



MEDICARE AMBULANCE TRANSPORTS

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Please note: The information in this publication applies only to the Medicare Fee-For-Service Program (also known as Original Medicare).

This publication provides the following information about Medicare ambulance transports:

- ❖ The 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); and
- ❖ Resources.

When “you” is used in this publication, we are referring to ambulance providers and suppliers.

THE 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 may be covered and payable as a beneficiary transportation service under Part A.

AMBULANCE TRANSPORTS

Ground Ambulance Transport

A beneficiary may be transported on land or on water for a ground ambulance transport. Ground ambulance transports include the following:

- ❖ **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 may be 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. An ALS intervention is a procedure that 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 and:
 - 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 the following procedures:
 - Manual defibrillation/cardioversion;
 - Endotracheal intubation;
 - Central venous line;
 - Cardiac pacing;
 - Chest decompression;
 - Surgical airway; or
 - 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 a paramedic with additional training); and

- ❖ **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 beneficiary may be transported by fixed wing (airplane) or rotary wing (helicopter) aircraft for a medically necessary air ambulance transport.

GROUND AND AIR AMBULANCE PROVIDERS AND SUPPLIERS

You may furnish ground and air Medicare ambulance transportation to a beneficiary when:

- ❖ The transportation is medically necessary;
- ❖ Any other means of transportation is contraindicated; and
- ❖ 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); and
- ❖ 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:

- ❖ A beneficiary is a resident of a SNF;
- ❖ The beneficiary must be transported by ambulance for a covered SNF service; and
- ❖ 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 certain other high end outpatient hospital services, 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.

If a HHA has a beneficiary transported by ambulance to a hospital or a SNF to obtain needed medical services that are 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; and
- ❖ 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 the following:

- ❖ 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; and
- ❖ 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; and
- ❖ 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 furnished, and at least one of the staff members must be certified in accordance with applicable State and/or local laws 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 the following 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; and
- ❖ 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. Find your MAC contact information on the [Review Contractor Directory - Interactive Map](#) on the Centers for Medicare & Medicaid Services (CMS) website.

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 the following destinations:

- ❖ Hospitals;
- ❖ Beneficiaries' homes;
- ❖ CAHs;
- ❖ Dialysis facilities for End-Stage Renal Disease (ESRD) beneficiaries who require dialysis;

- ❖ Physicians' offices only as follows:
 - The transport is en route to a Medicare-covered destination;
 - The ambulance stops because of the beneficiary's dire need for professional attention; and
 - Immediately thereafter, the ambulance continues to the covered destination; and
- ❖ SNFs.

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 the following destinations are not covered:

- ❖ Nursing facilities;
- ❖ Physicians' offices; and
- ❖ Beneficiaries' homes.

Coverage Requirements

Ground Ambulance Transports

The following 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; and
- 4) The facility is appropriate.

Each requirement is discussed in more detail on pages 8–9.

1) The Transport Is Medically Reasonable and Necessary

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

- ❖ Due to the beneficiary's condition, the use of any other method of transportation is contraindicated; and
- ❖ 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; and
- ❖ 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:

- ❖ 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; or
- ❖ Outside the locality of the institution but in relation to the beneficiary's home, it is the nearest appropriate facility.

Air Ambulance Transports

The following 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; and
- 4) The facility is appropriate.

Each requirement is discussed in more detail below and on pages 11–12.

1) The Transport Is Medically Reasonable and Necessary

A medically reasonable and necessary air ambulance transport must meet the following 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 the following poses 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 United States). 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); or
 - 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, the following (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; or
- ❖ Life-threatening trauma.

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

- ❖ Burn care;
- ❖ Cardiac care;
- ❖ Trauma care; and
- ❖ 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 the following 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; and
- ❖ 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 that is only available at the more distant hospital; and
- ❖ 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 freestanding ED is provider based (a department of the hospital), the ambulance transport from the freestanding ED to the hospital is not a separately payable service under Part B if the beneficiary is admitted as an inpatient prior to ambulance transport. 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](#)" on the CMS website.

