DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare & Medicaid Services

Medicare Ambulance Services
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This publication provides the following information about Medicare ambulance services:

• The ambulance service benefit;
• Ambulance transports;
• Ground and air ambulance providers and suppliers;
• Ground and air ambulance vehicles and personnel requirements;
• Covered destinations;
• Ambulance transport coverage requirements;
• Ambulance services payments; and
• Resources.

THE AMBULANCE SERVICE BENEFIT

The ambulance service benefit is a transport by an ambulance. The transport may be covered where the use of any other method of transportation is contraindicated due to the beneficiary’s condition and the additional requirements discussed below are met. Ambulance services are separately payable only under Medicare Part B. There are certain circumstances in which ambulance services are 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 services as defined by the State where the services are provided. An emergency response is one that, at the time the ambulance provider or supplier is called, it responds immediately. A BLS emergency is an immediate emergency response in which the ambulance provider or supplier begins 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 that only an ALS crew is qualified to perform the assessment. An ALS assessment does not necessarily result in a determination that requires an ALS level of service. An ALS intervention is a procedure that must be performed by an emergency medical technician-intermediate (EMT-Intermediate) or EMT-Paramedic in accordance with State and local laws. An ALS1 emergency is an immediate emergency response in which the ambulance provider or supplier begins 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:
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- 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 beyond the scope of an EMT-Paramedic. SCT is 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 (e.g., emergency or critical care nursing, emergency medicine, respiratory or cardiac care, or paramedic with additional training); and

- Paramedic intercept (PI) is when an entity that does not provide the ambulance transport provides ALS services. PI may be required when the ambulance provider or supplier can provide only a BLS level of service and the beneficiary requires an ALS level of service (e.g., electrocardiogram monitoring, chest decompression, or intravenous therapy). Additional requirements apply that, as of the publication of this booklet, are met only by certain entities that operate 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

Ground and air ambulance providers and suppliers may furnish Medicare ambulance transportation services when medically necessary.

Ambulance Providers

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

- Hospitals;
- Critical Access Hospitals (CAH);
- Skilled Nursing Facilities (SNF);
- Comprehensive Outpatient Rehabilitation Facilities;
- Home Health Agencies (HHA);
- Hospice programs; and
- Funds, as specified in Sections 1814(g) and 1835(e) of the Social Security Act (the Act).
Although ambulance providers can and do furnish ambulance services that are covered under Medicare Part B, an ambulance service that transports an individual from one provider to another is generally included in the Part A provider service. For example, a beneficiary who has been admitted to a hospital, CAH, or SNF may require patient transportation, which is 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. Patient transportation is covered under Part A as a SNF service when a beneficiary is a resident of a SNF and must be transported by ambulance for an intra-campus transfer between different departments of the same hospital or to receive dialysis or certain other high-end outpatient hospital services. If a HHA has a beneficiary transported by ambulance to a hospital or a SNF in order to obtain needed medical services that are not otherwise available, the trip is covered as a Part B service only if the requirements are met for ambulance transportation from the beneficiary’s place of origin. This transportation will not be 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 service companies; and
- Independently-owned and operated ambulance service companies.

**GROUND AND AIR AMBULANCE VEHICLES AND PERSONNEL REQUIREMENTS**

**Ambulance Vehicles**

Ground and air ambulance vehicles must comply with State 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 and reusable devices (e.g., inflatable leg and arm splints, backboards, and neckboards);
- 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.
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Ambulance Personnel

A BLS ambulance vehicle must be staffed by at least two individuals, one of whom must be qualified in accordance with State and local laws as an EMT-Basic and is legally authorized to operate all lifesaving and life-sustaining equipment on board the vehicle.

An ALS ambulance vehicle must be staffed by at least two individuals, one of whom must be qualified in accordance with State and local laws as an EMT-Intermediate or an EMT-Paramedic.

