National AB MAC Ambulance Provider/Supplier Coalition Meeting

Medicare Part A and B
Provider Outreach and Education
Multi-MAC Collaboration Group

September 17, 2025

National A/B MAC Ambulance Provider/Supplier Coalition

The Provider Outreach and Education (POE) staff from each of the A/B Medicare Administrative Contractors (MACs) developed this material. The goals of this group are identified within our Charter Statement which is included in this material.

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Agenda

- Welcome and Introductions
- Questions Submitted Prior to Event

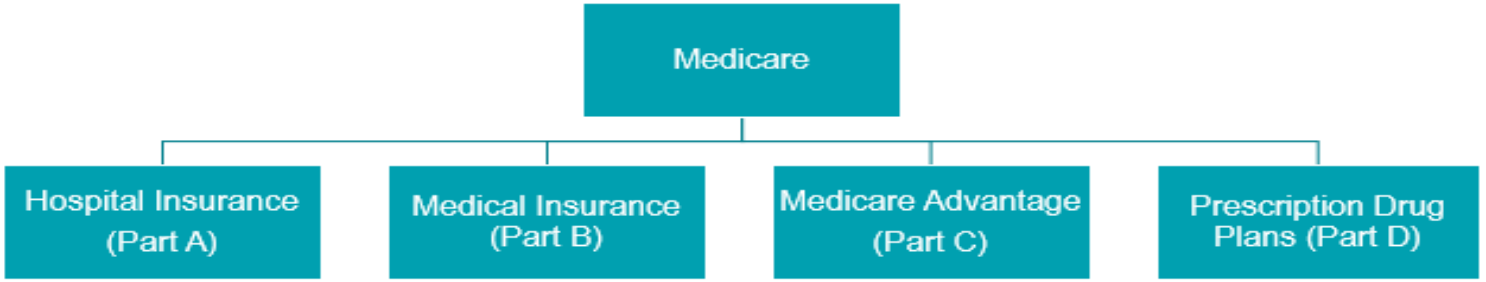
Acronym List

Acronym	Definition
ABN	Advanced Beneficiary Notice
ADR	Additional Documentation Request
ALS	Advance Life Support
CMS	Centers for Medicare & Medicaid
CWF	Common Working File
EMS	Emergency Medical Services
ET3	Emergency Triage, Treat, and Transport
FISS	Fiscal Intermediary Shared System (FISS)
MAC	Medicare Administrative Contractor
PCS	Physician Certification Statement
RSNAT	Repetitive scheduled non-emergent ambulance transports
SNF	Skilled Nursing Facility
TPE	Targeted Probe & Educate (TPE)

Welcome and Introductions

Medicare Part A and B
Provider Outreach and Education
Multi-MAC Collaboration Group

Medicare Program

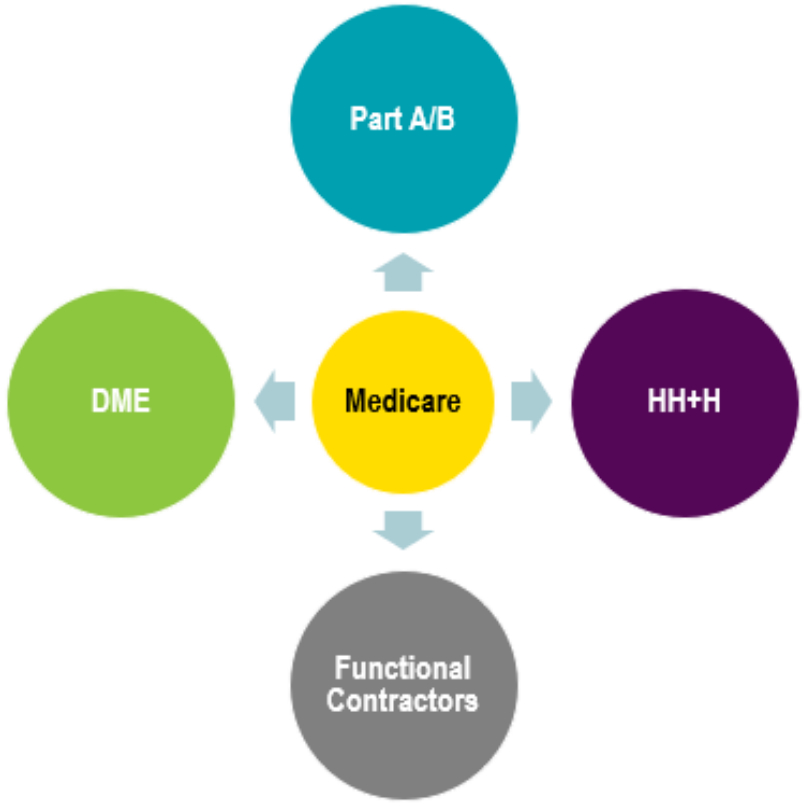


- **Background:**
  - Centers for Medicare & Medicaid (CMS) is the federal agency responsible for providing health coverage for the Medicare program
  - Medicare program is the largest health insurance program in the United States
- **Purpose:**
  - Provides insurance coverage to individuals eligible to enroll based on:
    - Age 65 and older
    - Disability under the age of 65
    - Permanent kidney failure (end stage renal disease)

- **References:**
  - Centers for Medicare & Medicaid Services
  - What Medicare Part A Covers
  - What Medicare Part B Covers
  - Medicare Advantage Plan Directory
  - Prescription Drug Plan Directory
- **Note:** MACs do not have information or answer questions on Medicare Advantage plans (Part C) or Prescription Drug plans (Part D)

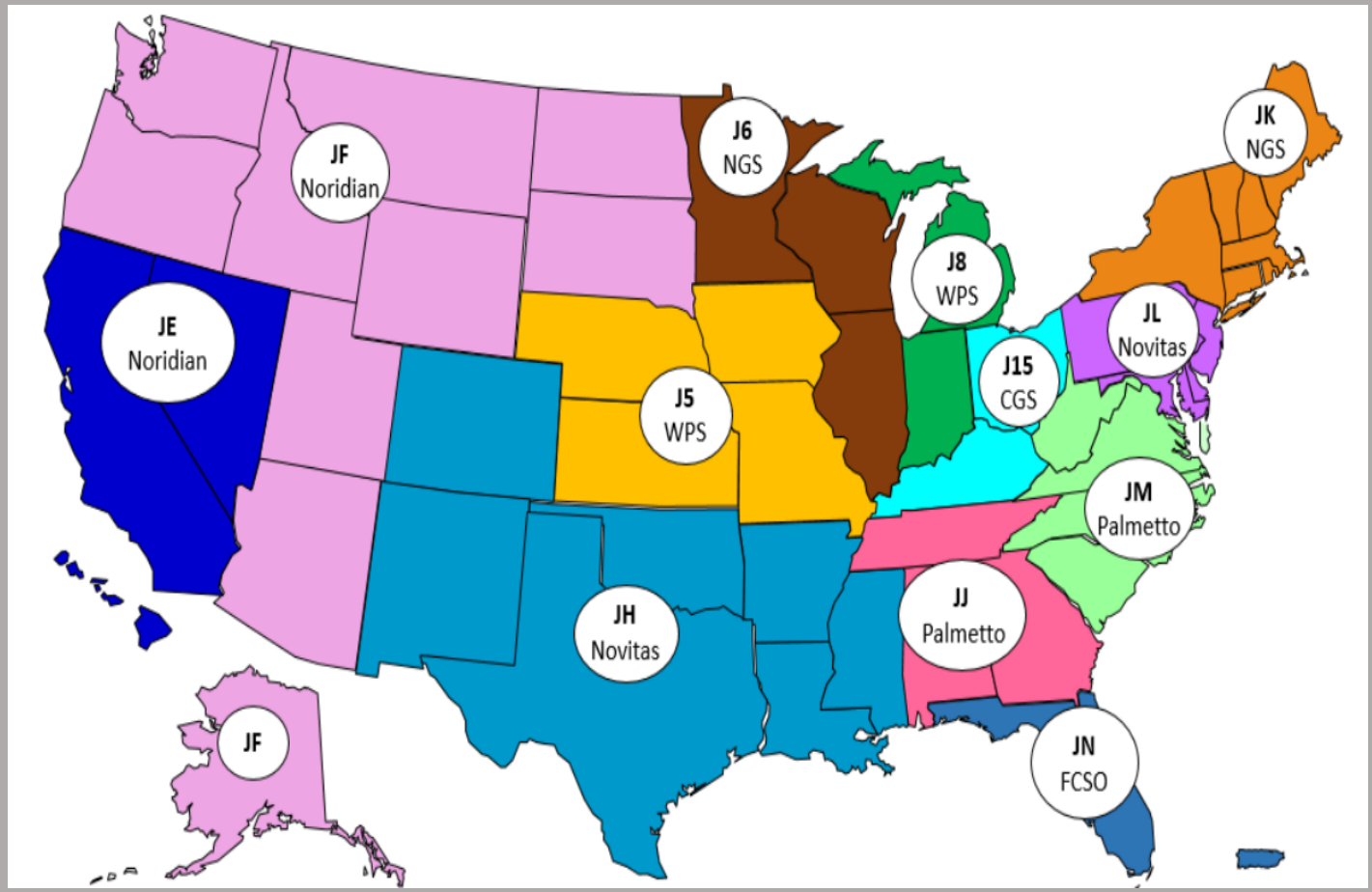
CMS Contractors

- Medicare Administrative Contractor (MAC) definition:
  - MACs are multi-state, regional contractors responsible for processing Medicare claims for a defined geographic area or "jurisdiction":
    - Part A: hospital insurance
    - Part B: medical insurance
    - Durable Medical Equipment, Orthotics, and Prosthetics (DMEPOS)
    - Home Health and Hospice (HH+H)
- Functional contractors' definition:
  - Other CMS contractors who assist with:
    - Facilitating program integrity activities
    - Performing administrative functions
    - Promoting equitable access to high quality and affordable health care
  - Reference: What's a MAC



