



AMBULANCE FEE SCHEDULE AND MEDICARE TRANSPORTS



TARGET AUDIENCE

Medicare Fee-For-Service Providers

The Hyperlink Table, at the end of this document, provides the complete URL for each hyperlink.

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Learn about these Medicare ambulance transports topics:

- Ambulance transport benefit
- Ambulance transports
- Ground and air ambulance providers and suppliers
- Ground and air ambulance vehicles and personnel requirements
- Documentation requirements
- Coverage, billing, and payments
- Advance Beneficiary Notice of Noncoverage (ABN)
- Resources

When we use “you” in this booklet, we are referring to ambulance providers and suppliers.

AMBULANCE TRANSPORT BENEFIT

The ambulance transport benefit under Medicare Part B covers a medically necessary transport of a beneficiary by ambulance to the nearest appropriate facility that can treat his or her condition when any other methods of transportation are contraindicated. Under certain circumstances, ambulance transports are covered and payable as a beneficiary transportation service under Part A.

AMBULANCE TRANSPORTS

Ground Ambulance Transport

Ground ambulance transports include transports on land and water. Ground ambulance transports include these levels of service:

- **Basic Life Support (BLS)** – Includes the provision of medically necessary supplies and services and BLS ambulance transportation as defined by the State where you provide the transport. An emergency response is one that, at the time you are called, you respond immediately. A BLS emergency is an immediate emergency response in which you begin as quickly as possible to take the steps necessary to respond to the call.

- **Advanced Life Support, Level 1 (ALS1)** – Includes the provision of medically necessary supplies and services and the provision of an ALS assessment or at least one ALS intervention. An ALS assessment is performed by an ALS crew as part of an emergency response that is necessary because the beneficiary's reported condition at the time of dispatch indicates only an ALS crew is qualified to perform the assessment. An ALS assessment does not necessarily result in a determination that the beneficiary requires an ALS level of transport. 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 are covered at the ALS emergency level. This is regardless of whether the beneficiary required ALS intervention services during the transport, provided the ambulance transportation itself was medically reasonable and necessary and all other coverage requirements are met. An ALS intervention must be performed by an emergency medical technician-intermediate (EMT-Intermediate) or an EMT-Paramedic in accordance with State and local laws. An ALS1 emergency is an immediate emergency response in which you begin as quickly as possible to take the steps necessary to respond to the call.
- **Advanced Life Support, Level 2 (ALS2)** – Includes the provision of medically necessary supplies and services, involving:
 - At least three separate administrations of one or more medications by intravenous push/bolus or by continuous infusion (excluding crystalloid fluids) or
 - At least one of these ALS2 procedures:
 - Manual defibrillation/cardioversion
 - Endotracheal intubation
 - Central venous line
 - Cardiac pacing
 - Chest decompression
 - Surgical airway
 - Intraosseous line
- **Specialty Care Transport (SCT)** – Includes the provision of medically necessary supplies and services at a level of service beyond the scope of an EMT-Paramedic. SCT is the interfacility transportation of a critically ill or injured beneficiary that is necessary because the beneficiary's condition requires ongoing care furnished by one or more professionals in an appropriate specialty (such as emergency or critical care nursing, emergency medicine, respiratory or cardiovascular care, or an EMT-Paramedic with additional training).
- **Paramedic Intercept (PI)** – When an entity that does not provide the ambulance transport provides ALS services, PI may be required when you can provide only a BLS level of service and the beneficiary requires an ALS level of service (such as electrocardiogram monitoring, chest decompression, or intravenous therapy). Certain additional requirements apply that, as of the publication of this booklet, are met only by certain entities operating in some western counties of New York State.

Air Ambulance Transport

A medically necessary air ambulance transport refers to transportation of a beneficiary by fixed wing (airplane) or rotary wing (helicopter) aircraft.

GROUND AND AIR AMBULANCE PROVIDERS AND SUPPLIERS

You may furnish ground and air Medicare ambulance transportation to a beneficiary when all of these criteria are met:

- The transportation is medically necessary
- Any other means of transportation is contraindicated
- The destination is to the nearest appropriate facility that can treat the beneficiary's condition



Ambulance Providers

An ambulance provider is a provider that owns and operates an ambulance transportation service as an adjunct to its institutionally-based operations. These providers include:

- Hospitals
- Critical Access Hospitals (CAHs)
- Skilled Nursing Facilities (SNFs)
- Comprehensive Outpatient Rehabilitation Facilities
- Home Health Agencies (HHAs)
- Hospice programs

Although ambulance providers can and do furnish ambulance transports that are covered under Medicare Part B, transports of a beneficiary from one provider to another are generally included in the Part A provider service.

For example, a beneficiary admitted to a hospital, CAH, or SNF may require ambulance transportation to another hospital or other site while he or she receives specialized care and maintains inpatient status with the original provider. This transportation is covered under Part A as an inpatient hospital or CAH service.

Ambulance transportation is covered under Part A as a SNF service when all of these criteria are met:

- A beneficiary is a resident of a SNF
- The beneficiary must be transported by ambulance for a covered SNF service
- Payment is made under Part A for that service

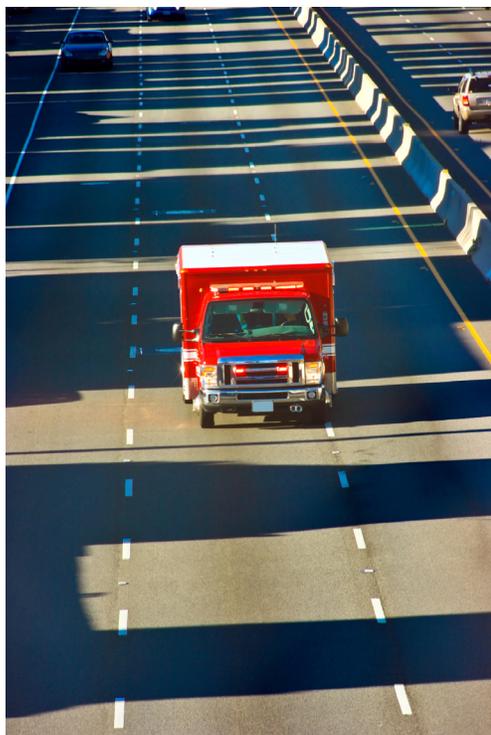
If the beneficiary is a resident of a SNF and must be transported by ambulance to receive dialysis or outpatient hospital services that are excluded from SNF Part A, the ambulance transport may be separately payable under Medicare Part B. If the ambulance transport is covered and payable as a service under Part A, the ambulance transport cannot be classified and paid as a service under Part B. In addition, if the beneficiary is a SNF resident and not in a Part A covered stay and must be transported by ambulance to the nearest supplier of medically necessary services not available at the SNF, the ambulance transport, including the return trip, may be covered under Part B.