Statement About Ambulance Vehicles and Personnel

Ambulance providers and suppliers may show that they meet the above requirements by providing the Medicare Carrier or A/B Medicare Administrative Contractor (MAC) a statement that includes the following information about its ambulance vehicles and personnel:

• 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 Medicare Carrier or A/B MAC of any change in operation that could affect the coverage of ambulance services; and
• Documentary evidence (e.g., a letter or copy of a license, permit, or certificate issued by State and local authorities) indicating that the vehicles are equipped as required.

COVERED DESTINATIONS

Ground Ambulance Transport

When all other coverage requirements are met, ground ambulance transports are covered only to and from the following destinations:

• Hospitals;
• CAHs;
• SNFs;
• Dialysis facilities;
• Physicians’ offices only as follows –
  ◦ When 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
• Beneficiaries’ homes.

An institution must at least meet the requirements of Sections 1861(e)(1) or 1861(j)(1) of the Act. It is not required to be a Medicare participating provider.
Air Ambulance Transport
When all other coverage requirements 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.

AMBULANCE TRANSPORT COVERAGE REQUIREMENTS

Ground Ambulance Transports
The following coverage requirements apply to ground ambulance transports:
1) The service is medically reasonable and necessary;
2) A beneficiary is transported;
3) The destination is local; and
4) The facility is appropriate.

Each requirement is discussed in more detail below.

1) The Service is Medically Reasonable and Necessary
A medically reasonable and necessary ground ambulance service must meet the following requirements:
- Due to the beneficiary’s condition, the use of any other method of transportation is contraindicated; and

2) A Beneficiary is Transported
The transport of a beneficiary must occur for there to be a payable Medicare service. When multiple ambulance providers and suppliers respond, payment may be made only to the provider or supplier that actually transports 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 will be covered. If two or more facilities meet this requirement and can appropriately treat the beneficiary, the full mileage to any of these facilities will be 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.
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Because all duly licensed hospitals and SNFs are presumed to be appropriate sources of health care, there must be clear evidence indicating that an ambulance transport to a more distant institution is the nearest appropriate facility. Some circumstances that may justify 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 available only at the more distant hospital; and
- No beds are available at the nearest institution.

A specialized service is a covered service that is not available at the facility where the beneficiary is a patient.

A ground ambulance transport to a more distant hospital solely to avail the beneficiary of the services of a specific physician or physician specialist will not be covered.

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 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 in order to obtain necessary diagnostic and/or therapeutic services (e.g., a Computerized Axial Tomography scan or cobalt therapy), the transport is covered only to the extent of the payment that would have been made to bring the service to the beneficiary.

A ground ambulance service from an institution to the beneficiary’s home is covered when the home:

- Is within the locality of the institution; or
- Is outside the locality of the institution but in relation to the beneficiary’s home, it is the nearest appropriate facility.

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.

Air Ambulance Transports

The following coverage requirements apply to air ambulance transports:

1) The service is medically reasonable and necessary;
2) A beneficiary is transported;
3) The destination is local; and
4) The facility is appropriate.

Each requirement is discussed in more detail below.

1) The Service 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;
- The transport cannot be furnished by BLS or ALS ground ambulance transport because one of the following 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 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.

POP is the location of the beneficiary at the time he or she is placed on board the ambulance. The ZIP code of the POP must be reported on the claim in order to apply the correct Geographic Adjustment Factor (GAF) and Rural Adjustment Factor, as appropriate.

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 Beneficiary is Transported
The transport of a beneficiary must occur for there to be a payable Medicare service. When multiple ambulance providers and suppliers respond, payment may be made only to the provider or supplier that actually transports 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 would endanger 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 will be covered. If two or more facilities meet this requirement and can appropriately treat the beneficiary, the full mileage to any of these facilities will be 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, there must be clear evidence indicating that an 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 available only 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 will not be covered.

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 services claims with dates of service on or after April 1, 2002. The Ambulance FS applies to all ambulance services. Section 1834(l) of the Act also required mandatory assignment for all ambulance services, which means that the provider or supplier will be paid the Medicare allowed amount as payment in full for their services. In addition, providers and suppliers may bill or collect only any unmet Part B deductible and coinsurance amounts from the beneficiary.