Coverage and Billing Charts

The charts on the following pages provide ground and air ambulance transport coverage and billing guidelines that apply to the following 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
Beneficiary is transported by ground ambulance to 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.	Hospital bills MAC separately under Part B.
Beneficiary who is inpatient of hospital is transported by ground ambulance to or from nearest appropriate Long Term Care Facility (LTCH), Inpatient Psychiatric Facility (IPF), or Inpatient Rehabilitation Facility (IRF) for specialized services that are not available at the first hospital. Inpatient status is maintained at first hospital.	First hospital bills MAC under Part A.
Beneficiary who is inpatient of hospital or freestanding facility (such as a LTCH, IPF, or IRF) is transported by ground ambulance to or from nearest appropriate hospital to receive specialized services that are not available at first hospital. Inpatient status is maintained at first hospital.	First hospital, LTCH, IPF, or IRF bills MAC under appropriate Prospective Payment System.
Beneficiary who is inpatient of hospital is transported by ground ambulance to transfer him or her to nearest appropriate hospital equipped to provide needed hospital or skilled nursing services that are not available at first hospital. Beneficiary is admitted as an inpatient to the second hospital.	Second hospital or ambulance supplier bills MAC separately under Part B.
Beneficiary under a home health plan of care (POC) is transported by ground ambulance to or from home to nearest appropriate hospital to obtain needed medical services that are not otherwise available. Place of origin requirements must be met.	HHA bills MAC separately under Part B.

Coverage and Billing Guidelines – Acute Care Hospitals (cont.)

Covered Transports	Billing Guidelines
Beneficiary under a hospice POC is transported by ground ambulance to or from home to nearest appropriate hospital for services related to terminal illness and/or related conditions.	Ambulance transports are included in hospice per diem payment. Ambulance transports related to the terminal illness or related conditions should be arranged by the hospice. Payment to ambulance supplier is the responsibility of the hospice.
Beneficiary under hospice POC is transported by ground ambulance to or from home to nearest appropriate hospital for services that are not related to terminal illness and/or related conditions.	Follow usual ambulance billing procedures as if the beneficiary is not under a hospice election.
Beneficiary is transported by ground ambulance to hospital in connection with a covered foreign hospitalization.	Hospital or beneficiary submits bill to MAC separately under Part B.
Railroad Retirement beneficiary in Canada is transported by ground ambulance to hospital in connection with covered hospital services.	Hospital bills Railroad Retirement Board separately under Part B.
<p>Beneficiary who is a SNF resident is transported by ground ambulance to or from nearest appropriate hospital for the following 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; and ❖ Certain lymphatic and venous procedures. 	SNF or ambulance supplier bills MAC separately under Part B.

Coverage and Billing Guidelines – Acute Care Hospitals (cont.)

Covered Transports	Billing Guidelines
<p>Beneficiary who is a hospital inpatient is transported by air ambulance to transfer him or her to another hospital. The following 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); and ❖ The second hospital is nearest appropriate facility. 	<p>Second hospital or ambulance supplier bills MAC under Part A.</p>
<p>Beneficiary is transported from the scene of an accident by air ambulance to acute care hospital.</p>	<p>Ambulance supplier bills MAC under Part B.</p>

Non-Covered Transports – Acute Care Hospitals

Non-Covered Transports
<p>Transports that do not meet coverage guidelines discussed in the Coverage Requirements section on pages 7–12.</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 hospital in connection with a covered foreign hospitalization.</p>

Beneficiaries' Homes

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

- ❖ 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; or
- ❖ 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
Beneficiary is transported by ground ambulance to or from home and nearest appropriate hospital, CAH, or SNF.	See billing guidelines for hospitals, CAHs, and SNFs on pages 13–15, 18, and 21–23.
Beneficiary is transported by ground ambulance from home to 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.	SNF bills MAC under Part A. Ambulance supplier looks to SNF for payment.
Beneficiary is transported by ground ambulance from home to SNF after being discharged as resident of SNF. He or she is readmitted or returned to that or another SNF after day of discharge from first SNF.	Second SNF bills MAC separately under Part B.
Beneficiary under a home health plan of care (POC) is transported by ground ambulance to or from home to nearest appropriate hospital or SNF to obtain needed medical services that are not otherwise available. Place of origin requirements must be met.	HHA bills MAC separately under Part B.
Beneficiary under a hospice POC is transported by ground ambulance to or from home to nearest appropriate hospital or CAH for services related to terminal illness and/or related conditions.	Ambulance transports are included in hospice per diem payment. Ambulance transports related to the terminal illness or related conditions should be arranged by the hospice. Payment to ambulance supplier is the responsibility of the hospice.
Beneficiary under a hospice POC is transported by ground ambulance to or from home to nearest appropriate hospital or CAH for services that are not related to terminal illness and/or related conditions.	Follow usual ambulance billing procedures as if the beneficiary is not under a hospice election.

Non-Covered Transports – Beneficiaries’ Homes

Non-Covered Transports
Transports that do not meet coverage guidelines discussed in the Coverage Requirements section on pages 7–12.
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.

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

Non-Covered Transports – CAHs

Non-Covered Transports
Transports that do not meet coverage guidelines discussed in the Coverage Requirements section on pages 7–12.
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 hospital in connection with a covered foreign hospitalization.