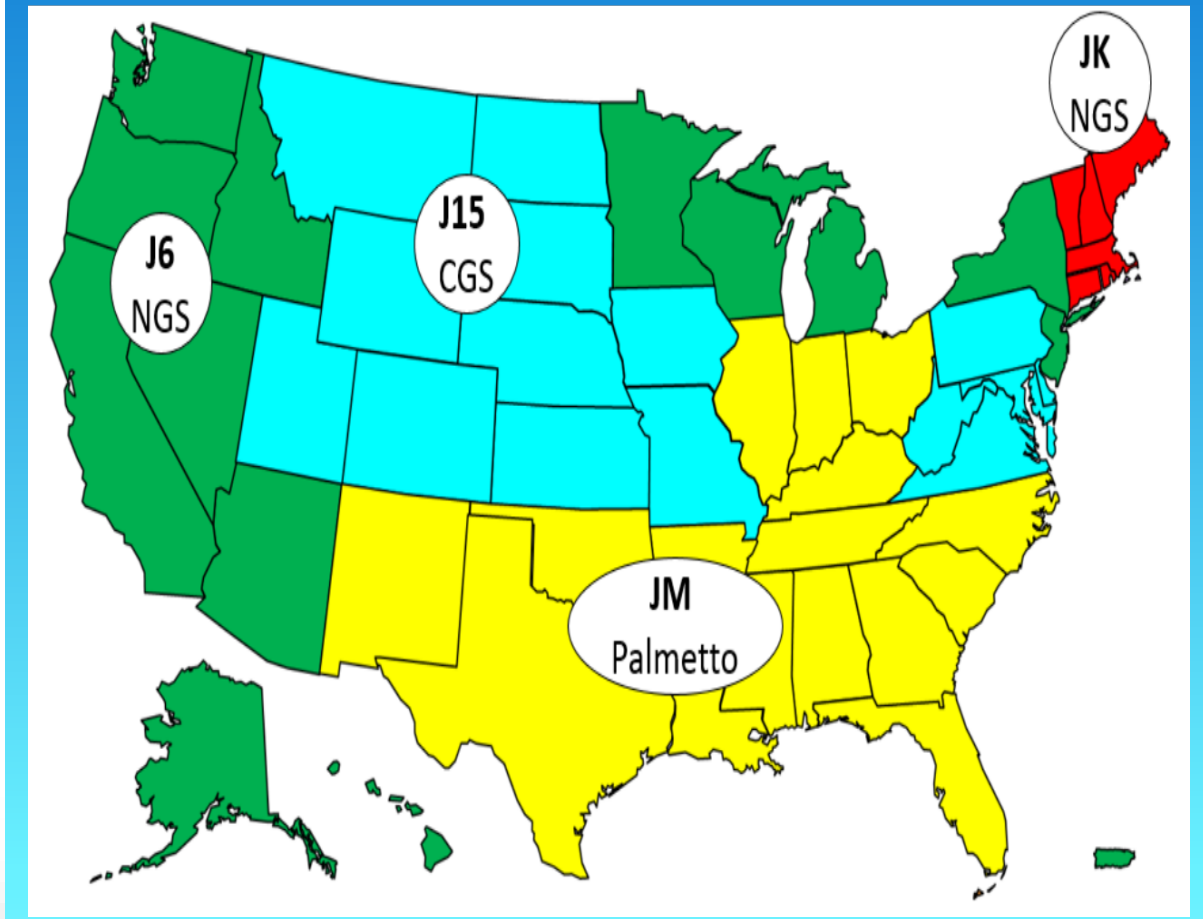
A/B MACs

- A MAC is a contractor that performs Medicare fee-for-service claims administration services that is awarded a contract through competitive procedures based on Section 1874A of the Social Security Act.
- Reference:
  - CMS: Who are the MACs



Home Health and Hospice (HHH) MACs

- There are four A/B MACs that process home health and hospice claims in addition to their typical Medicare Part A and Part B claims
- The four HHH areas do not coincide with the jurisdictional areas covered by the A/B MACs
  - National Government Services (NGS)
    - Jurisdictions K & 6
  - CGS
    - Jurisdiction 15
  - Palmetto GBA
    - Jurisdiction M



What MACs Do


Enforce program integrity
Enroll providers and suppliers
Coordinate with CMS and other Medicare contractors
Process claims
Issue decisions regarding appeal requests (redeterminations)
Reconcile Medicare reimbursement
Facilitate outreach and education
Respond to provider inquiries

Goal of the National AB MAC Ambulance Provider/Supplier Coalition

- Improve Communication
- Support Innovation
- Preserve Integrity
- Provide Quality Customer Service
- Create a Responsible, Collaborative Provider Community
- Protect Beneficiaries and Providers

Questions Submitted Prior to Event: CGS

Medicare Part A and B
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CGS Questions 1 - 2

1. **Question: If any, what documentation can be submitted to substantiate a medically necessary transport tied to a Part A stay when the Common Working File (CWF) does not show admission or discharge at the time of ambulance claim submission?**

   Answer: Some examples of documentation include but are not limited to: Physician Certification Statement (PCS) or other medical record documentation, ambulance trip/run sheet, medical records from the originating and destination facilities and inpatient documentation (if applicable). However, while this is a list of appropriate documentation, this is not a list that guarantees processing and payment of a submitted claim.

2. **Question: Can you clarify whether ambulance claims for transfers during Part A stays require the facility's claim to be paid first or are there modifiers or conditions under which suppliers may bill prior to the facility claim is submitted?**

   Answer: When a patient is transferred to another facility during an inpatient Part A stay, the ambulance claim is bundled into the facility's payment and is not paid separately under Part B. The ambulance company must seek payment directly from the original facility. The facility's claim does not need to be paid first for the ambulance company to submit their claim, but the ambulance claim will be denied by Medicare if it is submitted to Part B while the patient is under a covered Part A stay. There are no modifiers or conditions that allow prior billing.

CGS Questions 3 - 4

3. **Question: What is the MAC's position on ambulance suppliers billing Medicare for interfacility transports when the facility won't append the transport to their Part A claim, even when the trip is clearly related to the inpatient encounter?**

   Answer: Under Medicare bundling rules, an ambulance supplier cannot bill Medicare Part B for interfacility transport of an inpatient. When the transport is related to a hospital inpatient stay, the originating hospital is responsible for payment, and the transport is considered part of the hospital's Part A claim. The ambulance provider should look to the hospital for payment, not Medicare or the beneficiary. An ambulance supplier billing Medicare Part B for such a service will have the claim denied automatically, since Medicare's claims processing system has edits in place to prevent payment for bundled services.

4. **Question: Are there recommended modifiers, condition codes, or statements that ambulance suppliers can use to bill transports that occurred within a Part A stay but are not being billed by the facility?**

   Answer: For ambulance services to be separately billable by a supplier during an inpatient stay, they must be for a non-emergency transport to a diagnostic or therapeutic site, where the Skilled Nursing Facility (SNF) prospective payment system (PPS) rate may apply, or be explicitly covered by a specific program like Medicare Advantage. The use of modifiers such as GY for non-covered services or specific origin/destination codes would be appropriate if such services were allowed and billable.

CGS Questions 5 - 6

5. **Question: When a SNF calls 911 and the patient is transported by ambulance to the hospital, but the SNF fails to discharge the patient or reflect the transfer in their billing, how should the ambulance provider handle the claim especially when Medicare Part A is active and the transport appears bundled?**

   Answer: When an SNF patient on Medicare Part A is transported to a hospital via 911 but the SNF fails to discharge the patient, the ambulance provider is expected to first bill the SNF for the transport. This is because under Medicare's consolidated billing rules, the ambulance service is included in the Part A payment made to the SNF. If the ambulance provider opts to directly bill Medicare Part B, they likely will have to appeal their claim (denial) with supporting documentation.

6. **Question: In situations where the transport is later determined to be not medically necessary (e.g., SNF calls 911 for evaluation without emergency symptoms), can MACs clarify the appropriate path for billing the SNF directly?**

   Answer: A MAC cannot clarify a path to bill a certain SNF directly. Ambulance providers will need to contact the SNF regarding their unique and specific billing guidelines.

CGS Questions 7 - 9

7. **Question: Is a SNF's failure to discharge or submit a PCS form sufficient justification to bill the SNF under consolidated billing rules?**

   Answer: The failure of a SNF to properly discharge a patient or submit a PCS does not justify billing the SNF under consolidated billing rules. Under consolidated billing, outside suppliers must seek payment from the SNF for most services provided during a covered Part A stay.

8. **Question: What is the MAC's guidance on billing a SNF when a non-covered transport is requested by clinical staff such as a nurse or physician but later denied by the facility's finance or administrative team after the ambulance transport has already occurred?**

   Answer: Based on CGS and CMS guidelines, when an ambulance transport is ordered for an SNF resident but later deemed non-covered, the financial responsibility likely falls on the resident, provided an Advance Beneficiary Notice of Noncoverage (ABN) was properly issued. A denial by the SNF's administrative team after the fact does not absolve the ambulance company of its billing obligation to the patient.

9. **Question: D Modifier: Denials for modifier D (Diagnostic or therapeutic site other than P or H) as a noncovered service. Do you have written literature on this modifier being noncovered?**

   Answer: For CGS, modifier D is a valid modifier. (D - Diagnostic or Therapeutic Site other than "P" or "H" when these are used as Origin Codes). For more information, you may refer to the “Modifier Finder Tool” on the website, CGSmedicare.com, as well as the Medicare Benefit Policy Manual (100-02, Chapter 10, Section: 10.3 / 100-04, Chapter 15, Section: 30.A / 100-02, Chapter 15).

CGS Questions 10 - 12

10. **Question: Common working file updates: What options do skilled nursing facilities have available to get the CWF updated?**

    Answer: This depends on the information that the SNF feels needs to be updated. SNFs update the CWF indirectly through specific claim submissions or by communicating with the appropriate Medicare entities.

11. **Question: Signature Requirements: What documents, other than the ABN, are acceptable for proof of patient signature? Like documentation from an attorney's office. Are there other forms from other entities that are acceptable in place of the ABN?**

    Answer: If an ABN is required per CMS guidelines, it must be submitted. Documentation from an attorney's office would not take the place of an ABN.

12. **Question: Signature requirements: For statutorily excluded services, is an ABN required?**

    Answer: No, an ABN is not required for items and services that are statutorily excluded.

CGS Questions 13 - 15

13. **Question: Claim status inquiry: Is there another way, other than by phone, to get claim status on a claim submitted through a clearinghouse?**

    Answer: CGS providers may obtain claim status through the myCGS web portal and the IVR (Interactive Voice Response System). While the IVR is "by phone", live representatives are not present.

14. **Question: Existing Unique tracing number (UTN): Are there plans for Medicare to provide a resource for checking on existing authorizations with another provider?**

    Answer: For CGS, you may currently check through the myCGS web portal or by sending your inquiry via email: j15apriorautheducation@cgsadmin.com or j15bpriorautheducation@cgsadmin.com

15. **Question: What documentation is required when submitting claims with excessive mileage?**

    Answer: Medicare considers mileage to the nearest appropriate facility. Nearest appropriate facility means the institution has a bed and equipment available to treat the patient's medical condition as well as a physician or non-physician specialist available to provide the care required for the patient's condition. Contractors assume the closest facility meets these requirements, unless documented otherwise. Documentation must demonstrate that the patient's condition required a level of care not available at a closer facility, or a detailed statement of why the patient could not be transported to the nearest appropriate facility. Perhaps the nearest facility was on diversion or other issues preventing transport to the closest location (weather, traffic, construction, etc.).

CGS Questions 16 - 18

16. **Question: Target Probe and Educate (TPE) Audit: How far back will you look at service dates in a TPE review?**

    Answer: While the immediate focus of a TPE review is on recent claims to assess and educate on current billing practices, the potential for investigation and recovery of overpayments can extend further back in time, particularly if fraud is suspected.

17. **Question: As more software companies adopt AI-generated narratives, are there any regulations governing their use?**

    Answer: None that CGS can speak to, as we do not currently engage in the use of AI and have not been informed of any pending implementation of this tool within our MAC.

18. **Question: Why does Medicare reimburse only at the Basic Life Support (BLS) level when Emergency Medical Services (EMS are dispatched for a possible DOA (Dead on Arrival) and Advanced Life Support (ALS) procedures are performed at the scene?**

    Answer: Medicare only reimburses ambulance services at the level of service that was furnished and medically necessary, regardless of the initial dispatch or procedures performed on scene. For a possible DOA call where ALS interventions are performed, if the patient is not ultimately transported and no medical transport service is provided, Medicare will not pay. In this specific scenario, Medicare covers the services of the ambulance crew, not the ALS interventions, as the ambulance benefit is for transportation.

CGS Questions 19 - 20

19. **Question: When will Medicare start reimbursing EMS providers for treatment in place, as many commercial insurers already do?**

    Answer: Medicare currently does not broadly reimburse for treatment in place (TIP) services, as it does not cover the response, treatment, and no transport services under HCPCS Code A0998. However, Medicare had a voluntary pilot program called the Emergency Triage, Treat, and Transport (ET3) Model that tested this concept, but it concluded on December 31, 2023, due to low participation and use. It is unknown if or when Medicare will implement a permanent, nationwide TIP reimbursement system, though advocates continue to push for policy changes and data collection to support such reforms.

20. **Question: How is CMS addressing the financial strain on EMS agencies cause by non-reimbursed treatment in place?**

    Answer: In response to the financial strain on EMS agencies from non-reimbursed treatment in place (TIP), CMS) continues to test and evaluate new payment models. Most notably, the now-terminated the ET3 Model provided temporary payment for TIP services, but a long-term solution has not yet been implemented.