If an HHA has a beneficiary transported by ambulance to a hospital or a SNF to obtain needed medical services not otherwise available, the trip is only covered as a Part B service if the requirements are met for ambulance transportation from the beneficiary's place of origin. This transportation is not covered as a home health service.

Ambulance Suppliers

An ambulance supplier is not owned or operated by a provider and is enrolled in Medicare as an independent ambulance supplier. These suppliers include:

- Volunteer fire and/or ambulance companies
- Local government ambulance companies
- Privately-owned and operated ambulance companies
- Independently-owned and operated ambulance companies



GROUND AND AIR AMBULANCE VEHICLES AND PERSONNEL REQUIREMENTS

Ambulance Vehicles

Ground and air ambulance vehicles must comply with State and/or local laws governing the licensing and certification of emergency medical transportation vehicles and must be designed and equipped to respond to medical emergencies. At a minimum, ambulance vehicles must be equipped with:

- A stretcher
- Linens
- Emergency medical supplies
- Oxygen equipment
- Other lifesaving emergency medical equipment
- Emergency warning lights, sirens, and telecommunications equipment as required by State or local law
- A 2-way voice radio or wireless telephone

In nonemergency situations, ambulance vehicles must be capable of transporting beneficiaries with acute medical conditions.

Ambulance Personnel

A BLS ambulance vehicle must be staffed by at least two people who meet the requirements of State and local laws where the services are being furnished, and at least one of the staff members:

- Must be certified in accordance with State and local laws, at a minimum, as an EMT-Basic
- Is legally authorized to operate all lifesaving and life-sustaining equipment on board the vehicle

These laws may vary from State to State or within a State.

An ALS ambulance vehicle must be staffed by:

- At least two people who meet the requirements of State and local laws where the services are being furnished
- At least one staff member who meets the vehicle staffing requirements above for a BLS ambulance vehicle and is certified in accordance with applicable State and/or local laws where the services are being furnished to perform one or more ALS services as an EMT-Intermediate or an EMT-Paramedic

DOCUMENTATION REQUIREMENTS

You must meet State and/or local requirements related to ambulance vehicles and personnel. To indicate that you meet these requirements, include this information about your ambulance vehicles and personnel in a statement you provide to the Medicare Administrative Contractor (MAC):

- The first aid, safety, and other patient care items with which the vehicles are equipped
- The extent of first aid training acquired by the personnel assigned to the vehicles
- An agreement to notify the MAC of any change in operation that could affect coverage of ambulance transports
- Documentary evidence (such as a letter or copy of a license, permit, or certificate issued by State and/or local authorities) indicating that the vehicles are equipped as required

You must retain all appropriate documentation on file for an ambulance transport furnished to a Medicare beneficiary and present this documentation to the MAC upon request. This documentation may be used to assess, among other things, whether the transport meets medical necessity, eligibility, coverage, benefit category, and any other criteria necessary for payment. If you have questions, your MACs may have more information. Find their website at <http://go.cms.gov/MAC-website-list>.

COVERAGE, BILLING, AND PAYMENTS

Covered Destinations

Ground Ambulance Transport

When all other program requirements for coverage are met, ground ambulance transports are covered only to and from these destinations:

- Hospitals
- Beneficiaries' homes
- CAHs
- Dialysis facilities for End-Stage Renal Disease (ESRD) beneficiaries who require dialysis
- Physicians' offices only when:
 - The transport is en route to a Medicare-covered destination
 - The ambulance stops because of the beneficiary's dire need for professional attention
 - Immediately thereafter, the ambulance continues to the covered destination
- SNFs
- From a SNF to the nearest supplier of medically necessary services not available at the SNF where the beneficiary is a resident and not in a covered Part A stay, including the return trip

An institution must at least meet the requirements of [Sections 1861\(e\)\(1\) or 1861\(j\)\(1\) of the Social Security Act](#) (the Act). The institution is not required to be a Medicare participating provider.

Air Ambulance Transport

When all other program requirements for coverage are met, air ambulance transports are covered only to an acute care hospital. Air ambulance transports to these destinations are not covered:

- Nursing facilities
- Physicians' offices
- Beneficiaries' homes

Coverage Requirements

Ground Ambulance Transports

All of these coverage requirements apply to ground ambulance transports:

1. The transport is medically reasonable and necessary
2. A Medicare beneficiary is transported
3. The destination is local
4. The facility is appropriate

1. The Transport Is Medically Reasonable and Necessary

A medically reasonable and necessary ground ambulance transport must meet these requirements:

- Due to the beneficiary's condition, the use of any other method of transportation is contraindicated
- The purpose of the transport is to obtain a Medicare-covered service or to return from obtaining such service

While you must obtain a signed Physician Certification Statement (PCS) for the ambulance transport from the beneficiary's attending physician in some circumstances, this statement does not, in and of itself, demonstrate that an ambulance transport is medically reasonable and necessary. You must retain all appropriate documentation on file for an ambulance transport furnished to a Medicare beneficiary and present this documentation to the MAC upon request. This documentation may be used to assess, among other things, whether the transport meets medical necessity, eligibility, coverage, benefit category, and any other criteria necessary for payment.

The ambulance transport is not covered if some means of transportation other than ambulance could be used without endangering the beneficiary's health, regardless of whether the other means of transportation is actually available.

