

Fact Sheet

Waiver for Ground Ambulance Services: Treatment in Place

Section 9832 of the American Rescue Plan Act of 2021 gives the Secretary the authority to waive any requirement under Section 1861(s)(7) or Section 1834(l) of the Act that an ambulance service include the transport of an individual to the extent necessary to allow Medicare payment for ground ambulance services during the COVID-19 public health emergency (PHE) in cases where both of these apply:

- The ground ambulance service was furnished in response to a 911 call (or the equivalent in areas without a 911 call system)
- The patient would have been transported to a destination permitted under Medicare regulations but such transport didn't occur as a result of community-wide emergency medical service (EMS) protocols due to the COVID-19 PHE.¹

Why is CMS Implementing the Waiver?

Due to the COVID-19 PHE, some states, regional authorities, localities, and individual hospitals that have the requisite legal authority implemented community-wide EMS protocols instructing ground ambulance providers and suppliers to:

- Not transport certain patients to the hospital and/or other destinations
- Treat these patients at the scene of the response (sometimes called "treatment in place")

Because of these protocols, in response to a 911 call (or the equivalent in areas without a 911 call system) some ground ambulance providers and suppliers have been:

- Unable to transport certain patients (instead, treating them in place) who otherwise would have required medically necessary ground ambulance transport to the nearest appropriate facility able to treat the patient's condition, and any other means of transportation would have been contraindicated
- Ineligible to submit claims for Medicare payment without a medically necessary ground ambulance transport

What's the Effective Date?

The waiver is retroactively effective to March 1, 2020.

¹ To reduce the total number of ground ambulance transports of patients to hospitals and other facilities, some protocols may apply to more than just COVID-19 positive or presumptive COVID-19 positive patients.

I'm enrolled as a Medicare Ground Ambulance Provider or Supplier, how Can I Qualify for the Waiver?

To qualify for Medicare payment under the terms of the waiver, you must meet the following conditions:

- You provided the ground ambulance services in response to a 911 call (or the equivalent in areas without a 911 call system)
- The Medicare beneficiary being treated would have been transported to the nearest appropriate facility permitted under Medicare regulations, but the transport didn't happen because of community-wide EMS protocols due to the COVID-19 PHE
- Without the community-wide EMS protocols due to the COVID-19 PHE, the claim would have met the existing Medicare ambulance services coverage criteria, as follows:
 - The beneficiary would have required a medically necessary ground ambulance transport to the nearest appropriate facility able to treat the patient's condition
 - Any other means of transportation would have been contraindicated (meaning that traveling to the destination by other means would have endangered the patient's health)
 - You maintain, and can provide upon request, documentation to support that a community-wide EMS protocol due to the COVID-19 PHE:
 - Dictated, or allowed with patient consent, that ambulance providers and suppliers not transport certain patients
 - Was in effect for the area and at the time you treated the patient
- You provided the ambulance service on or after March 1, 2020

Medicare won't pay for claims when:

- You didn't transport the patient based solely on the patient's decision, including when a patient refused transport "against medical advice"
- The ambulance service would not have been medically necessary
- You can't provide documentation, upon request, to support that a community-wide EMS protocol (as described above) was in place

What Should My Claims Include?

Based on the level of service provided, your claims should include 1 of the following HCPCS codes:

- A0429 (Ambulance service, basic life support, emergency transport (BLS-emergency))
- A0427 (Ambulance service, advanced life support, emergency transport, level 1 (ALS1))

and

- A valid origin/destination modifier combination (in the first modifier position) that would have been appropriate if you had transported the patient
- The **CR** modifier to distinguish these waiver claims from other claims, including claims for interventions covered under the Emergency, Triage, and Transport (ET3) model

Do not report codes for mileage because you didn't transport the patient.

You must also maintain (and submit upon request) documentation that:

- Supports medical necessity. You must demonstrate that the patient's condition required the level of service provided and would normally require ambulance transport (without the community-wide EMS protocol).
- Establishes the community-wide EMS protocol was in effect for the area at the time ambulance services were provided to the patient. If a verbal protocol (such as from an individual hospital in a remote area) was issued at the time services were furnished, we expect you to provide adequate written documentation explaining that the verbal protocol in effect was exercised. We believe that in most cases, such protocols were/will be issued in written format, and such format may have included, but is not limited to: state or local agency and official correspondence or electronic platforms that provided just-in-time updates to standard operative procedure or protocols. However, to the extent that a verbal protocol (such as from an individual hospital in a remote area) was/is in effect at the time of transport, we expect the verbal protocol to be fully documented.

Do I Have to Submit Claims?

You must submit claims to get paid by Medicare unless you choose to provide the services for free.

For Which Dates of Service May I Submit Claims?

You may submit claims for services provided on or after March 1, 2020 through the end of the COVID-19 PHE.

What's the Deadline for Submitting Claims?

This waiver is effective March 1, 2020 through the end of the COVID-19 PHE. For services provided under this waiver from March 1, 2020 – May 5, 2021, the deadline to submit claims is May 5, 2022.

For services provided after May 5, 2021, you must file claims within 1 calendar year after the date of service.

Under Medicare rules, you must generally submit claims within 1 calendar year of the date of service. But, for services allowed under this waiver that you provided between March 1, 2020 – May 5, 2021, CMS exercised its authority under Section 1135(b)(5) of the Act to change the deadline for filing claims.

How Much Will Medicare Pay?

Medicare will pay based on the level of service you provided:

- Basic Life Support (BLS) emergency rate
- Advanced Life Support, level 1 (ALS1) emergency rate

Medicare won't pay for mileage because you didn't transport the patient.

You must accept the Medicare allowed amount as payment in full, and you can't bill or collect any amount from the patient other than the unmet deductible and coinsurance, however, for services that occurred in the past, please note that the HHS Office of Inspector General (OIG) [has issued an FAQ](#) that

would permit the ambulance provider or supplier to not seek to collect any cost-sharing from the beneficiary for a retroactive service.

If ambulance services are provided by a Critical Access Hospital (CAH) or an entity owned and operated by a CAH **and** the ambulance service provider or supplier is the only such provider or supplier of ambulance services located within a 35-mile drive of the CAH, Medicare will pay 101% percent of the reasonable costs of providing those services. This doesn't include ambulance providers or suppliers that are not legally authorized to provide ambulance transport services to or from the CAH.

Do I Have to Collect the Patient's Cost-sharing Amount?

At [HHS Office of Inspector General \(OIG\) FAQ](#), the OIG provides guidance about ambulance provider or supplier collection of patient cost-sharing amounts applicable to services to which this waiver applies.

What if I Already Collected Payment from the Medicare Patient?

If you previously collected payment from a patient for services that Medicare now covers under the waiver, you must refund any amounts paid that are more than the applicable cost sharing under the waiver.