CGS Questions 21 - 22

21. **Question: What steps are being taken to align Medicare policies with evolving EMS practices and patient care models?**

    Answer: Key steps to align Medicare policy with evolving Emergency Medical Services (EMS) practices focus on reforming outdated payment models to support innovative, patient-centered care. Legislative efforts, such as the proposed Emergency Medical Services Reimbursement for On-scene Care and Support (EMS ROCS) Act, also aim to reimburse EMS agencies for non-transport services.

22. **Question: What is Medicare's position on reimbursing MES for community paramedicine or mobile integrated healthcare services?**

    Answer: Medicare currently has no national policy to reimburse medical and emergency services (MES) for community paramedicine (CP) or mobile integrated healthcare (MIH) services. In general, Medicare only reimburses ambulance services for patient transport to an emergency department, not for care provided in the field without transport.

CGS Questions 23 - 25

23. **Question: Will CMS reintroduce or expand pilot programs like ET3 to support reimbursement for alternative EMS care models?**

    Answer: While CMS terminated the ET3 Model in 2023, the agency acknowledges the lessons learned from it will inform future initiatives. CMS has not announced a specific pilot program to replace ET3, but its focus on alternative payment models, value-based care, and incorporating lessons from past models and the COVID-19 pandemic indicates continued interest in supporting alternative EMS care.

24. **Question: How can EMS agencies participate in future CMS innovation initiatives related to mobile integrated healthcare or community paramedicine?**

    Answer: To participate in future CMS innovation initiatives for Mobile Integrated Healthcare (MIH) or Community Paramedicine (CP), EMS agencies should focus on developing partnerships, adopting interoperable technology, standardizing data collection, and advocating for policy change. Key steps include performing a local needs assessment, aligning with national data standards, and engaging with stakeholders to create sustainable funding models and improved patient access to care.

25. **Question: What are the most common documentation deficiencies found in EMS audits, and how can providers proactively address them?**

    Answer: The most common documentation deficiencies found in CGS EMS audits relate to the lack of clear, complete, and specific records, most notably the failure to establish medical necessity for ambulance transport. Proactively addressing this issue requires standardizing documentation practices, conducting regular internal audits, and providing ongoing staff training.

CGS Question 26 - 27

26. **Question: What steps can ambulance providers take to maximize reimbursement while staying fully compliant?**

    Answer: To maximize reimbursement while remaining compliant, ambulance providers must integrate robust processes for documentation, coding, claims management, and denial appeals. (For example: Establish a strong intake process, verify insurance eligibility, understand service levels, develop a denial management strategy, provide continuous staff training, stay updated on regulations.)

27. **Question: What key elements must always be included in a patient care report to support medical necessity for Medicare?**

    Answer: Patient care reports (PCRs) must include the patient's current condition, symptoms, and medical background, clearly linking these to specific skilled interventions provided. Key elements include the patient's chief complaint, history of present illness, physical assessment, specific skilled treatments, their response to those treatments, and the rationale for the intervention, all documented to meet accepted standards of medical practice.

Questions Submitted Prior to Event: NGS

national government SERVICES

Medicare Part A and B
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NGS Questions 1 - 4

1. **Question: Will Community Paramedicine and Treatment No Transport components be expanded to provide better care in the field without the need for EMS Transport?**

   Answer: We have not received word from CMS on whether this will be expanded.

2. **Question: Can you provide an update on 2025-2026 Medicare Rates for Emergency Medical Transports by 911 service providers?**

   Answer: CMS is accepting comments until Sept. 12 and will review them afterwards. Check this link for further developments. https://www.cms.gov/medicare/coverage/ambulances-services-center

3. **Question: What are the best patient care report documentation practices to ensure timely claim processing?**

   Answer: To ensure timely claim processing, patient care reports should be completed accurately and timely, including detailed analysis, history, and a thorough account of the patient's condition, assessments, treatment performed and response to such treatment.

4. **Question: Can you provide guidance on determining medical necessity for non-emergency transports?**

   Answer: Ambulance suppliers should always refer to CMS' bed confinement criteria to assist in determining whether the patient needs to be transported via ambulance. This is not the only criteria, but it assists in determining medical necessity.

NGS Questions 5 - 7

5. **Question: Is there a mileage max?**
   Answer: We are not aware of a mileage max amount; however, we do have an edit in the claims processing system that will suspend claims for exceeding 60 miles. Medicare will want to know why the excessive miles were driven, and whether the patient was transported to the closest available location. Mileage does not have a max number of miles allowed. That said, CMS IOM 100-02, Chapter 10, Section 10.3 - Destination states: "An ambulance transport is covered to the nearest appropriate facility to obtain necessary diagnostic and/or therapeutic services (such as a CT scan or cobalt therapy) as well as the return transport". Note: The hospital to hospital are excluded from this edit. (https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/bp102c10.pdf)
6. **Question: Claims being denied for Hospice eligibility, but not yet formally enrolled in Hospice at time of transport. Is the patient liable?**
   Answer: This is an issue that would require contacting Customer Service with a claim example.
7. **Question: Would like to know why claims that are for deceased 911 patients are not being covered when we put in the correct information with QL and how it is determined if we are the ones calling.**
   Answer: It is difficult for us to indicate what could be causing the denial without viewing the claim. We recommend you reach out to the PCC. QL modifier claims are only payable with A0428 and A0429 (BLS emergent versus non-emergent).

NGS Questions 8 - 9

8. **Question: When does Medicare take over when patient enrolls in hospice and has a Medicare Advantage?**

   Answer: When a patient with a Medicare Advantage plan enrolls in hospice, original Medicare takes over coverage for the terminal illness and related conditions starting on the date of hospice enrollment. Your Medicare Advantage Plan will continue to cover medically necessary services for health problems unrelated to your terminal illness, and any extra benefits it offers.

9. **Question: We would like this ruling explained more to us as to what you are implying here. What is the exact criteria they have to meet? Does blood running alone enough to qualify? Or do other criteria need to be met? Does this include interfacility transports? We would info about the new ruling on the ALS2 blood products. Does this include H to H? Do they have to be intubated, etc.?**

   Answer: If a hospital-to-hospital transport involves administering one of the qualifying blood products, it is considered an ALS2 transport. After consideration of public comments and upon further review CMS added the administration of low titer O+ whole blood to the list of procedures that independently qualify as an ALS2 procedure, therefore, the patient does not have to be intubated.

NGS Questions 10 - 12

10. **Question: Would like to learn more about billing for treating but not transporting calls.**

    Answer: Code A0998 (ambulance response/treatment, no transport) is not payable by Medicare. You may submit a claim to Medicare to obtain a denial by using code A0999 (unlisted ambulance service), along with the GY modifier to indicate the service is statutorily excluded from coverage. Also indicate in the extra narrative field that the patient refused to be transported. Medicare will deny the claim with a patient liability.

11. **Question: Can MAC s walk through common pitfalls in ambulance claim appeals and how to strengthen supporting documentation?**

    Answer: NGS conducts ambulance webinars on a monthly basis, and common pitfalls are reviewed with attendees. Please see our "Events" page at www.ngsmedicare.com for the webinar schedule.

12. **Question: Will there be future opportunities for real-time feedback or claim correction before final claim decisions are issued?**

    Answer: There are no future opportunities for claim correction to occur before claims processing decision are made. You would have to appeal the denial.

NGS Questions 13 - 15

13. **Question: We would like this ruling explained more to us as to what you are implying here. What is the exact criteria they have to meet? Does blood running alone enough to qualify? Or do other criteria need to be met? Does this include interfacility transports? We would info about the new ruling on the ALS2 blood products. Does this include H to H? Do they have to be intubated, etc.?**

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14. **Question: What trends are MACs seeing in audit denials, and what can providers do to prevent recurring issues?**

    Answer: Most claim denials occur due to medical necessity reasons. You can avoid this by including as much information as you can on the claim to establish the necessity of the transport. Additionally, you can utilize the transportation indicators.

15. **Question: How do A/B MACs handle claims for ambulance services? Explain the processes for submitting claims and how MACs may require documentation and reviews to verify medical necessity and proper billing and why it would be different between MAC's.**

    Answer: All incoming claims are processed in the same manner. The MAC may request documentation via an ADR. This is your opportunity to provide additional information to substantiate the claim. We can only speak on how NGS processes claims, however we cannot comment on how other MACs process claims.

NGS Questions 16 - 18

16. **Question: What are the most frequent reasons for Medicare ambulance claim denials or rejections?**

    Answer: The most frequent reasons for claim denial, from an NGS standpoint, are medical necessity.

17. **Question: Can you please give the definition of an emergency response?**

    Answer: An emergency response is an immediate response to a 911 call by an ambulance supplier, where the patient's health is in serious danger, and they cannot be safely transported by any other means (wheelchair van, friend/family member). Key factors include the patient's medical condition at the time of transport, the need for medically necessary care, the inability to use other transportation, and the ambulance being staffed and equipped to provide the necessary level of service.

18. **Question: What is the process for getting ALS 1 rate for calls run by advanced EMTs?**

    Answer: Transports are billed based on the level of service provided to the beneficiary. It is not based on the vehicle and/or staffing. If the patient required ALS level services, then you may bill ALS.

NGS Question 19

19. **Question: What qualifies as an ALS assessment vs paramedics?**

    Answer: Each state/local laws have differing rules on certification requirements. You would be best advised to seek state requirements in determining what certification levels meet each level of service, and what each level is authorized to perform.

    Change Request 10110 states "ALS assessment is defined in 42 CFR 414.605 as 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."

    (https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R236BP.pdf)

    The Medicare Benefit Policy Manual, chapter 10, section 30.1.1, states that "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 may be 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, as defined in section 10.2."

NGS Questions 20 - 22

20. **Question: Modifier for 2 transports in the same day – what is recognized by each Supplier? Could the modifier be consistent?**

    Answer: Each MAC can choose whether to allow the 76 modifier to be used in ambulance billing. NGS does allow this. However, for areas that do not, you may bill both transports that occurred on the same day to the same patient on the same claim. It is also a good idea to include a comment indicting multiple transports same patient same day. By billing both on the same claim (if there were two), you have a lesser chance of the second transport denying as a duplicate to the first, which is what would likely happen if they were billed separately.

21. **Question: What are some upcoming rule requirements to be aware of?**

    Answer: We recommend you subscribe to CMS/NGS' email updates to hear firsthand of changes coming via Final Rule for 2026.

22. **Question: How to handle deceased patient signatures?**

    Answer: If the patient is deceased and cannot sign, you should pursue their legal representative/guardian's signature. You can view CMS' signature requirements here:

    https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/pim83c03.pdf

NGS Questions 23 - 26

23. **Question: Explain how to pay back when VA pays after Medicare has paid?**

    Answer: If you need to return funds to Medicare, you should complete a Voluntary Refund form and send the money back to Medicare as soon as possible. The direct link to this form is here:

    https://www.ngsmedicare.com/web/ngs/forms/-/categories/95650?p_r_p_categoryId=95650&lob=96664&state=97118&rgion=93623

24. **Question: Will there be an LCD for ground ambulance issued soon?**

    Answer: LCDs are offered by each individual MAC. NGS does not plan to offer an LCD due to CMS' regulations in the IOMs (100-02, Chapter 10 & 100-04, Chapter 15).

25. **Question: Are claims and appeals both handled by AI?**

    Answer: No, Medicare does not utilize AI in the claims/appeals processing system.

26. **Question: How do we know when to bill hospice vs Medicare?**

    Answer: Medicare Part B pays for transports on the first and last date of hospice, as well as transports unrelated to the patient's terminal condition. You should append the GW modifier to these transports. If a patient is under hospice care and requires an ambulance transport for a condition related to their terminal illness, the hospice provider should arrange and bill for the service.

