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Provider Compliance Tips for Ambulance Services (Emergent and Non-Emergent)

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Provider Types Affected:

- Ambulance Providers and Suppliers

Background

Under the Ambulance Fee Schedule (AFS), Medicare Part B only covers ambulance services furnished to a beneficiary that are deemed medically necessary. In order for ambulance services to be deemed medically necessary, they must meet all of the following requirements:

1. The beneficiary is transported to the nearest facility that can treat the patient's condition
2. Any other methods of transportation are contraindicated (traveling to the destination by any other means would endanger the health of the beneficiary)
3. The beneficiary's condition requires the ambulance transportation itself
4. The beneficiary's condition requires the level of service provided

It should be noted that the beneficiary's condition **at the time of ambulance transport** determines whether the service is medically necessary.

Reasons for Denial of Emergency Ambulance Services

1. No documentation to support the medical necessity for ambulance services
2. Lack of a signature of the beneficiary or that of a person authorized to sign the claim form on behalf of the beneficiary

To Prevent Denials of Emergency Ambulance Services

The following conditions are coverage guidelines that must be met to be considered eligible for Medicare ambulance services:

- Patient was transported by an approved provider or supplier of ambulance services. (See [“Medicare Benefit Policy Manual,” Chapter 10, Section 101.3](#))
- The patient was suffering from an illness or injury, which contraindicated transportation by other means and was transported to the nearest appropriate facility. (See “Medicare Benefit Policy Manual,” Chapter 10, Section 10.2). The following scenarios (see Medicare Benefit Policy Manual, Chapter 10, Section 20) may constitute medical necessity:
 - The patient was transported in an emergency situation, for example, as a result of an accident, injury, or acute illness
 - The patient needed to be restrained in order to prevent injury to themselves or others
 - The patient required oxygen or other emergency treatment during transport to the nearest appropriate facility
 - The patient was unconscious or in shock
 - The patient exhibited signs and symptoms of acute respiratory distress or cardiac distress such as shortness of breath or chest pain
 - The patient exhibited signs and symptoms that indicate the possibility of acute stroke
 - The patient needed to remain immobile because of a fracture that had not been set or the possibility of a fracture
 - The patient experienced severe hemorrhage or the patient was confined to a bed before and after the ambulance trip

NOTE: Bed confinement is not the sole criterion in determining the medical necessity of ambulance transportation. It is one factor that is considered in medical necessity determinations.

Reasons for Denials of Non-Emergent Ambulance Services

1. Lack of documentation to support that the beneficiary meets the criteria to qualify for non-emergent ambulance transportation:
 - Evidence supporting that the beneficiary is bed-confined
 - Evidence that the beneficiary’s condition is such that other methods of transportation are contraindicated or
 - Evidence that the beneficiary’s medical condition, regardless of bed confinement, is such that transportation by ambulance is medically required

NOTE: Bed confinement is not the sole criterion in determining the medical necessity of ambulance transportation. It is one factor that is considered in medical necessity determinations.

2. Lack of a signature of the beneficiary or that of a person authorized to sign the claim form on behalf of the beneficiary

To Prevent Denials of Non-Emergent Ambulance Services

The following criteria are coverage guidelines that must be met to be considered eligible for Medicare non-emergent ambulance services (See [“Medicare Benefit Policy Manual,” Chapter 10](#), and Section 20):

- Documentation that the patient was transported by an approved provider or supplier of ambulance services
- Documentation that the beneficiary was transported from hospital to hospital or skilled nursing facility to skilled nursing facility. The following condition must be met for coverage:
 - The discharging institution was not an appropriate facility and the admitting institution was the nearest appropriate facility
- Documentation that the beneficiary was transported from a hospital or skilled nursing facility to patient’s residence. The following conditions must be met for coverage:
 - The patient’s residence is within the institution’s service area as shown in the Medicare Administrative Contractor’s (MAC) locality guide
 - The patient’s residence is outside the institution’s service area if the institution was the nearest appropriate facility
- Documentation that the beneficiary’s transport was a round trip for hospital or participating skilled nursing facility inpatients to the nearest hospital or nonhospital treatment facility. The following condition must be met for coverage:
 - The ambulance transport was medically necessary for diagnostic or therapeutic service required by the patient’s condition that is not available at the institution where the beneficiary is an inpatient

NOTE: Certificates of Medical Necessity (CMN), DME Information Forms (DIF), and supplier prepared statements and physician attestations by themselves do NOT provide sufficient documentation of medical necessity, even if signed by the ordering physician. ([“Program Integrity Manual,” Chapter 3, Section 3.3.2.1.1 B](#))

For Emergency and Non-Emergent Ambulance Services

Medicare requires the signature of the beneficiary, or that of a person authorized to sign the claim form on behalf of the beneficiary in order for an ambulance supplier or provider to submit a claim. If the beneficiary is unable to sign because of a mental or physical condition, the following individuals may sign the claim form on behalf of the beneficiary:

- Beneficiary’s legal guardian
- A relative or other person who receives social security or other governmental benefits on behalf of the beneficiary
- A relative or other person who arranges for the beneficiary’s treatment or exercises other responsibility for his or her affairs
- A representative of an agency or institution that did not furnish the services for which payment is claimed, but furnished other care, services or assistance to the beneficiary or
- A representative of the provider or of the nonparticipating hospital claiming payment for services it has furnished, if the provider or nonparticipating hospital is unable to have the claim signed in accordance with [42 CFR 424.36\(b\) \(1-4\)](#)

NOTE: Certificates of Medical Necessity (CMN), DME Information Forms (DIF), and supplier prepared statements and physician attestations by themselves do NOT provide sufficient documentation of medical necessity, even if signed by the ordering physician. ([“Program Integrity Manual,” Chapter 3, Section 3.3.2.1.1 B](#))

Resources

The following resources are available to assist in complying with Medicare’s policy for ambulance services:

For More Information About...	Resource
Medicare Ambulance Transports Booklet	https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Medicare-Ambulance-Transports-Booklet-ICN903194.pdf
42 CFR 424.36(b) (1-4)	https://www.gpo.gov/fdsys/pkg/CFR-2012-title42-vol3/pdf/CFR-2012-title42-vol3-sec424-36.pdf
“Program Integrity Manual,” Chapter 3, Section 3.3.2.1.1 B	https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/pim83c03.pdf
“Medicare Benefit Policy Manual,” Chapter 10, Section 101	https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c10.pdf

Hyperlink Table

Embedded Hyperlink	Complete URL
“Medicare Benefit Policy Manual,” Chapter 10, Section 101.3	https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c10.pdf
42 CFR 424.36(b) (1-4)	https://www.gpo.gov/fdsys/pkg/CFR-2012-title42-vol3/pdf/CFR-2012-title42-vol3-sec424-36.pdf
“Program Integrity Manual,” Chapter 3, Section 3.3.2.1.1 B	https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/pim83c03.pdf



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