2. A Medicare Beneficiary Is Transported

The transport of a Medicare beneficiary must occur for an ambulance transport to be payable under the Medicare Program. When multiple ambulance providers and suppliers respond, payment is made only if you actually transport the beneficiary.

3. The Destination Is Local

As a general rule, the ground ambulance transport destination must be local, which means that only mileage to the nearest appropriate facility equipped to treat the beneficiary is covered. If two or more facilities meet this requirement and can appropriately treat the beneficiary, the full mileage to any of these facilities is covered.

4. The Facility Is Appropriate

An appropriate facility is an institution that is generally equipped to provide the needed hospital or skilled nursing care for the beneficiary's illness or injury. An appropriate hospital must have a physician or a physician specialist available to provide the necessary care required to treat the beneficiary's condition.

Because all duly licensed hospitals and SNFs are presumed to be appropriate sources of health care, clear evidence must indicate that a ground ambulance transport to a more distant institution is the nearest appropriate facility. Some circumstances that may justify ground ambulance transport to a more distant institution include:

- The beneficiary's condition requires a higher level of trauma care or other specialized service that is only available at the more distant hospital. A specialized service is a covered service that is not available at the facility where the beneficiary is a patient.
- No beds are available at the nearest institution.

A ground ambulance transport to a more distant hospital solely to avail the beneficiary of the services of a specific physician or physician specialist is not covered. Medicare will pay the base rate and mileage for a medically necessary ambulance transport to the nearest appropriate facility. If the transport is to a facility that is not the nearest appropriate facility, the beneficiary is only responsible for additional mileage to his or her preferred facility.

If a beneficiary is initially transported to an institution that is not equipped to provide the needed hospital or skilled nursing care for the beneficiary's illness or injury and is then transported to a second institution that is adequately equipped, both ground ambulance transports will be covered provided the second transport is to the nearest appropriate facility.

When a ground ambulance transports a beneficiary to and from the nearest appropriate facility to obtain necessary diagnostic and/or therapeutic services (such as a Computerized Axial Tomography scan or cobalt therapy), the transport is only covered to the extent of the payment that would have been made to bring the service to the beneficiary.

A ground ambulance transport from an institution to the beneficiary's home is covered when the home is either:

- Within the locality of the institution; locality is the service area surrounding the institution to which individuals normally travel or are expected to travel to receive hospital or skilled nursing services. MACs have the discretion to define locality in their service areas.
- Outside the locality of the institution but in relation to the beneficiary's home, it is the nearest appropriate facility.

Air Ambulance Transports

These coverage requirements apply to air ambulance transports:

1. The transport is medically reasonable and necessary
2. A Medicare beneficiary is transported
3. The destination is local
4. The facility is appropriate

1. The Transport Is Medically Reasonable and Necessary

A medically reasonable and necessary air ambulance transport must meet these requirements:

- The beneficiary's medical condition requires immediate and rapid ambulance transport
- It cannot be furnished by BLS or ALS ground ambulance transport because one of these pose a threat to the beneficiary's survival or seriously endangers his or her health:
 - The point-of-pick-up (POP) is not accessible by ground vehicle (this requirement may be met in Hawaii, Alaska, and other remote or sparsely populated areas of the continental U.S.). The POP is the location of the beneficiary at the time he or she is placed on board the ambulance. Report the ZIP code of the POP on the claim to apply the correct Geographic Adjustment Factor (GAF) and Rural Adjustment Factor, as appropriate.

- The distance to the nearest appropriate facility or the time a ground ambulance transport will take (generally more than 30-60 minutes).
- The instability of ground transportation.

While you must obtain a signed PCS for the ambulance transport from the beneficiary's attending physician in some circumstances, this statement does not, in and of itself, demonstrate that an ambulance transport is medically reasonable and necessary. You must retain all appropriate documentation on file for an ambulance transport furnished to a Medicare beneficiary and present this documentation to the MAC upon request. This documentation may be used to assess, among other things, whether the transport meets medical necessity, eligibility, coverage, benefit category, and any other criteria necessary for payment.



The medical conditions that may justify air ambulance transport include, but are not limited to, these (this list is not intended to justify air ambulance transport in all localities):

- Intracranial bleeding that requires neurosurgical intervention
- Cardiogenic shock
- Burns that require treatment in a burn center
- Conditions that require treatment in a Hyperbaric Oxygen Unit
- Multiple severe injuries
- Life-threatening trauma

Specialized medical services that are generally not available at all facilities include, but are not limited to, these:

- Burn care
- Cardiac care
- Trauma care
- Critical care

2. A Medicare Beneficiary Is Transported

The transport of a Medicare beneficiary must occur for an ambulance transport to be payable under the Medicare Program. When multiple ambulance providers and suppliers respond, payment is made only if you actually transport the beneficiary. An air ambulance transport to transfer a beneficiary from one hospital to another hospital must meet these requirements:

- A ground ambulance transport endangers the beneficiary's health
- The transferring hospital does not have the needed hospital or skilled nursing care for the beneficiary's illness or injury
- The second hospital is the nearest appropriate facility

3. The Destination Is Local

As a general rule, the air ambulance transport destination must be local, which means that only mileage to the nearest appropriate facility equipped to treat the beneficiary is covered. If two or more facilities meet this requirement and can appropriately treat the beneficiary, the full mileage to any of these facilities is covered.

4. The Facility Is Appropriate

An appropriate facility is an acute care hospital that is generally equipped to provide the needed hospital or skilled nursing care for the beneficiary's illness or injury. An appropriate hospital must have a physician or a physician specialist available to provide the necessary care required to treat the beneficiary's condition.

Because all duly licensed acute care hospitals are presumed to be appropriate sources of health care, clear evidence must indicate that an air ambulance transport to a more distant hospital is the nearest appropriate facility. Some circumstances that may justify air ambulance transport to a more distant institution include:

- The beneficiary's condition requires a higher level of trauma care or other specialized service only available at the more distant hospital
- No beds are available at the nearest hospital

Air ambulance transport to a more distant hospital or from a hospital that is capable of treating the beneficiary to a different hospital solely to avail the beneficiary of the services of a specific physician or hospital is not covered. Medicare will pay the base rate and mileage for a medically necessary ambulance transport to the nearest appropriate facility. If the transport is to a facility that is not the nearest appropriate facility, the beneficiary is only responsible for additional mileage to his or her preferred facility.