NGS Questions 27 - 29

27. **Question: How much will CMS reimbursement be increasing the payments to ground ambulance services to reflect a more reasonable rate?**

    Answer: CMS developed the GADCS to gather cost, revenue, and utilization information from ground ambulance providers. This data will be used to create a long-term system to establish a more reasonable payment rate for ambulance services. You can read more about this at https://www.cms.gov/medicare/payment/fee-schedules/ambulance/medicare-ground-ambulance-data-collection-system

28. **Question: Any update in regards to the Medicare Ground Ambulance Data Collection System?**

    Answer: For the latest information please visit: https://www.cms.gov/medicare/payment/fee-schedules/ambulance/medicare-ground-ambulance-data-collection-system

29. **Question: There is a limit on mileage that we can transport patents back home. Where can we find this specific information?**

    Answer: Medicare Benefit Policy Manual, Chapter 10 - Ambulance Services, Section 10.3 - The Destination: https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/bp102c10.pdf

NGS Questions 30 - 31

30. **Question: How can we easily tell if the patient's transport is part of SNF consolidated billing? The SNF also doesn't know?**

    Answer: You need to first confirm if the patient is in a Part A covered SNF stay. If so, the SNF is responsible for billing the transport unless it falls under a specific service exception, such as medically necessary ambulance transport or transport for services explicitly listed as excluded from consolidated billing.

    Certain ambulance services, including ambulance services that transport the beneficiary to the SNF initially, ambulance services that transport the beneficiary from the SNF at the end of the stay (other than in situations involving transfer to another SNF), and roundtrip ambulance services furnished during the stay that transport the beneficiary offsite temporarily in order to receive dialysis, or to receive certain types of intensive or emergency outpatient hospital services

    Reference: https://www.cms.gov/medicare/coding-billing/skilled-nursing-facility-snf-consolidated-billing

31. **Question: Claims, code changes and billing information for Bariatric patient's and their codes**

    Answer: Ambulance claims and billing depend on the medical necessity of the transport, the specific services required, and proper documentation. There are no specific ambulance billing codes for bariatric patients. Billing reflects the level of service, equipment, and required personnel. As with any ambulance transport, Medicare requires that using other means of transportation would have endangered the patient's health, regardless of whether that transportation was available. For obese patients, transport can require specialized equipment, but the fundamental medical necessity rules apply.

NGS Question 32

32. **Question: Beneficiary Signatures: Does the patient signature need to have a date by the signature and if it does, does the patient need to write the date, or can the medic or other person write the date?**

Answer: The date shows when a service was provided, ensuring the documentation is timely and valid for the service period. Therefore, the patient signature should always be dated by the patient, however, if the patient is unable to sign due to duress, the following are authorized to sign on their behalf:

- The beneficiary's legal guardian;
- A relative or other person who receives social security or other governmental benefits on behalf of the beneficiary;
- A relative or other person who arranges for the beneficiary's treatment or exercises other responsibility for his/her affairs;
- A representative of an agency or institution that did not furnish the services for which payment is claimed, but furnished other care, services, or assistance to the beneficiary;
- A representative of the provider or of the nonparticipating hospital claiming payment for services it has furnished, if the provider or nonparticipating hospital is unable to have the claim signed in accordance with 42 CFR 424.36(b)(1 – 4); A representative of the ambulance provider or supplier who is present during an emergency and/or nonemergency transport, provided that the ambulance provider or supplier maintains certain documentation in its records for at least 4 years from the date of service. 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.

NGS Questions 33 - 34

33. **Question: Can/Should Authorized Rep signature (legal guardian person receiving SS or other Govt benefits Relative who arranges Patient affairs or other Facility Rep) be used as a lifetime signature for past present or future transports?**

    Answer: CMS regulations emphasize that each transport must be acknowledged by the beneficiary's signature at the time of service. If the patient is unable or unwilling to sign, CMS permits other individuals, such as the patient's legal guardian or healthcare power of attorney, to sign on their behalf. If none of these individuals are available, the transport crew may sign and must document why the patient could not sign, alongside obtaining validation from the receiving facility. CMS has left it up to MAC discretion to allow lifetime signatures.

34. **Question: Paramedic Intercepts (for NY) – Due to rural agreements going away due to Fire Dept Ambulance (volunteer) now not considered "prohibited by State law as a billing third party payer" and can now bill – will Paramedic Intercept be considered for payment? Will the wording for A0432 definition be amended for this change so claims can be billed A0432, or should A0999 continue to be used for Paramedic Intercept billing?**

    Answer: Please see this web page from the Association of Fire Districts of the State of New York which includes all details of Paramedic Intercept services and how they should be billed. Medicare still accepts Paramedic Intercept services since the NY legislation waiver continues through July 8, 2026. https://afdsny.org/news_manager.php?page=25134

NGS Questions 35 - 37

35. **Question: Denials for modifier D (Diagnostic or therapeutic site other than P or H) as a noncovered service. Do you have written literature on this modifier being noncovered?**

    Answer: This sounds like a claim specific issue where we would need to see the reasons for denials as currently, origin/destination modifier "D" is payable. We recommend you contact our PCC to review these denials with them.

36. **Question: Common working file updates: What options do skilled nursing facilities have available to get the CWF updated?**

    Answer: SNFs are not able to update the CWF directly.

37. **Question: Signature Requirements: What documents, other than the ABN, are acceptable for proof of patient signature? Like documentation from an attorney's office. Are there other forms from other entities that are acceptable in place of the ABN?**

    Answer: Please see our prior answer on beneficiary signatures and who is eligible to sign on behalf of them. According to Medicare Claims Processing Manual Chapter 30 - Financial Liability Protections, section 50.5 - ABN Standards The ABN, Form CMS-R-131, is the OMB approved standard written notice. Failure to use this notice as mandated could result in the notice being invalidated and/or the notifier being held liable for the items or services in question. The online replicable copies of the OMB approved ABN (CMS-R-131) and instructions for notice completion are available on the CMS website at: http://www.cms.gov/Medicare/Medicare-General- Information/BNI/ABN.html. See https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c30.pdf#page=34 for more information.

NGS Questions 38 - 40

38. **Question: Signature requirements: For statutorily excluded services, is an ABN required?**

    Answer: No, but as a courtesy a voluntary notice alerting financial responsibility to the beneficiary could be provided.

39. **Question: Claim status inquiry: Is there another way, other than by phone, to get claim status on a claim submitted through a clearinghouse?**

    Answer: No, you will have to work with your clearinghouse for claim status information. Once the claim is in our system, you may obtain information via the IVR or NGSConnex.

40. **Question: Existing UTN: Are there plans for Medicare to provide a resource for checking on existing authorizations with another provider?**

    Answer: No, there are no plans to offer this. Ambulance suppliers can check with the beneficiary to see if an existing Repetitive scheduled non-emergent ambulance transports (RSNAT) is currently in place.

NGS Questions 41 - 44

41. **Question: What documentation is required when submitting claims with excessive mileage?**

    Answer: Claims will suspend for medical necessity if billed over 60 miles. Medicare will want to know the reason for excessive mileage. You can support loaded miles by providing a trip/odometer reading, GPS/navigation system, Mapquest/Google maps or other mapping program, proving the destination is the closest facility.

42. **Question: TPE Audit: How far back will you look at service dates in a TPE review?**

    Answer: The regulation requires you to maintain medical records for 7 years from the date of service (DOS). Reference: https://www.cms.gov/files/document/mln4840534-medical-record-maintenance-and-access-requirements.pdf

43. **Question: Which MACs have specific coding Instruction?**

    Answer: NGS does not have an ambulance LCD. The CMS IOMs include coding information.

44. **Question: Does Medicare plan to continue with RSNAT prior authorization forms?**

    Answer: If you are referring to the RSNAT cover sheet form, it is not mandatory to use. You may create your own cover sheet; however, it should contain the same information as the cover sheet. If you are asking about whether RSNAT Prior Authorization will be continuing, we have not heard any word on the process stopping.

NGS Question 45

45. Question: Signature Documentation, if the crew is unable to get the patient signature, does a Face sheet suffice?

Answer: CMS IOM Publication 100-02, Medicare Benefit Policy Manual, Chapter 10, Section 20.1.2 Beneficiary Signature Requirements: This section states “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, the following individuals may sign the claim form on behalf of the beneficiary:

(1) The beneficiary’s legal guardian.

(2) A relative or other person who receives social security or other governmental benefits on behalf of the beneficiary.

(3) A relative or other person who arranges for the beneficiary’s treatment or exercises other responsibility for his or her affairs.

(4) A representative of an agency or institution that did not furnish the services for which payment is claimed, but furnished other care, services, or assistance to the beneficiary

(5) A representative of the provider or of the nonparticipating hospital claiming payment for services it has furnished, if the provider or nonparticipating hospital is unable to have the claim signed in accordance with 42 CFR 424.36(b) (1 – 4).

NGS Question 45 (continued)

Answer (continued):

(6) A representative of the ambulance provider or supplier who is present during an emergency and/or nonemergency transport, provided that the ambulance provider or supplier maintains certain documentation in its records for at least 4 years from the date of service. 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. (Note: there is a 12 month period for filing a Medicare claim, depending upon the date of service.)

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.

NGS Questions 46 - 47

46. **Question: How often is the common working file updated for Part A Stay?**

    Answer: When an inpatient claim processes through CWF, it posts the information in CWF and updates the patient's records.

47. **Question: ADR – are these sent randomly? What determines if a claim gets an ADR?**

    Answer: ADRs are sent as part of the TPE Process. Typically, medical review determines what services to focus on and then selects providers/suppliers that bill for that service by focusing on providers/suppliers who have the highest claim denial rates or who have billing practices that vary significantly from their peers. Once a provider/supplier is selected for review, an ADR is sent to request medical records.

Questions Submitted Prior to Event: Novitas

Medicare Part A and B
Provider Outreach and Education
Multi-MAC Collaboration Group

Novitas Questions 1 - 2

1. **Question: Are there any regulations specifically pertaining to the Entry, Importing or presentation of the Sequestration amount included in either the electronic 835 or Paper Explanation of Benefits. If there is, can you please point me to the supporting documentation. My question is from the Practice Management perspective. I am looking for solutions to when Commercial Payors truncate the Sequestration Amount instead of rounding, therefore resulting in balancing issues within the posting application. So, I am trying to understand if there are regulations around the provider editing the Sequestration amount within the Practice Management software in these instances? Or in the case of manually posting a payment from the EOB, can they manually enter the CO253 amount as well?**

   Answer: Questions for commercial insurance companies or practice management software will need to be directed to them.

2. **Question: Which MACs have specific Coding Instruction?**

   Answer: Novitas does not have a local coverage policy and at this time do not plan on developing one. For information on coverage and documentation requirements, refer to:

   - CFR, Title 42, Chapter IV, Subchapter B, Part 410, Subpart B, Section 410.40 - Coverage of Ambulance Services
   - CFR, Title 42, Chapter IV, Subchapter B, Part 410, Subpart B, Section 410.41- Requirements for Ambulance Suppliers
   - Medicare Benefit Policy Manual, Pub. 100-02, Chapter 10 - Ambulance Services
   - Medicare Claims Processing Manual, Pub. 100-04, Chapter 15 - Ambulance

Novitas Questions 3 - 5

3. **Question: Does Medicare plan to continue with RSNAT prior authorization forms?**

   Answer: The RSNAT prior authorization form is not required however CMS and Novitas encourage supplier to complete the form for us to process the request timely

4. **Question: How often is the common working file updated for Part A Stay?**

   Answer: This file is updated as the Part A claims are submitted and processed.

