practice requirements.

Revised: 3/26/20

- 11. Question:** How will ambulance services be paid when patients are moved from hospital to hospital or other approved locations?

Answer: Medicare will pay for ambulance transportation according to the usual payment guidelines. Ambulance transportation charges for patients who were evacuated from and returned to originating hospitals should be included on the inpatient claims submitted by

the originating hospitals. Payment will be included in the diagnostic related group (DRG) payment amounts made to hospitals paid under the prospective payment system.

Revised: 3/26/20

12. Question: If a beneficiary who is living at home and using a stationary oxygen unit, has to be transported to another location by ambulance (because other means of transportation are contraindicated), can Medicare pay for any portable oxygen necessary to transport the beneficiary?

Answer: Medicare’s standard payment to ambulance providers and suppliers under the Ambulance Fee Schedule for ambulance transports already includes payment for all necessary supplies, including oxygen, provided during the transport. Thus, if the transport is a Medicare-covered service (e.g., the beneficiary must be transported by ambulance to a covered destination because other means of transportation are contraindicated), then no separate payment for furnishing oxygen would be made.

However, if the transport does not qualify as a Medicare-covered service, then payment under Part B may be made to a Durable Medical Equipment supplier for furnishing portable oxygen when supplemental oxygen is needed for the beneficiary during the transport.

Revised: 3/26/20

13. Question: In emergency/disaster situations, how does CMS define an “approved destination” for ambulance transports and would it include alternate care centers, field hospitals and other facilities set up to provide patient care in response to the emergency/disaster?

Answer: CMS defines “approved destination” at 42 CFR 410.40(f), Origin and destination requirements. Medicare can only pay for ambulance transportation when it meets the origin and destination requirements and all other coverage requirements.

42 CFR 410.40(f) allows Medicare to pay for an ambulance transport (provided that transportation by any other means is contraindicated by the patient’s condition and all other Medicare requirements are met) to the following destinations:

- From any point of origin to the nearest hospital, Critical Access Hospital (CAH), or SNF that is capable of furnishing the required level and type of care for the beneficiary’s illness or injury and the return trip to the beneficiary’s home. The hospital or CAH must have available the type of physician or physician specialist needed to treat the beneficiary’s condition.
- For beneficiaries residing in a SNF who are receiving Part B benefits only, ambulance transport from a SNF to the nearest supplier of medically necessary services not available at the SNF where the beneficiary is a resident, including the return trip. For SNF residents receiving Medicare Part A benefits, this type of ambulance service is subject to SNF consolidated billing.

- For a beneficiary who is receiving renal dialysis for treatment of ESRD, from a beneficiary's home to the nearest facility that furnishes renal dialysis, including the return trip.

A physician's office normally is not a covered destination under Medicare Part B. However, under certain circumstances an ambulance transport may temporarily stop at a physician's office without affecting the coverage status of the transport. Note that there is an exception to this rule during the COVID-19 PHE, as explained further below.

Should a facility that would normally be the nearest appropriate facility be unavailable during an emergency/disaster, Medicare may pay for transportation to another facility so long as that facility meets all Medicare requirements and is still the nearest facility that is available and equipped to provide the needed care for the illness or injury involved.

Medicare payment for an ambulance transport to a temporary expansion site may be available if the site is determined to be part of a hospital, CAH or SNF that is an approved destination for an ambulance transport under 42 CFR 410.40(f). If the temporary expansion site is part of a hospital, CAH or SNF that is an approved destination under 42 CFR 410.40(f) for an ambulance transport, Medicare will pay for the transport on the same basis as it would to any other approved destination.

In addition, to provide ground ambulance providers and suppliers the flexibility to furnish medically necessary emergency and non-emergency ambulance transports for beneficiaries during the PHE for the COVID-19 pandemic, we are temporarily expanding the list of allowable destinations for ground ambulance transports. During the COVID-19 PHE, a covered destination for a ground ambulance transport may include any destination that is equipped to treat the condition of the patient in a manner consistent with state and local Emergency Medical Services (EMS) protocols in use where the services will be furnished. These destinations may include, but are not limited to: any location that is an alternative site determined to be part of a hospital, CAH or SNF; community mental health centers; federally qualified health centers; rural health clinics, physician's offices; urgent care facilities; ambulatory surgical centers; any location furnishing dialysis services outside of the ESRD facility when an ESRD facility is not available; and the beneficiary's home. There must be a medically necessary ground ambulance transport of a patient in order for the ambulance service to be covered.

Physicians, non-physician practitioners, and suppliers should contact their Part B MAC or DME MAC with questions about SNF consolidated billing. There is also additional information about SNF consolidated billing on the CMS Medicare Learning Network (MLN) Publications webpage.

Institutional providers should contact their Part A MAC with questions about SNF consolidated billing. There is also additional information about SNF consolidated billing on the CMS MLN Publications webpage.

Revised: 4/10/20

- 14. Question:** Our ambulance uses an electronic patient care reporting device to record beneficiary signatures that authorize submission of claims to Medicare. We are concerned that a known or suspected COVID-19 patient using a touch screen to sign or holding an electronic pen or stylus could contaminate these devices for future patients and for ambulance personnel. Are we permitted to sign on behalf of a patient with known or suspected COVID-19?