Coverage and Billing Guidelines



Freestanding Emergency Department (ED)

If a beneficiary is admitted as an inpatient to a freestanding ED (provider-based department of the hospital) prior to ambulance transport, the ambulance transport from the freestanding ED to the hospital is not a separately payable service under Part B. For more information about criteria for coverage of ambulance transports separately payable under Part B or as a packaged hospital inpatient service under Part A, refer to [Chapter 10, Section 10.3.3, of the Medicare Benefit Policy Manual](#).

Coverage and Billing Tables

These tables provide ground and air ambulance transport coverage and billing guidelines that apply to these destinations covered under the Medicare ambulance transport benefit: acute care hospitals, beneficiaries' homes, CAHs, ESRD facilities, physicians' offices, and SNFs.

Acute Care Hospitals

An acute care hospital provides acute hospital inpatient care to the beneficiary. A hospital inpatient is defined as a beneficiary who has been formally admitted to a hospital. It does not include a beneficiary who is in the process of being transferred from one hospital to another hospital.

Coverage and Billing Guidelines – Acute Care Hospitals

COVERED TRANSPORTS	BILLING GUIDELINES
<p>A beneficiary is transported by ground ambulance to the nearest hospital equipped to provide needed hospital or skilled nursing care on admission or discharge date or within occurrence span code 74 “From” and “Through” dates plus 1 day.</p>	<p>The ambulance provider or supplier bills the MAC separately under Part B.</p>
<p>A beneficiary who is an inpatient of a hospital is transported by ground ambulance to or from the nearest appropriate Long-Term Care Facility (LTCH), Inpatient Psychiatric Facility (IPF), or Inpatient Rehabilitation Facility (IRF) for specialized services not available at the first hospital. Inpatient status is maintained at the first hospital.</p>	<p>The first hospital bills the MAC under Part A.</p>
<p>A beneficiary who is an inpatient of a hospital or freestanding facility (such as an LTCH, IPF, or IRF) is transported by ground ambulance to or from the nearest appropriate hospital to receive specialized services not available at the first hospital. Inpatient status is maintained at the first hospital.</p>	<p>The first hospital, LTCH, IPF, or IRF bills the MAC under the appropriate Prospective Payment System.</p>
<p>A beneficiary who is an inpatient of a hospital is transported by ground ambulance to transfer him or her to the nearest appropriate hospital equipped to provide needed hospital or skilled nursing services not available at the first hospital. The beneficiary is admitted as an inpatient to the second hospital after the ambulance transport</p>	<p>The ambulance provider or supplier bills the MAC separately under Part B.</p>
<p>A beneficiary under a home health plan of care (POC) is transported by ground ambulance to or from home to the nearest appropriate hospital to obtain needed medical services not otherwise available. Place of origin requirements must be met.</p>	<p>The ambulance provider or supplier bills the MAC separately under Part B.</p>
<p>A beneficiary under a hospice POC is transported by ground ambulance to or from home to the nearest appropriate hospital for services related to terminal illness and/or related conditions.</p>	<p>Ambulance transports are included in the hospice per diem payment. Ambulance transports related to the terminal illness or related conditions should be arranged by the hospice. Payment to the ambulance supplier is the responsibility of the hospice.</p>

COVERED TRANSPORTS	BILLING GUIDELINES
A beneficiary under a hospice POC is transported by ground ambulance to or from home to the nearest appropriate hospital for services not related to terminal illness and/or related conditions.	Follow usual ambulance billing procedures as if the beneficiary is not under a hospice election.
A beneficiary is transported by ground ambulance to hospital in connection with a covered foreign hospitalization.	The hospital or beneficiary submits bill to the MAC separately under Part B.
A Railroad Retirement beneficiary in Canada is transported by ground ambulance to a hospital in connection with covered hospital services.	The hospital bills the Railroad Retirement Board separately under Part B.
<p>A beneficiary who is a SNF resident is transported by ground ambulance to or from the nearest appropriate hospital for these exceptionally intensive outpatient hospital services:</p> <ul style="list-style-type: none"> • Cardiac catheterization • Computerized axial tomography scans • Magnetic resonance imaging services • Ambulatory surgery that involves use of an operating room or comparable setting • Emergency services • Radiation therapy services • Angiography • Certain lymphatic and venous procedures 	The ambulance provider or supplier bills the MAC separately under Part B.
<p>A beneficiary who is a hospital inpatient is transported by air ambulance to transfer him or her to another hospital. These requirements must be met:</p> <ul style="list-style-type: none"> • A ground ambulance transport endangers the beneficiary's health • The first hospital does not have needed hospital or skilled nursing care for the beneficiary's illness or injury (such as burn care, cardiac care, trauma care, and critical care) • The second hospital is nearest appropriate facility 	The ambulance provider or supplier bills the MAC under Part B.
A beneficiary is transported from the scene of an accident by air ambulance to an acute care hospital.	The ambulance provider or supplier bills the MAC under Part B.

Non-Covered Transports – Acute Care Hospitals

NON-COVERED TRANSPORTS
Transports that do not meet coverage guidelines discussed in the Coverage Requirements section
Transports in which some other means of transportation could be used without endangering the beneficiary’s health, regardless of whether the other means of transportation is actually available
Transports to a more distant hospital solely to avail the beneficiary of the services of a specific physician or physician specialist: Medicare will pay the base rate and mileage for a medically necessary ambulance transport to the nearest appropriate facility. If the transport is to a facility that is not the nearest appropriate facility, the beneficiary is only responsible for additional mileage to his or her preferred facility.
Transports from a hospital in connection with a covered foreign hospitalization

Beneficiaries’ Homes

Home is defined as where the beneficiary makes his or her home and permanently dwells. It does not include a hospital or other facility. The home must meet one of these requirements:

- It is within the locality of the institution. A locality is the service area surrounding the institution to which individuals normally travel or are expected to travel to receive hospital or skilled nursing services. MACs have the discretion to define locality in their service areas.
- It is outside the locality of the institution but in relation to the beneficiary’s home, it is the nearest appropriate facility.