5. **Question: Signature Documentation, if the crew is unable to get the patient signature, does a Facesheet suffice?**

   Answer: Complete guidelines regarding the patient's signature can be located in: CFR, Title 42, Chapter IV, Subchapter B, Part 424, Subpart C, Section 424.36 - Signature requirements

Novitas Question 6

6. **Question: ADR – Are these sent randomly? What determines if a claim gets an ADR?**

   Answer: No, ADRs are only sent if Novitas requires additional information. Examples: (not an all-inclusive list):

   - Ambulance supplier not utilizing the prior authorization process:
   - Medicare will allow 3-round trips (6 one-way trips), without reviewing the medical records
   - Medicare will request medical records prior to the 7th one-way trip being processed (paid or denied), even if the initial transports were rendered by a different ambulance supplier
   - Medicare will request medical records using the ADR process
   - Novitas requires suppliers in the Jurisdiction L to provide documentation for mileage over 76 miles. Ambulance claims submitted without sufficient justification/documentation in the appropriate electronic fields, freeform fields, claim notes or other forms of documentation, at the time of submission, will receive an ADR letter requesting the necessary information/documentation to support the mileage billed beyond the above mileage: Ambulance Mileage Claims May Require Supporting Documentation (JH) (JL)
   - ADRs are sent as part of the TPE Process. Typically, medical review determines what services to focus on and then selects providers/suppliers that bill for that service by focusing on providers/suppliers who have the highest claim denial rates or who have billing practices that vary significantly from their peers. Once a provider/supplier is selected for review, an ADR is sent to request medical records.

Questions Submitted Prior to Event: Palmetto GBA

Medicare Part A and B
Provider Outreach and Education
Multi-MAC Collaboration Group

Palmetto GBA Questions 1 - 2

1. **Question: Which MACs have specific coding instructions?**

   Answer: Palmetto GBA does not have an ambulance LCD for Part A or Part B. Providers and suppliers can check this link, Medicare Coverage Database (MCD), to locate MAC local coverage polices.

2. **Question: ADR – Are these sent randomly? What determines if a claim gets an ADR?**

   Answer: ADRs are sent as part of the TPE Process. Typically, medical review determines what services to focus on and then selects providers/suppliers that bill for that service by focusing on providers/suppliers who have the highest claim denial rates or who have billing practices that vary significantly from their peers. Once a provider/supplier is selected for review, an ADR is sent to request medical records.

Questions Submitted Prior to Event: WPS

Medicare Part A and B
Provider Outreach and Education
Multi-MAC Collaboration Group

WPS Questions 1 - 5

1. **Question: D Modifier: Denials for modifier D (Diagnostic or therapeutic site other than P or H) as a noncovered service. Do you have written literature on this modifier being noncovered?**

   Answer: Modifier D is a valid origin and destination modifier.

2. **Question: Common working file updates: What options do skilled nursing facilities have available to get the CWF updated?**

   Answer: This depends on the information that the SNF feels needs to be updated. A claim? MSP data?

3. **Question: Signature Requirements: What documents, other than the ABN, are acceptable for proof of patient signature? Like documentation from an attorney's office. Are there other forms from other entities that are acceptable in place of the ABN?**

   Answer: If an ABN is required per CMS guidelines, it must be submitted. Documentation from an attorney's office would not take the place of an ABN.

4. **Question: Signature requirements: For statutorily excluded services, is an ABN required?**

   Answer: No, an ABN is not required for items and services that are statutorily excluded.

5. **Question: Claim status inquiry: Is there another way, other than by phone, to get claim status on a claim submitted through a clearinghouse?**

   Answer: WPS providers can obtain claim status via the Secure Net Access Portal (SNAP) or the Interactive Voice Response (IVR). Part A providers may also use Direct Data Entry (DDE).

WPS Questions 6 - 8

6. **Question: WPS Authorization Process: What is the most effective way to complete a repetitive authorization request, and receive a timely response?**

   Answer: We encourage providers to use SNAP or esMD to submit documentation. However, providers may submit their documentation via postal mail, encrypted CD/DVD/flash drive, or secure fax.

7. **Question: WPS Authorization Process: What standard documentation should be submitted with the pre-auth request to move the approval process along?**

   Answer: The provider should submit the following documentation with their request: PCS, documentation from the medical record to support the medical necessity of the transports, information on the origin and destination of the transports, number of transports requested, certifying physician/practitioner name and NPI, and any other relevant document as deemed necessary.

8. **Question: Existing UTN: Are there plans for Medicare to provide a resource for checking on existing authorizations with another provider?**

   Answer: WPS has a Prior Authorization Request Status Search tool (https://www.wpsgha.com/tools/prior-auth-request-search). Users need the provider/supplier's NPI and PTAN.

WPS Questions 9 - 10

9. **Question: What documentation is required when submitting claims with excessive mileage?**

   Answer: I am uncertain what is meant by “excessive.” Medicare considers mileage to the nearest appropriate facility. Nearest appropriate facility means the institution has a bed and equipment available to treat the patient’s medical condition as well as a physician or non-physician specialist available to provide the care required for the patient's condition. Contractors assume the closest facility meets these requirements, unless documented otherwise. Documentation must demonstrate that the patient's condition required a level of care not available at a closer facility, or a detailed statement of why the patient could not be transported to the nearest appropriate facility. Perhaps the nearest facility was on diversion or other issues preventing transport to the closest location (weather, traffic, construction, etc.).

10. **Question: TPE Audit: How far back will you look at service dates in a TPE review?**

    Answer: While the immediate focus of a TPE review is on recent claims to assess and educate on current billing practices, the potential for investigation and recovery of overpayments can extend further back in time, particularly if fraud is suspected.

WPS Questions 11 - 13

11. **Question: Fee for Service Medicare's system is run the best - can we ever go back to only this? If not, why?**

    Answer: Per CMS, all MACs use Fiscal Intermediary Shared System (FISS), for Part A and MCS for Part B to process fee-for-service claims.

12. **Question: What is the future of Medicare - Fee for Service vs. Managed Care/Advantage plans?**

    Answer: We are unable to answer this question. Sign-up for the eNews from WPS and CMS to stay current on changes as they are communicated.

13. **Question: Will there be changes to Medicare with new administration?**

    Answer: Medicare changes frequently. Sign-up for the eNews from WPS and CMS to stay current.

WPS Questions 14 - 16

14. **Question: Why is it taking longer to get clients approved for billing?**

    Answer: WPS is currently meeting all CMS application processing timeframes. The number of days to process an application may vary depending the MACs workload and other contributing factors. To review the timeframes, see our Provider Enrollment Timeframes webpage. (https://www.wpsgha.com/guides-resources/view/529)

15. **Question: Reimbursement for treatment in place and transport to alternate destinations.**

    Answer: Traditional Medicare does not reimburse for treat no transport. If the destination is not defined by the CMS Medicare Claims Processing Manual, Chapter 15 - Ambulance,Section 30 - General Billing Guidelines A, then we can't pay the claim. (https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/clm104c15.pdf)

16. **Question: What changes are coming in the future?**

    Answer: Sign-up for the eNews from WPS and CMS to stay current on changes as they are communicated.

WPS Questions 17 - 18

17. **Question: Can we balance bill Medicare patients, if so, is it traditional Medicare only?**

    Answer: We are only able to answer for Traditional Medicare. You may bill patient for the Medicare assigned amounts. This includes co-pays, co-insurance, and deductible. The difference between the allowed amount and billed is a provider responsibility.

18. **Question: Do you plan on dropping the 21-day rules for CMN's if the facility does not provide us with one?**

    Answer: The Physician Certification Statement requirements are not WPS rules, they are in the Code of Federal Regulations.

WPS Question 19

19. **Question: What are the most frequent reasons for Medicare ambulance claim denials or rejections?**

    Answer: Claims submitted 4/1/25 - 6/30/25

    - Top 5 Rejections:
        - Claims lacks information needed for adjudication - 7,906
        - RSNAT number issues - 1,640
        - Send claim to Railroad Medicare - 1,359
        - Patient eligibility information - 559
        - Incomplete primary payer information - 425
    - Top 5 Denials:
        - Patient in Medicare Advantage - 11,825
        - Procedure code not covered - 5,854
        - Hospice patient - 3,424
        - Medicare doesn't pay for this service - 2,576
        - Not covered when performed by this provider - 2,459

WPS Questions 20 - 22

20. **Question: Will you consider covering Treat & No Transports in the near future?**

    Answer: CMS establishes the coverage guidelines, it is up to them, not the MAC.

21. **Question: When a patient is enrolled in a Medicare Replacement Plan, why can you not supply their policy number?**

    Answer: WPS processes claims for Traditional Medicare. We do not use the Part C plan's number. We have no business need for that information.

22. **Question: What has caused an increase in PR-180 Residency Requirement denials? Confirmed in WPS no Part B due to residency.**

    Answer: Individuals who are not lawfully present in the U.S. cannot enroll in Medicare coverage, and no payments will be made on their behalf for Part A or Part B claims. The reason for the increase in these denials is uncertain.

WPS Questions 23 - 25

23. **Question: Will Medicare increase their rates anytime soon and are they considering an additional benefit for administering whole blood?**

    Answer: We are unable to answer this as CMS controls the rates and the payable items.

24. **Question: We are receiving denials for ambulance transports (medically necessary) when the patient is transported from one hospital to another hospital for a higher level of care because the date of discharge of from the originating hospital is the same date as the departure date.**

    Answer: If the transferring hospital's claim has not processed yet, the system would not know they have been discharged from that facility. Depending on the denial code, you should be able to rebill or appeal.

25. **Question: QMB patients with full Medicaid benefits and advantage plans. Do advantage plans have to pay the secondary amount per state guidelines?**

    Answer: We can't answer questions about Medicare Advantage plans. WPS only processes claims for Traditional fee-for-service Medicare.

WPS Questions 26 - 28

26. **Question: How do I identify a Part A stay via WPS?**

    Answer: Use the Secure Net Access Portal (SNAP) on our website. Once a claim processes, the Common Working File (CWF) updates the eligibility information on the Part A deductible screen.

27. **Question: Will the Medicare reimbursement rate be changing?**

    Answer: WPS is unable to answer this as CMS controls the rates

28. **Question: If a provider is ordering an interfacility transfer, why are we seeing more prior authorizations being required?**

    Answer: Traditional Medicare does not require prior authorizations for this type of transport.

WPS Questions 29 - 32

29. **Question: What type of audits is CMS going to do with the Managed Care Medicare Advantage plans?**

    Answer: We can't answer questions regarding Medicare Advantage plans.

30. **Question: Why do the Part C insurances not follow the same rules as Part B?**

    Answer: We can't answer questions about Medicare Advantage plans. WPS only processes claims for Traditional fee-for-service Medicare.

31. **Question: Provide example(s) of any frequently seen documentation issues or other common issues found on submitted claims.**

    Answer: Our number one medical review issue is the lack of medical necessity. We are offering a class on 10/1/25 for the EMT assessment to help address this.

    Other issues are contained in the other question regarding data for rejections and denials.

32. **Question: What changes to the current system can we expect?**

    Answer: WPS is not changing the current system.

WPS Questions 33 - 37

33. **Question: Which MACs have specific Coding Instruction?**

    Answer: WPS does not have specific coding instructions.

34. **Question: Does Medicare plan to continue with RSNAT prior authorization forms?**

    Answer: This is a question for CMS. WPS will continue until CMS instructs us to stop.

35. **Question: How often is the common working file updated for Part A Stay?**

    Answer: Once a claim finalizes in the FISS, it posts to the CWF and updates the patient's records.

36. **Question: Signature Documentation, if the crew is unable to get the patient signature, does a Facesheet suffice?**

    Answer: WPS is unable to answer this. We need to see the documentation to support why a patient can't sign and verify the provider followed the CMS signature guidance.

37. **Question: ADR - are these sent randomly? What determines if a claim gets an ADR?**

    Answer: WPS sends an ADR for the TPE process. What are you receiving the ADR for and we can explain which item is causing them.