Answer: Yes, but only under specific, limited circumstances. CMS will accept the signature of the ambulance provider's or supplier's transport staff if that beneficiary or an authorized representative gives verbal consent. CMS has determined that there is good cause to accept transport staff signatures under these circumstances. See 42 CFR 424.36(e). CMS recommends that ambulance providers and suppliers follow the Centers for Disease Control's Interim Guidance for Emergency Medical Services (EMS) Systems and 911 Public Safety Answering Points (PSAPs) for COVID-19 in the United States, which can be found at the following link: <https://www.cdc.gov/coronavirus/2019-ncov/hcp/guidance-for-ems.html>. This guidance includes general guidelines for cleaning or maintaining EMS transport vehicles and equipment after transporting a patient with known or suspected COVID-19. However, in cases where it would not be possible or practical (such as a difficult to clean surface) to disinfect the electronic device after being touched by a beneficiary with known or suspected COVID-19, documentation should note the verbal consent.

New: 4/10/20

[Ambulance Services- Vehicle and Staffing Requirements for Ambulance Providers and Suppliers](#)

- 1. Question:** Would a ground ambulance vehicle operating without a renewed license nevertheless satisfy the Medicare requirements at 42 CFR § 410.41 if, during the PHE for the COVID-19 pandemic, a state or locality issues a law or regulation, or a legally adequate waiver, that permits ground ambulance vehicles to operate without a renewed license?

Answer: Yes, depending on state or local law. 42 CFR § 410.41 specifies Medicare's requirements for ambulance vehicles, and § 410.41(a)(1) states that a vehicle used as an ambulance must be specially designed to respond to medical emergencies or provide acute medical care to transport the sick and injured and comply with all State and local laws governing an emergency transportation vehicle. Key to this is that § 410.41(a) requires compliance with state and local laws. During the PHE for the COVID-19 pandemic, should a state or locality enact or promulgate a law, regulation, or legally adequate waiver permitting an ambulance vehicle to operate without a renewed license, such an ambulance would be in compliance with Medicare's requirements at § 410.41(a). We also note that the

staffing requirements at § 410.41(b) must be met in order for the ambulance transport to meet the § 410.41 requirements (see discussion in the FAQs below regarding waivers of these provisions).

New: 5/1/20

2. **Question:** During the PHE for the COVID-19 pandemic, if a state law or local law permits ambulance staffing by personnel licensed/certified below the levels of certification required under 42 CFR § 410.41(b), would an ambulance so staffed be considered to meet the Medicare requirements of § 410.41(b)? For example, CMS has heard that, during the course of the PHE for the COVID-19 pandemic, and pursuant to state waiver, one or more states may permit an Emergency Medical Responder (EMR), which is a certification status below the scope of practice of an Emergency Medical Technician (EMT) to staff a Basic Life Support (BLS) vehicle, or a Registered Nurse (RN), which is a health care professional status different than an EMT-paramedic, to staff an Advanced Life Support (ALS) vehicle.

Answer: Yes, depending on state or local law. During the PHE for the COVID-19 pandemic, and pursuant to 42 U.S.C. 1320b-5(b)(1)(B), Medicare is waiving the specified ambulance staffing certification requirements of 42 CFR § 410.41(b) such that, if a state and/or local law, or regulation, or a waiver issued by the applicable state or local authority permits a BLS or ALS ambulance to be alternatively staffed, such staffing arrangement would satisfy Medicare requirements. For example, should it be permitted by a state or local law, or regulation, or a waiver issued by the applicable state or local authority, for purposes of meeting Medicare's staffing requirements for a covered transport, a BLS vehicle could be staffed with an EMR instead of an EMT-basic or an ALS vehicle could be staffed with an RN instead of a EMT or paramedic. Note that the onus is on an ambulance provider or supplier to ensure that it otherwise continues to meet all applicable Medicare enrollment, coverage, and other requirements.

New: 5/1/20

3. **Question:** During the PHE for the COVID-19 pandemic, if an ambulance provides services across state lines and the vehicle staff are not licensed or certified to provide services in the state in which the ambulance services are provided, will the ambulance be considered to meet the vehicle staff certification requirements under 42 CFR § 410.41(b) while providing services in that state?

Answer: During the PHE for the COVID-19 pandemic, pursuant to 42 U.S.C. 1320b-5(b)(2), Medicare is waiving the requirement at 42 CFR § 410.41(b) that vehicle personnel be licensed or certified in the State in which they are furnishing services if they have equivalent licensing or certification in another State and are not affirmatively excluded from practice in that State or in any other State. Where the terms of this waiver are met, the ambulance staff certification requirements of § 410.41(b) could be met when ambulances provide services across state lines. Note, however, that this does not waive state or local laws (only Medicare's own certification requirements in § 410.41(b) for purposes of Medicare payment and coverage) such that, should a state not permit out of state ambulances to

provide services, Medicare's waiver would not affect a state's potential enforcement of its provisions.

New: 5/1/20