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
Beneficiary who is a SNF resident under SNF Prospective Payment System Consolidated Billing, has ESRD, and requires Part B dialysis services is transported by ground ambulance to or from nearest appropriate hospital-based or freestanding Renal Dialysis Facility in a non-emergency Basic Life Support level of service.	SNF or ambulance supplier bills MAC separately under Part B.
Beneficiary under a hospice plan of care (POC) is transported by ground ambulance to or from home to nearest appropriate ESRD facility for services related to terminal illness and/or related conditions.	Ambulance transports are included in hospice per diem payment. Ambulance transports related to the terminal illness or related conditions should be arranged by the hospice. Payment to ambulance supplier is the responsibility of the hospice.
Beneficiary under a hospice POC is transported by ground ambulance to or from home to nearest appropriate ESRD facility for services that are not related to terminal illness and/or related conditions.	Follow usual ambulance billing procedures as if the beneficiary is not under a hospice election.

Non-Covered Transports – ESRD Facilities

Non-Covered Transports
Transports that do not meet coverage guidelines discussed in the Coverage Requirements section on pages 7–12.
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 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.
Air ambulance transports.

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
Beneficiary who is a SNF resident under SNF Prospective Payment System Consolidated Billing is transported by ground ambulance to physician’s office.	SNF bills MAC under Part A. Ambulance supplier looks to SNF for payment.
Other ground ambulance transports to physician’s office only as follows: <ul style="list-style-type: none"> ❖ When transport is en route to a Medicare-covered destination; ❖ Ambulance stops because of beneficiary’s dire need for professional attention; and ❖ Immediately thereafter, ambulance continues to covered destination. 	Ambulance provider or supplier bills 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 on pages 7–12.
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 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 Prospective Payment System (PPS)/Consolidated Billing (CB)

Covered Transports Under SNF PPS/CB	Billing Guidelines
Beneficiary who is a SNF resident is transported by ground ambulance from one SNF to another SNF before midnight of the same day.	SNF bills MAC under Part A. Ambulance supplier looks to SNF for payment.
Beneficiary is transported by ground ambulance from home to 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.	SNF bills MAC under Part A. Ambulance supplier looks to SNF for payment.
Beneficiary who is a SNF resident, has ESRD, and requires Part B dialysis services is transported by ground ambulance to or from nearest appropriate hospital-based or freestanding Renal Dialysis Facility as a non-emergency BLS level of service.	SNF or ambulance supplier bills MAC separately under Part B.
Beneficiary who is a SNF resident is transported by ground ambulance to a physician’s office.	SNF bills MAC under Part A. Ambulance supplier looks to 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
Beneficiary is transported by ground ambulance to SNF for initial admission or from SNF following final discharge, unless the resident is readmitted or returns to that or another SNF before midnight of the same day.	SNF or ambulance supplier bills MAC separately under Part B.
Beneficiary who is a SNF resident is transported by ground ambulance to or from nearest appropriate hospital or CAH to obtain needed medical services that are not otherwise available.	SNF or ambulance supplier bills MAC separately under Part B.

Coverage and Billing Guidelines – Covered Transports Not Covered Under SNF PPS/CB (cont.)

Covered Transports Not Covered Under SNF PPS/CB	Billing Guidelines
Beneficiary who is a SNF resident is transported by ground ambulance to nearest appropriate Medicare-participating hospital or CAH to obtain needed medical services that are not otherwise available. Beneficiary is admitted as an inpatient to the hospital.	SNF or ambulance supplier bills MAC separately under Part B.
Beneficiary who is a SNF resident is transported by ground ambulance to and from nearest appropriate Ambulatory Surgical Center/non-hospital facility to obtain needed medical services that are not otherwise available.	SNF or ambulance supplier bills MAC separately under Part B.
Beneficiary who is a SNF resident, has ESRD, and requires Part B dialysis services is transported by ground ambulance to or from nearest appropriate hospital-based or freestanding Renal Dialysis Facility in a non-emergency BLS level of service.	SNF or ambulance supplier bills MAC separately under Part B.
Beneficiary under a home health plan of care (POC) is transported by ground ambulance to or from SNF to home. Place of service requirements must be met.	HHA bills MAC separately under Part B.
Beneficiary under a hospice POC is transported by ground ambulance to or from SNF to nearest appropriate hospital for services related to terminal illness and/or related conditions.	Ambulance transports are included in hospice per diem payment. Ambulance transports related to the terminal illness or related conditions should be arranged by the hospice. Payment to ambulance supplier is the responsibility of the hospice.
Beneficiary under hospice POC is transported by ground ambulance to or from SNF to nearest appropriate hospital for services that are not related to terminal illness and/or related conditions.	Follow usual ambulance billing procedures as if the beneficiary is not under a hospice election.