Questions Submitted Prior to Event: Noridian

NORIDIAN
HEALTHCARE SOLUTIONS

Medicare Part A and B
Provider Outreach and Education
Multi-MAC Collaboration Group

Noridian Questions 1 - 3

1. **Question: If a patient is pronounced Dead After Arrival, however, treatment was provided such as CPR, Intubation, IO medications, etc., then after treatment a POLST form was located and provided to the paramedics, so all resuscitation efforts were then stopped, is this still a billable call?**

   Answer: If the patient expired while the ambulance crew was onsite providing treatment, but prior to its departure, then the provider/supplier would be eligible for the BLS base rate (A0428), but not mileage or a rural adjustment. The QL modifier should be added to the claim line. More information is available in the Benefit Policy Manual, 100-02, Chapter 10, Section 10.2.6.

2. **Question: What are the most common things that delay payment or cause claim denials?**

   Answer: Missing or invalid PCS. A PCS is required to be signed on (or within 60 days before) the DOS by an MD or DO for repetitive, scheduled transports. A non-physician certification may be obtained for non-repetitive or non-scheduled transports. Insufficient documentation to support medical necessity. Must have evidence in the medical record that the beneficiary's medical condition contraindicates all other means of transportation, that include non-ambulance medical vehicles like a medivan or ambulette.

3. **Question: For 911 urban ambulance operation, can a receiving facility nurse sign as patient representative when patient is alone?**

   Answer: When the beneficiary is deemed incapable of signing, then there are situations that allow for this. CFR 424.36(b)(4) allows for the signatory: A representative of an agency or institution that did not furnish the services for which payment is claimed but furnished other care, services, or assistance to the beneficiary.

Noridian Questions 4 - 5

4. **Question: Will the MACs consider developing standardized education or templates for EMS providers that could help reduce claim denials?**

   Answer: Thank you for the suggestion. All MACs do develop educational presentations and resources that are based on the ambulance regulations covered in the Internet-Only Manual and the Code of Federal Regulations. Additionally, all MACs meet monthly to discuss potential improvements to education, training, and resources for Ambulance providers and suppliers. We will add this suggested item to next month's meeting agenda for the POE MAC workgroup.

5. **Question: Please cover a DETAILED explanation of medical necessity and ADR's (Additional Documentation Requests).**

   Answer: While we don't have the time to cover these two items in detail, medical necessity is detailed in CFR 410.40(e). In this section of the CFR, the emphasis centers on the General Rule that evaluates whether the transportation of a patient by any other means would be contraindicated. It also defines the Special Rules for nonemergency, scheduled, repetitive ambulance services and for nonemergency services that are either unscheduled or scheduled on a nonrepetitive basis. For ADRs, Noridian has pages under the Medical Review sections of its website that are dedicated to Additional Documentation Requests. Click on the link for "Documentation Requirements."

Noridian Questions 6 - 8

6. **Question: How are we supposed to get patients to pay their not-covered services, via an ABN, when their argument is "I have Medicare"? Is the ABN explained in a booklet to members? We explain it, but it does not matter. How can we get our bills paid for Treat no Transport (TNT) for Medicare eligible patients?**

   Answer: CMS does publish a 16-page booklet expressly for beneficiaries, entitled "Medicare Coverage of Ambulance Services," which explains when Medicare helps cover ambulance services, what patients pay and what Medicare pays, as well as what to do if Medicare doesn't cover the ambulance service. Ambulance reimbursement is considered a transportation benefit, and so with TNT services, no payment is made. In an emergent situation where the patient died before being transported, only the BLS base rate could be billed to Medicare.

7. **Question: How do we handle deceased patient signatures?**

   Answer: If a patient dies during ambulance transport, follow the rules that govern signatures when the beneficiary is incapable of signing. Those are detailed in 42 CFR 424.36(b).

8. **Question: Explain how to pay back when VA pays after Medicare has paid.**

   Answer: If the provider is seeking to refund Medicare after the Veterans Administration has paid a claim, use the non-MSP Voluntary Refund process that is outlined on the Noridian website, under the path Browse by Topic > Overpayment and Recoupment > Submit a Voluntary Refund.

Noridian Questions 9 - 11

9. **Question: Are claims and appeals both handled by AI?**

   Answer: No. Artificial Intelligence is not mature enough for the tasks you mention. The claims systems utilize robotic processing that is based on a complex set of instructions and commands input by humans. On a flowchart, these claims all run through a series of edits that act like gateways (using 'YES' and 'NO' criteria) to determine the next processing steps. Some edits stop (or 'flag') for human review to make a determination. Some claims with the correct coding pass through these edits more quickly than others. Appeals, on the other hand, are a manual process involving documentation review by a team of people. Appeals decisions result in instructions to the Adjudication team on how to uphold or overturn a claim's initial determination.

10. **Question: How can we hold Managed Medicare payers accountable for not processing claims according to Medicare Guidelines?**

    Answer: If you are having persistent problems with Medicare Advantage payers not following CMS payment rules according to CMS coverage, you may bring this concern to your regional CMS office.

11. **Question: Could we get a universal determination on using modifier 76?**

    Answer: Some carriers allow and some do not. Current usage of modifier 76 is left up to each MAC, and as such has been either purposefully utilized (or excluded) as a claims processing variable. There are options for providers to take this message directly to CMS, including their live calls and events, public comment periods on legislation and proposed rules, and directly via email to the provider's regional CMS office.

Noridian Questions 12 - 14

12. **Question: How to bill 2 transports on the same date of service to avoid a denial of "service included in another service" or "duplicate"?**

    Answer: Noridian does not accept the 76 modifier on Ambulance claims. We advise our providers that they may list more than one ambulance trip on the same claim if the ZIP code of all Points of Pickup (POPs) are the same. If the claim denies as a duplicate, use the Appeals process with supporting documentation. If the POPs are in different ZIP codes, prepare a separate claim for each trip.

13. **Question: What are the changes (current year) affecting suppliers of ambulance service?**

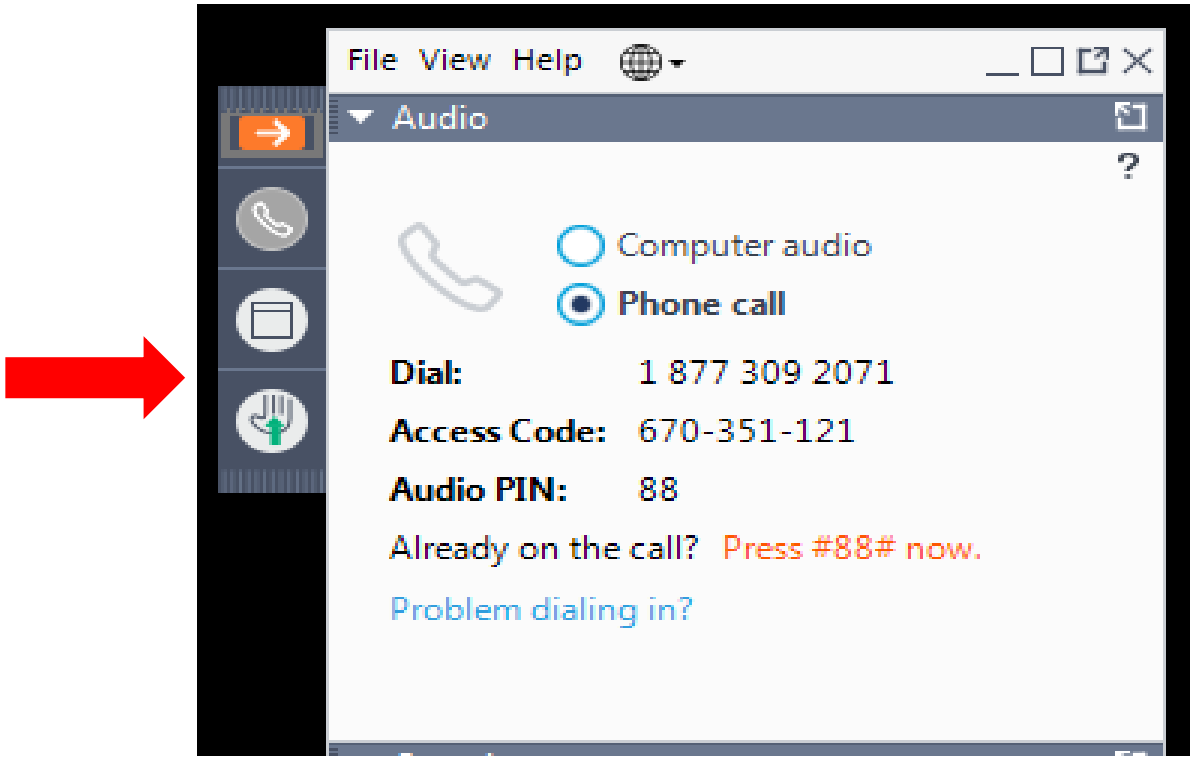
    Answer: Changes include the Ambulance Fee Schedule: (1) extension of three existing add-on payments to the ambulance base and mileage rates for ground ambulance transports through Sept. 30, 2025; (2) regulatory revisions to the CFR to align with these add-on payments; and an (3) ALS Level 2 procedure list update. CMS also continued implementation of the Medicare Ground Ambulance Data Collection System. Finally, updates were made to the Medicare Benefit Policy Manual, specifically Chapter 10, Section 30.1.1, to reflect the ALS2 changes.

14. **Question: Is there a rule that EMT's/Paramedics must obtain RN first and last name on an ePCR (electronic patient care report) when transporting a 911 ground ambulance?**

    Answer: Federal regulations address this requirement in two places. In CFR 410.40(a), the Non-physician certification statement makes the same requirement of an RN that it does for other non-physician practitioners. The signature requirements of the Program Integrity Manual, Chapter 3, Section 3.3.2.4 make the capture of the first and last name of the individual a necessity.

Asking Questions

- Verbal questions
- Hand with green arrow – ask question
- Hand with red arrow – put hand down after question asked
- Ask same question only once



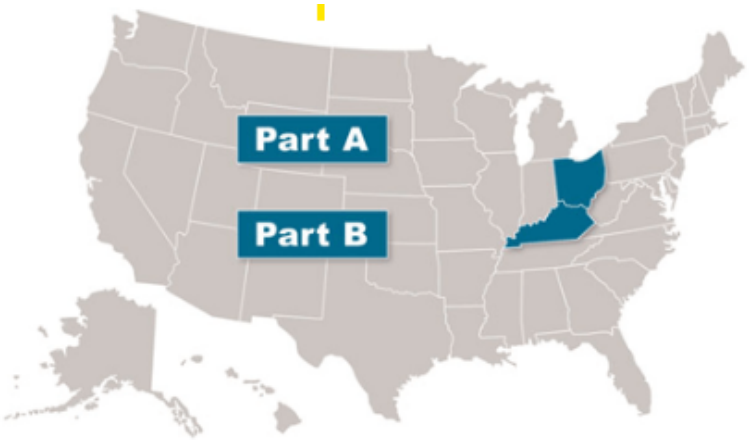
Questions

CGS Medicare Part A

Medicare Administrative Contractor

Jurisdiction 15

Includes Medicare Part A institutional providers in Kentucky and Ohio



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Jurisdiction 15 Part A

Provider Resources

Assistance is available!