Coverage and Billing Guidelines – Beneficiaries’ Homes

COVERED TRANSPORTS	BILLING GUIDELINES
A beneficiary is transported by ground ambulance to or from home and the nearest appropriate hospital, CAH, or SNF.	See billing guidelines for hospitals, CAHs, and SNFs.
A beneficiary is transported by ground ambulance from home to a SNF after being discharged as a resident of a SNF. He or she is readmitted or returned to that or another SNF before midnight of the same day.	The SNF bills the MAC under Part A. Ambulance supplier looks to SNF for payment.
A beneficiary is transported by ground ambulance from home to a SNF after being discharged as a resident of a SNF. He or she is readmitted or returned to that or another SNF after the day of discharge from the first SNF.	The ambulance provider or supplier bills the MAC separately under Part B.
A beneficiary under a home health POC is transported by ground ambulance to or from home to the nearest appropriate hospital or SNF to obtain needed medical services that are not otherwise available. Place of origin requirements must be met.	The ambulance provider or supplier bills the MAC separately under Part B.



COVERED TRANSPORTS	BILLING GUIDELINES
<p>A beneficiary under a hospice POC is transported by ground ambulance to or from home to the nearest appropriate hospital or CAH for services related to terminal illness and/or related conditions.</p>	<p>Ambulance transports are included in the hospice per diem payment. Ambulance transports related to the terminal illness or related conditions should be arranged by the hospice. Payment to the ambulance supplier is the responsibility of the hospice.</p>
<p>A beneficiary under a hospice POC is transported by ground ambulance to or from home to the nearest appropriate hospital or CAH for services that are not related to a terminal illness and/or related conditions.</p>	<p>Follow usual ambulance billing procedures as if the beneficiary is not under a hospice election.</p>

Non-Covered Transports – Beneficiaries’ Homes

NON-COVERED TRANSPORTS
<p>Transports that do not meet coverage guidelines discussed in the Coverage Requirements section</p>
<p>Transports in which some other means of transportation could be used without endangering the beneficiary’s health, regardless of whether the other means of transportation is actually available</p>
<p>Transports to a more distant hospital solely to avail the beneficiary of the services of a specific physician or physician specialist: Medicare will pay the base rate and mileage for a medically necessary ambulance transport to the nearest appropriate facility. If the transport is to a facility that is not the nearest appropriate facility, the beneficiary is only responsible for additional mileage to his or her preferred facility.</p>
<p>Air ambulance transports</p>

CAHs

A CAH is a small facility that provides limited inpatient and outpatient hospital services to beneficiaries in rural areas. A hospital inpatient is defined as a beneficiary who has been formally admitted to a hospital. It does not include a beneficiary who is in the process of being transferred from one hospital to another hospital.

Coverage and Billing Guidelines – CAHs

COVERED TRANSPORTS	BILLING GUIDELINES
<p>A beneficiary is transported by ground ambulance to the CAH by the CAH or by a CAH-owned and operated entity if the CAH is only provider or supplier of ambulance transports located within a 35-mile drive of the CAH.</p>	<p>The CAH bills the MAC under Standard Payment Method or Optional Payment method under Part A.</p>
<p>A beneficiary is transported by ground ambulance to the CAH by the CAH if there is no other provider or supplier of ambulance transports within a 35-mile drive of the CAH and the CAH owns and operates an entity furnishing ambulance transports more than a 35-mile drive from the CAH. That entity must be the closest provider of ambulance transports to the CAH.</p>	<p>The CAH bills the MAC under Standard Payment Method or Optional Payment method under Part A.</p>
<p>A beneficiary who is a hospital inpatient is transported by ground ambulance by the CAH or by a CAH-owned and operated entity to or from nearest appropriate hospital or other site for specialized services not available at the first CAH. Inpatient status is maintained with the first CAH.</p>	<p>The first CAH bills the MAC under Part A.</p>

Non-Covered Transports – CAHs

NON-COVERED TRANSPORTS
<p>Transports that do not meet coverage guidelines discussed in the Coverage Requirements section</p>
<p>Transports in which some other means of transportation could be used without endangering the beneficiary’s health, regardless of whether the other means of transportation is actually available</p>
<p>Transports to a more distant hospital solely to avail the beneficiary of the services of a specific physician or physician specialist: Medicare will pay the base rate and mileage for a medically necessary ambulance transport to the nearest appropriate facility. If the transport is to a facility that is not the nearest appropriate facility, the beneficiary is only responsible for additional mileage to his or her preferred facility.</p>
<p>Transports from a hospital in connection with a covered foreign hospitalization</p>

ESRD Facilities

An ESRD facility (other than a hospital) provides dialysis treatment, maintenance, and/or training to beneficiaries with ESRD.

Coverage and Billing Guidelines – ESRD Facilities

COVERED TRANSPORTS	BILLING GUIDELINES
<p>A beneficiary who is a SNF resident under the SNF Prospective Payment System (PPS)/Consolidated Billing (CB), has ESRD, and requires Part B dialysis services is transported by ground ambulance to or from the nearest appropriate hospital-based or freestanding Renal Dialysis Facility (RDF) in a non-emergency BLS level of service.</p>	<p>The ambulance provider or supplier bills the MAC separately under Part B.</p>
<p>A beneficiary under a hospice POC is transported by ground ambulance to or from home to the nearest appropriate ESRD facility for services related to a terminal illness and/or related conditions.</p>	<p>Ambulance transports are included in the hospice per diem payment. Ambulance transports related to the terminal illness or related conditions should be arranged by the hospice. Payment to the ambulance supplier is the responsibility of the hospice.</p>
<p>A beneficiary under a hospice POC is transported by ground ambulance to or from home to the nearest appropriate ESRD facility for services not related to terminal illness and/or related conditions.</p>	<p>Follow usual ambulance billing procedures as if the beneficiary is not under a hospice election.</p>

Non-Covered Transports – ESRD Facilities

NON-COVERED TRANSPORTS
<p>Transports that do not meet coverage guidelines discussed in the Coverage Requirements section</p>
<p>Transports in which some other means of transportation could be used without endangering the beneficiary’s health, regardless of whether the other means of transportation is actually available</p>
<p>Transports to a more distant facility solely to avail the beneficiary of the services of a specific physician or physician specialist: Medicare will pay the base rate and mileage for a medically necessary ambulance transport to the nearest appropriate facility. If the transport is to a facility that is not the nearest appropriate facility, the beneficiary is only responsible for additional mileage to his or her preferred facility.</p>
<p>Air ambulance transports</p>

Physicians' Offices

A physician is defined as a doctor of medicine or osteopathy, a doctor of dental surgery or dental medicine, a doctor of podiatry or surgical chiropody, a doctor of optometry, or a chiropractor.