Coverage and Billing Guidelines – Covered Transports Not Covered Under SNF PPS/CB (cont.)

Covered Transports Not Covered Under SNF PPS/CB	Billing Guidelines
<p>Beneficiary who is a SNF resident is transported by ground ambulance to and from nearest appropriate hospital for the following 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; and ❖ Certain lymphatic and venous procedures. 	<p>SNF or ambulance supplier bills 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 on pages 7–12.</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](#) web page and refer to “[Ambulance Fee Schedule](#)” on the CMS website.

Ground Ambulance Payment When the Beneficiary Dies

The chart below 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; and ❖ 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 air base rate, mileage, and rural adjustment, if applicable.

Air Ambulance Payment When the Beneficiary Dies

The chart below 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; and ❖ 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 take off 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; and ❖ 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.

Air Ambulance Aborted Flight Scenarios

The chart below 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 take off 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, the following applies to multiple beneficiary ground and air ambulance transports:

- ❖ When two Medicare beneficiaries are transported to the same destination simultaneously, 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; and
- ❖ When three or more Medicare beneficiaries are transported to the same destination simultaneously, 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 Ambulance 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 the chart below.

When Both the Origin and Destination Are Ambulance 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; and ❖ 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.

When Both the Origin and Destination Are Ambulance Providers (cont.)

Criterion	Payment
<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; and ❖ 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; and ❖ 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 that are not strictly contiguous to the main buildings but are located within 250 yards of the main buildings and any of the other areas determined to be part of the provider’s campus by the CMS Regional Office.

ADVANCE BENEFICIARY NOTICE OF NONCOVERAGE (ABN)

ABN Guidance for an Ambulance Transport

In general, you must not issue an ABN to a beneficiary who has an acute medical emergency or is under duress. You must issue an ABN only when a beneficiary’s covered ambulance transport is modified to a level that is not medically reasonable and necessary and will incur additional costs. To assist you in determining whether an ambulance transport requires an ABN, ask yourself the following three questions:

- 1) Is this service a covered ambulance benefit?
- 2) Will payment for part or all of this service be denied because it is not reasonable and necessary?
- 3) Is the beneficiary stable and the transport non-emergent?

If the answer is “Yes” to **all** three questions, you must issue an ABN.

General ABN Guidance for Fee-For-Service (FFS) Providers

You must give written notice to a FFS Medicare beneficiary before you provide items or services that are usually covered by Medicare, but are not expected to be paid in a specific instance (for example, a ground ambulance transport is medically necessary, but the beneficiary insists on an air ambulance transport). Ambulance providers and suppliers use the Advance Beneficiary Notice of Noncoverage (ABN), Form CMS-R-131, for this purpose.

The ABN allows the beneficiary to make an informed decision about whether to get the item or service that may not be covered and accept financial responsibility if Medicare does not pay. **If the beneficiary does not get written notice when it is required, he or she may not be held financially liable if Medicare denies payment, and you may be financially liable if Medicare does not pay.** If you properly notify the beneficiary that the item or service may not be covered and the beneficiary agrees to pay, you may seek payment from the beneficiary. You must keep a copy of the ABN in the medical record, and give the beneficiary a copy.

If you furnish items or services to the beneficiary based on the referral or order of another provider or supplier, you are responsible for notifying the beneficiary that the services may not be covered by Medicare and that the beneficiary can be held financially liable for them if payment is denied.

You are not required to notify the beneficiary before you furnish an item or service that Medicare never covers (for example, an ambulance transport by wheelchair van) or is not a Medicare benefit. You may, however, choose to issue a voluntary ABN or a similar notice as a courtesy to alert the beneficiary about his or her forthcoming financial liability. When you issue the ABN as a voluntary notice, it has no effect on financial liability, and the beneficiary is not required to check an option box or sign and date the notice.

RESOURCES

The chart below provides Medicare ambulance transport resource information.

Medicare Ambulance Transport Resources

For More Information About...	Resource
Ambulance Services Center	https://www.cms.gov/Center/Provider-Type/Ambulances-Services-Center.html on the CMS website
Ambulance Transports	Chapter 10 of the “ Medicare Benefit Policy Manual ” (Publication 100-02) on the CMS website Chapter 15 of the “ Medicare Claims Processing Manual ” (Publication 100-04) on the CMS website
ABN	https://www.cms.gov/Medicare/Medicare-General-Information/BNI/ABN.html on the CMS website
All Available Medicare Learning Network® Products	“ MLN Catalog ” on the CMS website
Provider-Specific Medicare Information	“ MLN Guided Pathways: Provider Specific Medicare Resources ” on the CMS website
Medicare Information for Beneficiaries	https://www.medicare.gov on the CMS website

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