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Education & Events
Part A Calendar of Events
Educational Resources
Online Education Center
Part A News & Publications
Self-Service Options

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Provider Enrollment
Provider Enrollment Processes
Applications and Forms
Revalidation
PECOS
Tools, Tracking & Resources

Electronic Data Interchange
EDI Enrollment
EDI Online Application Status Tool
PC-Ace Pro32 Software
EDI Manuals and User Guides

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myCGS
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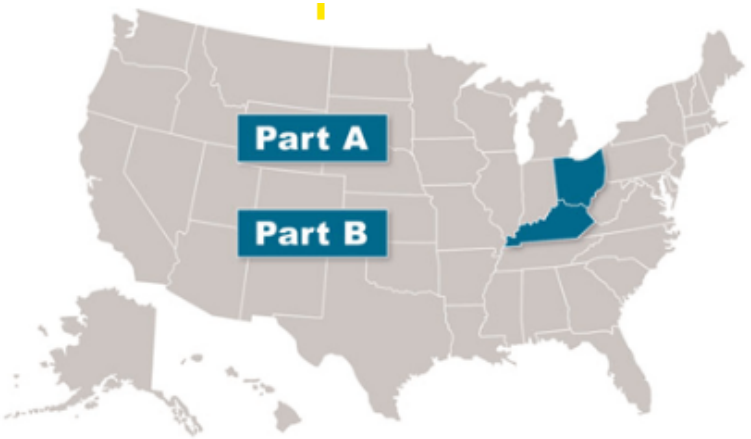
CGS Medicare Part B

Medicare Administrative Contractor

Jurisdiction 15

Includes Medicare Part B physicians, practitioners, and suppliers (not DMEPOS) in Kentucky and Ohio



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Jurisdiction 15 Part B

Provider Resources

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Education & Events
Part B Calendar of Events
Educational Resources
Part B New Provider Resource Center
Part B News & Publications
Self-Service Options

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Provider Enrollment
Provider Enrollment Processes
Applications and Forms
Revalidation
PECOS
Tools, Tracking & Resources

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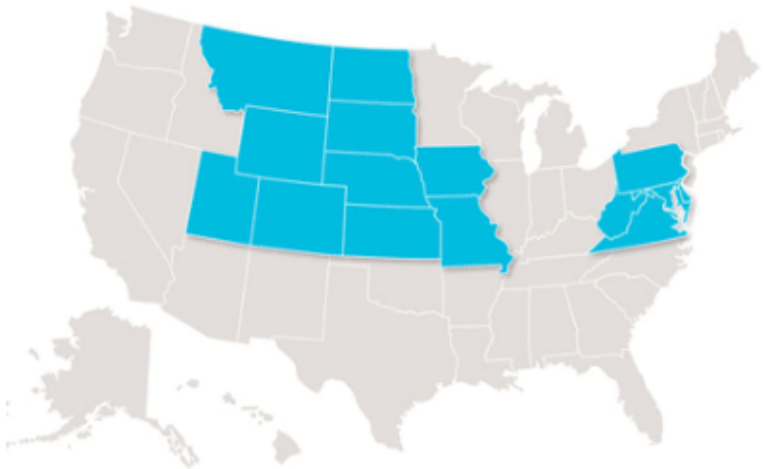
CGS Medicare HHH

Medicare Administrative Contractor

Jurisdiction 15

Includes Home Health and Hospice providers in Colorado, Delaware, Iowa, Kansas, Maryland, Missouri, Montana, Nebraska, North Dakota, South Dakota, Pennsylvania, Utah, Virginia, West Virginia, Wyoming, District of Columbia



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Home Health and Hospice

Provider Resources

Assistance is available!

Education
Education & Resources
HHH Calendar of Events
Educational Resources
Home Health & Hospice News & Publications
Home Health and Hospice New Provider Resource Center
Self-Service Options

Provider Enrollment
Provider Enrollment
Provider Enrollment Processes
Applications and Forms
Revalidation
PECOS
Tools, Tracking & Resources

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EDI User Guides

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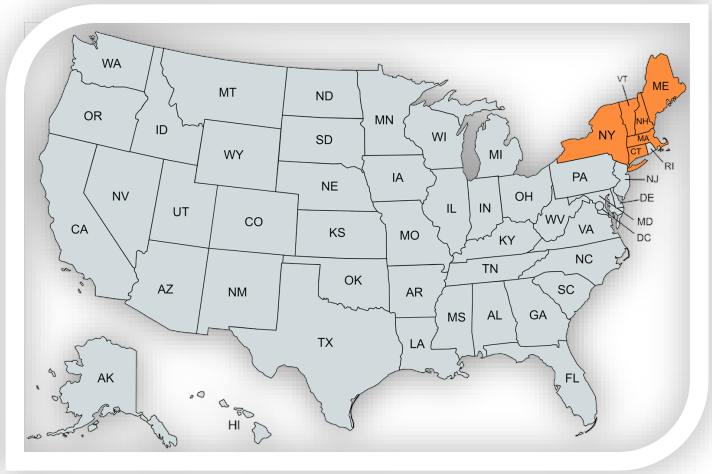
National Government Services, Inc.

Medicare Administrative Contractor

Jurisdiction K (JK)

Connecticut, Maine, Massachusetts, New Hampshire, New York, Rhode Island, Vermont



www.NGSMedicare.com

Provider Resources

Assistance is available!

Ambulance Guidance
NGS Part A Website
Part A Ambulance Articles

NGS Part B Website
Prior Authorization for RSNAT
Part B Ambulance Articles

CMS Resources
Ambulances Services Center
CMS Website -RSNAT Prior Authorization
CMS IOM Publication 100-04, *Medicare Claims Processing Manual*, Chapter 15
CMS IOM Publication 100-02, *Medicare Benefit Policy Manual*, Chapter 10

Education
- Events
- Self-Paced Online Learning

Provider Enrollment
- Enrollment Application Forms
- Submission Options

NGSConnex
- Portal Registration
- User Guide

Claims and Billing
- Claim Submission Options

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Customer Service	1-888-855-4356
IVR	1-877-567-7205

Monday – Friday 8 a.m. – 4 p.m. ET
Phone numbers and mailing addresses

Part B Customer Contact Center

Customer Service	1-866-837-0241
IVR	1-877-869-6504

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Phone numbers and mailing addresses

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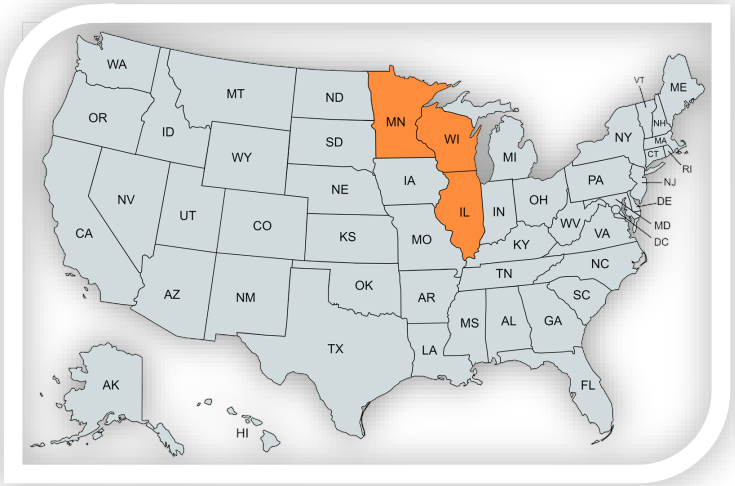
Social Media

National Government Services, Inc.

Medicare Administrative Contractor J6

Jurisdiction 6 (J6)

Illinois, Minnesota, Wisconsin



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Provider Resources

Assistance is available!

Ambulance Guidance
NGS Part A Website
Part A Ambulance Articles

NGS Part B Website
Prior Authorization for RSNAT
Part B Ambulance Articles

CMS Resources
Ambulances Services Center
CMS Website — RSNAT Prior Authorization
CMS IOM Publication 100-04, *Medicare Claims Processing Manual*, Chapter 15
CMS IOM Publication 100-02, *Medicare Benefit Policy Manual*, Chapter 10

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- Self-Paced Online Learning

Provider Enrollment
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- Submission Options

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- Portal Registration
- User Guide

Claims and Billing
- Claim Submission Options

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Customer Service 1-877-702-0990
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Part B Customer Contact Center

Customer Service 1-866-234-7340
IVR 1-877-908-9499
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Medicare Administrative Contractor

Jurisdiction N (JN)

Florida, Puerto Rico and the US Virgin Islands

English
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Spanish
Medicare.fcso.com/es

Provider Resources

Assistance is available!

Education

Events and Event Registration
On-Demand Learning
Tutorials

Provider Enrollment

Enrollment Application Forms
Enrollment Application Assistance Tool
New Enrollment: What forms do I need to complete?
Check Your Application Status

Electronic Enrollment Submission

PECOS
Provider Enrollment Gateway

SPOT Portal

Portal Registration
User Resources

Additional Help

Welcome to Medicare
Tools Center

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Customer Service	1-888-664-4112
Provider Enrollment	1-888-845-8614
SPOT Help Desk	1-855-416-4199
IVR	1-877-602-8816
EDI	1-888-670-0940

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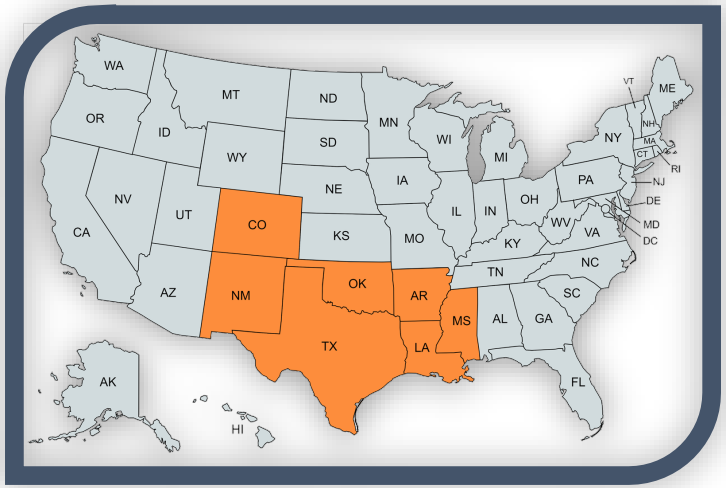
Medicare Administrative Contractor JH

Jurisdiction H (JH)

Arkansas, Colorado, Louisiana, Mississippi, New Mexico, Oklahoma, Texas, and includes Indian Health Service (IHS) and Veterans Affairs (VA) nationally



www.novitas-solutions.com

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Events and Registration
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Enrollment Application Forms
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Indian Health Services

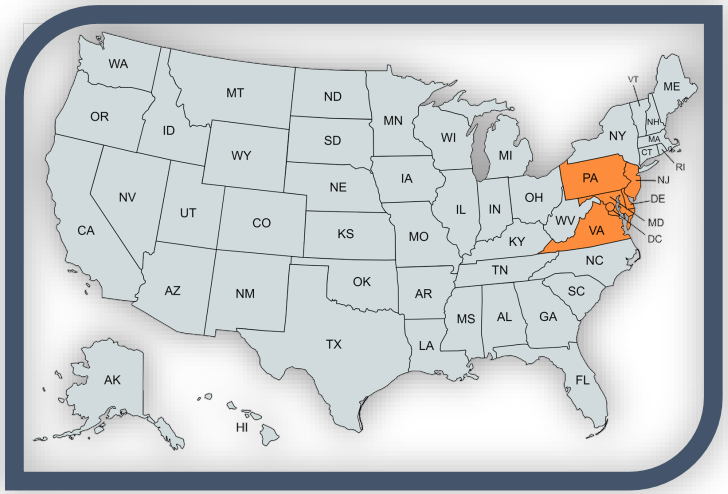
IHS Educational Events
Indian Health Services Reference Manual
Mailing Addresses
Electronic Mailing List

Novitas Solutions

Medicare Administrative Contractor JL

Jurisdiction L (JL)

Delaware, District of Columbia, Maryland, New Jersey, and Pennsylvania as well as Arlington and Fairfax counties in Virginia, and the cities of Alexandria, Fairfax, and Falls Church in Virginia for Part B services only



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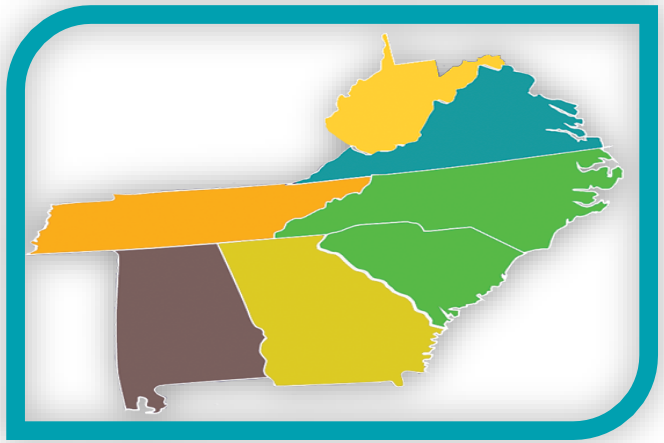
Palmetto GBA Medicare Part A/B

Medicare Administrative Contractor

Jurisdiction J (JJ)
Alabama, Georgia, and Tennessee

Jurisdiction M (JM)
Virginia, West Virigina, North Carolina, and South Carolina



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Provider Resources

Assistance is available!