Coverage and Billing Guidelines – Physicians' Offices

COVERED TRANSPORTS	BILLING GUIDELINES
A beneficiary who is a SNF resident under PPS/CB is transported by ground ambulance to a physician's office.	The SNF bills the MAC under Part A. The ambulance supplier looks to SNF for payment.
Other ground ambulance transports to physician's office only when: <ul style="list-style-type: none"> • Transport is en route to a Medicare-covered destination • Ambulance stops because of beneficiary's dire need for professional attention • Immediately thereafter, ambulance continues to covered destination 	The ambulance provider or supplier bills the MAC separately under Part B.

Non-Covered Transports – Physicians' Offices

NON-COVERED TRANSPORTS
Transports that do not meet coverage guidelines discussed in the Coverage Requirements section
Transports in which some other means of transportation could be used without endangering the beneficiary's health, regardless of whether the other means of transportation is actually available
Transports to a more distant hospital solely to avail the beneficiary of the services of a specific physician or physician specialist: Medicare will pay the base rate and mileage for a medically necessary ambulance transport to the nearest appropriate facility. If the transport is to a facility that is not the nearest appropriate facility, the beneficiary is only responsible for additional mileage to his or her preferred facility.
Air ambulance transports

SNFs

A Skilled Nursing Facility (SNF) is a facility that primarily provides inpatient skilled nursing care and related services to residents who require medical, nursing, or rehabilitative services.

Coverage and Billing Guidelines – SNF PPS/CB

COVERED TRANSPORTS UNDER SNF PPS/CB	BILLING GUIDELINES
A beneficiary who is a SNF resident is transported by ground ambulance from one SNF to another SNF before midnight of the same day.	The SNF bills the MAC under Part A. The ambulance supplier looks to the SNF for payment.
A beneficiary is transported by ground ambulance from home to a SNF after being discharged as resident of SNF. He or she is readmitted or returned to that or another SNF before midnight of the same day.	The SNF bills the MAC under Part A. The ambulance supplier looks to the SNF for payment.
A beneficiary who is a SNF resident, has ESRD, and requires Part B dialysis services is transported by ground ambulance to or from the nearest appropriate hospital-based or freestanding RDF as a non-emergency BLS level of service.	The ambulance provider or supplier bills the MAC separately under Part B.
A beneficiary who is a SNF resident is transported by ground ambulance to a physician's office.	The SNF bills the MAC under Part A. The ambulance supplier looks to the SNF for payment.

Coverage and Billing Guidelines – Covered Transports Not Covered Under SNF PPS/CB

COVERED TRANSPORTS NOT COVERED UNDER SNF PPS/CB	BILLING GUIDELINES
A beneficiary is transported by ground ambulance to a SNF for initial admission or from a SNF following final discharge, unless the resident is readmitted or returns to that or another SNF before midnight of the same day.	The ambulance provider or supplier bills the MAC separately under Part B.
A beneficiary who is a SNF resident is transported by ground ambulance to or from the nearest appropriate hospital or CAH to obtain needed medical services not otherwise available.	The ambulance provider or supplier bills the MAC separately under Part B.
A beneficiary who is a SNF resident is transported by ground ambulance to the nearest appropriate Medicare-participating hospital or CAH to obtain needed medical services not otherwise available. The beneficiary is admitted as an inpatient to the hospital.	The ambulance provider or supplier bills the MAC separately under Part B.
A beneficiary who is a SNF resident is transported by ground ambulance to and from the nearest appropriate Ambulatory Surgical Center/non-hospital facility to obtain needed medical services not otherwise available.	The ambulance provider or supplier bills the MAC separately under Part B.
A beneficiary who is a SNF resident, has ESRD, and requires Part B dialysis services is transported by ground ambulance to or from the nearest appropriate hospital-based or freestanding RDF in a non-emergency BLS level of service.	The ambulance provider or supplier bills the MAC separately under Part B.
A beneficiary under a home health POC is transported by ground ambulance to or from a SNF to home. Place of service requirements must be met.	The ambulance provider or supplier bills the MAC separately under Part B.

COVERED TRANSPORTS NOT COVERED UNDER SNF PPS/CB	BILLING GUIDELINES
<p>A beneficiary under a hospice POC is transported by ground ambulance to or from a SNF to the nearest appropriate hospital for services related to a terminal illness and/or related conditions.</p>	<p>Ambulance transports are included in the hospice per diem payment. Ambulance transports related to the terminal illness or related conditions should be arranged by the hospice. Payment to the ambulance supplier is the responsibility of the hospice.</p>
<p>A beneficiary under hospice POC is transported by ground ambulance to or from a SNF to the nearest appropriate hospital for services that are not related to a terminal illness and/or related conditions.</p>	<p>Follow usual ambulance billing procedures as if the beneficiary is not under a hospice election.</p>
<p>A beneficiary who is a SNF resident is transported by ground ambulance to and from the nearest appropriate hospital for these exceptionally intensive outpatient hospital services:</p> <ul style="list-style-type: none"> • Cardiac catheterization • Computerized axial tomography scans • Magnetic resonance imaging services • Ambulatory surgery that involves use of an operating room or comparable setting • Emergency services • Radiation therapy services • Angiography • Certain lymphatic and venous procedures 	<p>The ambulance provider or supplier bills the MAC separately under Part B.</p>