Education

JJ Part A Events and Education
JJ Part A Education on Demand
JM Part A Events and Education
JM Part A Education on Demand
JJ Part B Events and Education
JJ Part B Education on Demand
JM Part B Events and Education
JM Part B Education on Demand

Provider Enrollment

JJ Part A Provider Enrollment
JJ Part B Provider Enrollment
JM Part A Provider Enrollment
JM Part B Provider Enrollment
Revalidation Lookup Tool
PECOS

Electronic Data Interchange

JJ Part A EDI Enrollment, Tools, Software and Technical Specifications, and FAQs
JM Part A EDI Enrollment, Tools, Software and Technical Specifications, and FAQs
JJ Part B EDI Enrollment, Tools, Software and Technical Specifications, and FAQs
JM Part B EDI Enrollment, Tools, Software and Technical Specifications, and FAQs

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Provider Contact Center **JJ Part A**

1-877-567-7271
Monday – Friday 8 a.m. – 6 p.m. (ET)

Provider Contact Center **JM Part A**

1-855-696-0705
Monday – Friday 8 a.m. – 5 p.m. (ET)

Provider Contact Center **JJ Part B**

1-877-567-7271
Monday – Friday 8 a.m. – 6 p.m. (ET)

Provider Contact Center **JM Part B**

1-855-696-0705
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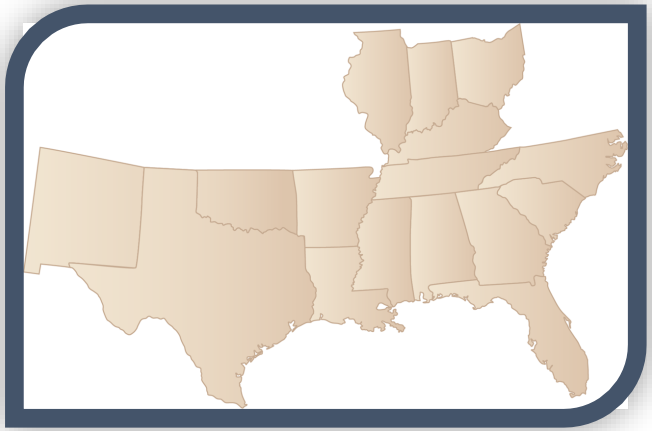
Palmetto GBA Medicare HHH

Medicare Administrative Contractor

Jurisdiction M (JM)

Alabama, Arkansas, Florida, Georgia, Illinois, Indiana, Kentucky, Louisiana, Mississippi, New Mexico, North Carolina, Ohio, Oklahoma, South Carolina, Tennessee and Texas



www.palmettogba.com

Provider Resources

Assistance is available!

Education

JM HHH Events and Education
JM HHH Education on Demand

Provider Enrollment

JM HHH Provider Enrollment
New to Medicare Step-by-Step Guide
JM HHH Provider Enrollment Application Status Lookup Tool
Revalidation Lookup Tool
PECOS

Electronic Data Interchange

HHH EDI Enrollment, Tools, Software and Technical Specifications, and FAQ

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Railroad Board Specialty Medicare Administrative Contractor (RRB SMAC

RRB SMAC

All US States and Territories
Special contractor for Part B services for Railroad Medicare beneficiaries.

The Railroad Retirement Board (RRB) works with CMS to ensure Railroad beneficiaries receive the same benefits as their SSA Medicare counterparts.

The RRB SMAC's jurisdiction covers Railroad Medicare patients nationwide for Part B services.

www.palmettogba.com/rr

Provider Resources

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Education

RRB SMAC Events and Education
RRB SMAC Education on Demand

Provider Enrollment

RRB SMAC Provider Enrollment
RRB SMAC Update Enrollment Record
PTAN Lookup and Request Tool

Electronic Data Interchange

RRB SMAC Part B EDI Enrollment, Tools, Software and Technical Specifications, and FAQs

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eServices Login

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1-888-355-9165
Mon. – Friday 8:30 a.m. – 4:30 p.m. (ET/CT/MT)
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Interactive Voice Response (IVR)

1-877-288-7600
Monday – Friday 7 a.m. – 11 p.m. (ET)

Email RRB SMAC

Fax: (803) 264-9844

U.S. Mail

Palmetto GBA Railroad Medicare
P.O. Box 10066
Augusta GA 30999

FedEx, USPS, Certified Mail

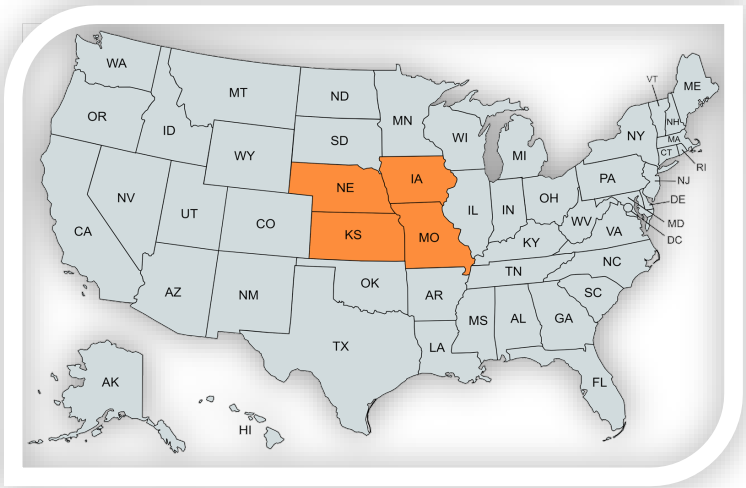
Palmetto GBA Railroad Medicare
2743 Perimeter Parkway, Bldg. 200
Augusta, GA 30999

Wisconsin Physicians Service

Medicare Administrative Contractor J5

Jurisdiction 5 (J5)

Iowa, Kansas, Missouri, Nebraska



www.wpsgha.com

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Education

Events
Encore Presentations

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Guides and Resources
Provider Enrollment Assistance Guide

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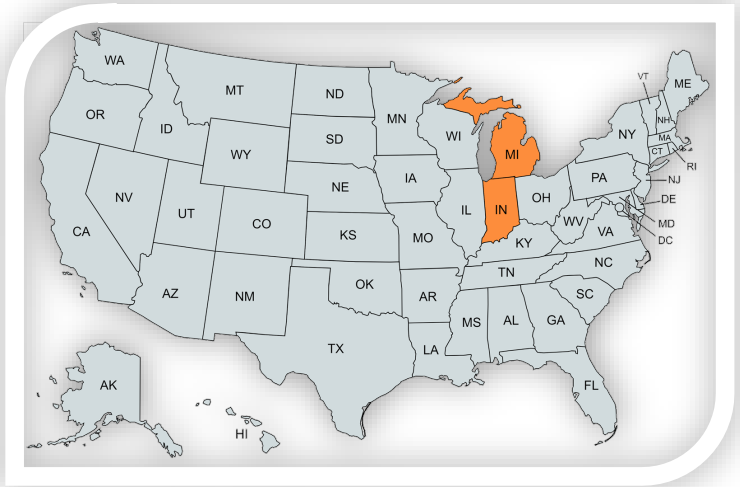
Wisconsin Physicians Service

Medicare Administrative Contractor J8

Jurisdiction 8 (J8)

Indiana and Michigan



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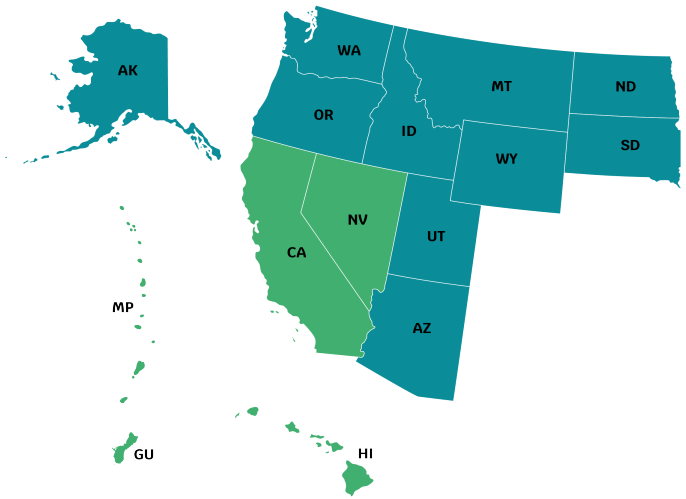
Noridian Healthcare Solutions

Medicare Administrative Contractor JE

Jurisdiction E (JE)

California, Hawaii, Nevada, American Samoa, Guam, Northern Mariana Islands



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Provider Resources

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Education
Part A Schedule of Events
Part A Ambulance
Part B Schedule of Events
Part B Ambulance

Provider Enrollment
Complex Specialties — Ambulance Revalidation
PECOS and the Identity & Access Management System
Enrollment Contact Center

Medical Review
Part A Ambulance Documentation Requirements
Part B Ambulance Documentation Requirements
Prior Authorization for Repetitive, Scheduled Non-Emergent Ambulance Transport (RSNAT)

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NMP User Guide

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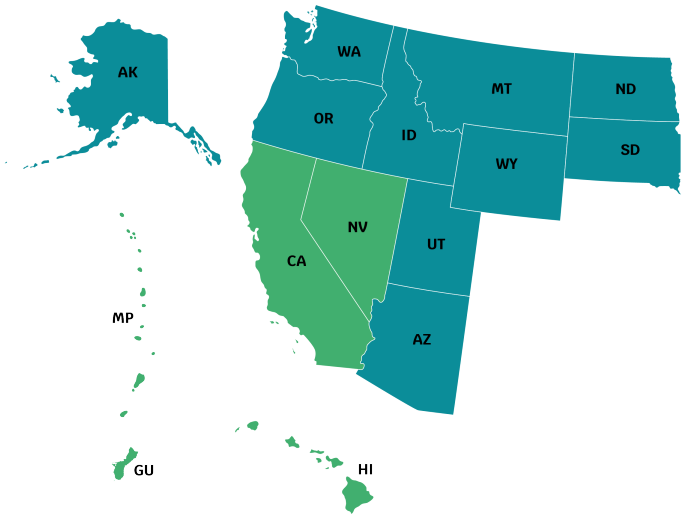
Noridian Healthcare Solutions

Medicare Administrative Contractor JF

Jurisdiction F (JF)

Alaska, Arizona, Idaho, Montana, North Dakota, Oregon, South Dakota, Utah, Washington, Wyoming



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Part A Ambulance
Part B Schedule of Events
Part B Ambulance

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Complex Specialties — Ambulance
Revalidation
PECOS and the Identity & Access Management System
Enrollment Contact Center

Medical Review
Part A Ambulance Documentation Requirements
Part B Ambulance Documentation Requirements
Prior Authorization for Repetitive, Scheduled Non-Emergent Ambulance Transport (RSNAT)

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NMP User Guide

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Medicare Part A and B
Provider Outreach and Education
Multi-MAC Collaboration Group

September 17, 2025