Non-Covered Transports – SNFs

NON-COVERED TRANSPORTS
<p>Transports that do not meet coverage guidelines discussed in the Coverage Requirements section</p>
<p>Transports in which some other means of transportation could be used without endangering the beneficiary’s health, regardless of whether the other means of transportation is actually available</p>
<p>Transports to a more distant hospital solely to avail the beneficiary of the services of a specific physician or physician specialist: Medicare will pay the base rate and mileage for a medically necessary ambulance transport to the nearest appropriate facility. If the transport is to a facility that is not the nearest appropriate facility, the beneficiary is only responsible for additional mileage to his or her preferred facility.</p>
<p>Air ambulance transports</p>



Ambulance Fee Schedule

Section 4531(b)(2) of the Balanced Budget Act of 1997 added [Section 1834\(l\)](#) to the Act, which mandated the implementation of a national Ambulance Fee Schedule (FS) effective for Part B ambulance transport claims with dates of service on or after April 1, 2002. The Ambulance FS applies to all ambulance transports. Section 1834(l) of the Act also required mandatory assignment for all ambulance transports, which means you will be paid the Medicare-allowed amount as payment in full for your transports. In addition, you may bill or collect only any unmet Part B deductible and coinsurance amounts from the beneficiary.

For more information about the Ambulance FS, visit the [Medicare Ambulance Fee Schedule](#) webpage.

Payments

Medicare pays for an ambulance transport under Part A as a packaged service or under Part B as a separately billed service. If an ambulance transport is covered and payable under Part A, it will not be covered or payable under Part B.

Payment for ambulance transports under the Ambulance FS:

- Includes a base rate payment (level of service provided) plus a separate payment for mileage to the nearest appropriate facility
- Covers both the transport of the beneficiary to the nearest appropriate facility and all medically necessary covered items and services (such as oxygen, drugs, extra attendants, and electrocardiogram testing) associated with the transport
- Precludes a separate payment for items and services furnished under the ambulance benefit

How Payment Rates Are Set

The Ambulance FS was fully implemented on January 1, 2006. Each year, an update is applied to the payment limits for ambulance transports that is equal to the percentage increase in the Consumer Price Index for All Urban Consumers (CPI-U) for the 12-month period ending with June of the previous year. Under the Affordable Care Act, [Section 1834\(l\)\(3\)\(B\) of the Act](#) was amended to apply a productivity adjustment to the update equal to the 10-year moving average of changes in economy-wide private nonfarm business multi-factor productivity (MFP) beginning on January 1, 2011. The resulting update percentage is called the Ambulance Inflation Factor (AIF).

Ground Ambulance Transports

The total payment amount for ground ambulance providers and suppliers is based on 100 percent of the national Ambulance FS. Payments for ground ambulance transports include these elements:

- A nationally uniform base rate for all ground ambulance transports updated annually by the AIF
- A numeric value for ambulance services relative to the value of a base level ambulance service called a relative value unit is assigned to each level of ground ambulance service
- A geographic adjustment factor (GAF) equal to the non-facility practice expense (PE) portion of the geographic practice cost index (GPCI) for the Medicare Physician Fee Schedule for each Ambulance FS locality area
- A nationally uniform loaded mileage rate
- An additional amount for certain mileage for a rural POP
- Additional payments to the base rate and/or mileage rate for certain specified temporary periods effective through December 31, 2022



NOTE: A required data collection system for ground ambulance providers and suppliers has been included in the draft 2020 Physician Fee Schedule (PFS) Notice of Proposed Rulemaking (NPRM). Representative samples of ambulance providers and suppliers will be determined by the Secretary of Health & Human Services (HHS). Those in the sample will be required to submit cost information through a data collection system. To receive email updates about the PFS, subscribe to the [Medicare Learning Network® newsletter](#). The CY 2020 PFS Final Rule will be posted to the [Physician Fee Schedule](#) webpage once it is published in [Federal Register](#).

Air Ambulance Transports

The total payment amount for air ambulance providers and suppliers is based on 100 percent of the national Ambulance FS. Payments for air ambulance transports include these elements:

- A nationally uniform base rate for fixed wing and a nationally uniform base rate for rotary wing
- A GAF equal to the non-facility PE portion of the GPCI for each Ambulance FS locality area
- A nationally uniform loaded mileage rate for each type of air ambulance transport
- A rural adjustment to the base rate and mileage for transports furnished for a rural POP

Updates to the Ambulance FS

For more information about Ambulance FS payment updates, refer to the [Ambulance Fee Schedule](#) and [Ambulance Services Center](#) webpages.

Ground Ambulance Payment When the Beneficiary Dies

This table provides payment information for three ground ambulance transport scenarios in which the beneficiary dies.

Ground Ambulance Payment When the Beneficiary Dies

TIME OF DEATH PRONOUNCEMENT	PAYMENT
1. Before dispatch	None
2. After dispatch and before the beneficiary is loaded on board the ambulance (before or after arrival at the POP)	<ul style="list-style-type: none"> Your BLS base rate No mileage or rural adjustment Use QL modifier, "Patient pronounced dead after ambulance called," on claim
3. After pickup and prior to or upon arrival at the receiving facility	Appropriate ground base rate, mileage, and rural adjustment, if applicable

Air Ambulance Payment When the Beneficiary Dies

This table provides payment information for three air ambulance transport scenarios in which the beneficiary dies.

Air Ambulance Payment When the Beneficiary Dies

TIME OF DEATH PRONOUNCEMENT	PAYMENT
1. Before the beneficiary is loaded on board the ambulance: <ul style="list-style-type: none"> The dispatcher receives the pronouncement of death and has a reasonable opportunity to notify the pilot to abort the flight The aircraft has taxied but has not taken off or, at a controlled airport, the aircraft has been cleared to take off but has not actually taken off 	None
2. After takeoff to the POP and before the beneficiary is loaded on board the air ambulance	<ul style="list-style-type: none"> Appropriate air base rate with no mileage or rural adjustment Use QL modifier on claim
3. After the beneficiary is loaded on board the air ambulance and before or upon arrival at the receiving facility	Appropriate air base rate, mileage, and rural adjustment, if applicable

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Air Ambulance Aborted Flight Scenarios

The table provides payment information for two air ambulance transport scenarios in which the flight is aborted due to bad weather or other circumstances beyond the pilot's control.

Air Ambulance Aborted Flight Scenarios

ABORTED FLIGHT SCENARIO	PAYMENT
1. Before the beneficiary is loaded on board the air ambulance (prior to or after takeoff to the POP)	None
2. After the beneficiary is loaded on board the air ambulance	Appropriate air base rate, mileage, and rural adjustment

Multiple Beneficiary Ground and Air Ambulance Transports

Effective April 1, 2002, these requirements apply to multiple beneficiary ground and air ambulance transports:

- When two Medicare beneficiaries are simultaneously transported to the same destination, the payment allowance for each beneficiary is equal to 75 percent of the base rate applicable to the level of care provided to the beneficiary plus 50 percent of the total mileage payment allowance for the entire trip
- When three or more Medicare beneficiaries are simultaneously transported to the same destination, the payment allowance for each beneficiary is equal to 60 percent of the base rate applicable to the level of care furnished to the beneficiary, and a single payment allowance for mileage will be prorated by the number of Medicare beneficiaries on board

Both Origin and Destination Are Institutional Providers

If both the origin and destination of ambulance transports are providers (such as hospitals, CAHs, or SNFs), the provider who seeks payment for the ambulance transport is shown in this table.

When Both the Origin and Destination Are Institutional Providers

CRITERION	PAYMENT
<p>Criterion 1: National Provider Identifier (NPI)</p>	<p>If the NPIs of the two providers are different:</p> <ul style="list-style-type: none"> The ambulance transport is separately billable <p>If the NPIs of both providers are the same:</p> <ul style="list-style-type: none"> See Criterion 2: Campus
<p>Criterion 2: Campus*</p>	<p>If the campuses of the two providers that share the same NPI are the same:</p> <ul style="list-style-type: none"> The transport is not separately billable The provider seeks payment <p>If the campuses of the two providers are different:</p> <ul style="list-style-type: none"> See Criterion 3: Beneficiary Status – Inpatient vs. Outpatient
<p>Criterion 3: Beneficiary Status – Inpatient vs. Outpatient</p>	<p>If the beneficiary is an inpatient at both providers (inpatient status at both the origin and the destination and the providers share the same NPI but are located on different campuses):</p> <ul style="list-style-type: none"> The transport is not separately billable The provider seeks payment All other combinations (outpatient-to-inpatient, inpatient-to-outpatient, and outpatient-to-outpatient) are separately billable <p>If the point of origin is not a provider:</p> <ul style="list-style-type: none"> The transport is not covered under Part A because the beneficiary is not an inpatient of any Part A provider at the time of transport Ambulance transports are excluded from the 3-day preadmission payment window

* Campus is the physical area immediately adjacent to the provider’s main buildings, other areas, and structures not strictly contiguous to the main buildings but is located within 250 yards of the main buildings and any of the other areas the Centers for Medicare & Medicaid Services Regional Office determines are part of the provider’s campus.



ADVANCE BENEFICIARY NOTICE OF NONCOVERAGE (ABN)

You must give written notice to a Fee-For-Service Medicare beneficiary before furnishing items or equipment that are usually covered by Medicare but are not expected to be paid in a specific instance, for certain reasons, such as lack of medical necessity. For more information about the ABN, [Form CMS-R-131](#), and requirements for issuing an ABN for an ambulance transport, refer to [Chapter 30, Section 50, of the Medicare Claims Processing Manual](#).

RESOURCES

FOR MORE INFORMATION ABOUT...	RESOURCE
Ambulance Fee Schedule	<p>Ambulance Fee Schedule https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AmbulanceFeeSchedule</p> <p>Chapter 10, Medicare Benefit Policy Manual (Publication 100-02) https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c10.pdf</p> <p>Chapter 15, Medicare Claims Processing Manual (Publication 100-04) https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c15.pdf</p>
Ambulances Services Center	<p>https://CMS.gov/Center/Provider-Type/Ambulances-Services-Center.html</p>
Ambulance Transports	<p>Chapter 10 of the Medicare Benefit Policy Manual (Publication 100-02) https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c10.pdf</p> <p>Chapter 15 of the Medicare Claims Processing Manual (Publication 100-04) https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c15.pdf</p>
Advance Beneficiary Notice of Noncoverage (ABN)	<p>https://CMS.gov/Medicare/Medicare-General-Information/BNI/ABN.html</p>
MLN Catalog	<p>https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/MLNCatalog.pdf</p>
Medicare Information for Beneficiaries	<p>https://www.Medicare.gov</p>

HYPERLINK TABLE

EMBEDDED HYPERLINK	COMPLETE URL
http://go.cms.gov/MAC-website-list	https://www.cms.gov/Medicare/Medicare-Contracting/FFSProvCustSvcGen/MAC-Website-List.html
Sections 1861(e)(1) or 1861(j)(1) of the Social Security Act	https://www.ssa.gov/OP_Home/ssact/title18/1861.htm
Chapter 10, Section 10.3.3, of the Medicare Benefit Policy Manual	https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c10.pdf
Section 1834(l) of the Act	https://www.ssa.gov/OP_Home/ssact/title18/1834.htm
Medicare Ambulance Fee Schedule	https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AmbulanceFeeSchedule
Ambulances Services Center	https://CMS.gov/Center/Provider-Type/Ambulances-Services-Center.html
Form CMS-R-131, Advance Beneficiary Notice (ABN)	https://www.cms.gov/MEDICARE/medicare-general-information/bni/abn.html
Chapter 30, Section 50, of the Medicare Claims Processing Manual	https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c30.pdf
Federal Register	https://www.federalregister.gov
Medicare Learning Network® Newsletter	https://public.govdelivery.com/accounts/USCMS/subscriber/new?
Physician Fee Schedule	https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/index.html

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