As of January 1, 2006, the total payment amount for air ambulance providers and suppliers is based on 100 percent of the national Ambulance FS. Payments for air ambulance services under the Ambulance FS include the following elements:

- A nationally uniform base rate for fixed wing and a nationally uniform base rate for rotary wing;
- A GAF for each Ambulance FS locality area (geographic practice cost index);
- A nationally uniform loaded mileage rate for each type of air service; and
- A rural adjustment to the base rate and mileage for services furnished for a rural POP.

AMBULANCE SERVICES PAYMENTS
Ambulance services are paid under Part A as a packaged service and under Part B as a separately billed service. If an ambulance service is covered and payable under Part A, it will not be covered or payable under Part B.
Ground Ambulance Payment When the Beneficiary Dies

The chart below provides payment information for three ground ambulance transport scenarios in which the beneficiary dies.

<table>
<thead>
<tr>
<th>Time of Death Pronouncement</th>
<th>Payment</th>
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</thead>
<tbody>
<tr>
<td>1) Before dispatch.</td>
<td>• None.</td>
</tr>
<tr>
<td>2) After dispatch and before the beneficiary is loaded onboard the ambulance (before or after arrival at the POP).</td>
<td>• The provider’s or supplier’s BLS base rate; • No mileage or rural adjustment; • Use QL modifier, “Patient pronounced dead after ambulance called,” on claim.</td>
</tr>
<tr>
<td>3) After pickup and prior to or upon arrival at the receiving facility.</td>
<td>• A medically reasonable and necessary level of service has been furnished.</td>
</tr>
</tbody>
</table>
Air Ambulance Payment When the Beneficiary Dies

The chart below provides payment information for three air ambulance transport scenarios in which the beneficiary dies.

<table>
<thead>
<tr>
<th>Time of Death Pronouncement</th>
<th>Payment</th>
</tr>
</thead>
</table>
| 1) Before the beneficiary is loaded onboard the ambulance:  
  • 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 onboard the ambulance. | • Appropriate air base rate with no mileage or rural adjustment; and  
  • Use QL modifier on claim. |
| 3) After the beneficiary is loaded onboard the ambulance and before or upon arrival at the receiving facility. | • As if the beneficiary had not died. |
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.

<table>
<thead>
<tr>
<th>Aborted Flight Scenario</th>
<th>Payment</th>
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<tbody>
<tr>
<td>1) Before the beneficiary is loaded onboard the ambulance (i.e., prior to or after take off to the POP).</td>
<td>None.</td>
</tr>
<tr>
<td>2) After the beneficiary is loaded onboard the ambulance.</td>
<td>Appropriate air base rate, mileage, and rural adjustment.</td>
</tr>
</tbody>
</table>

Multiple Beneficiary Ground and Air Ambulance Transports

Effective April 1, 2002, the following applies to multiple beneficiary ground and air ambulance transports:

- When two 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 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 beneficiaries on board.
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Both Origin and Destination Are Ambulance Providers

If both the origin and destination of ambulance transports are providers (e.g., hospitals, CAHs, or SNFs), responsibility for payment for the ambulance transport is determined as follows:

<table>
<thead>
<tr>
<th>Criterion 1: National Provider Identifiers (NPI)</th>
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<tbody>
<tr>
<td>If the NPIs of the two providers are different –</td>
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<tr>
<td>• The ambulance service is separately billable.</td>
</tr>
<tr>
<td>If the NPIs of both providers are the same –</td>
</tr>
<tr>
<td>• See Criterion 2: Campus.</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Criterion 2: Campus¹</th>
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<tbody>
<tr>
<td>If the campuses of the two providers that share the same NPI are the same –</td>
</tr>
<tr>
<td>• The transport is not separately billable; and</td>
</tr>
<tr>
<td>• The provider is responsible for payment.</td>
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<tr>
<td>If the campuses of the two providers are different –</td>
</tr>
<tr>
<td>• See Criterion 3: Patient Status – Inpatient vs. Outpatient.</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Criterion 3: Patient Status – Inpatient vs. Outpatient</th>
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</thead>
<tbody>
<tr>
<td>If the beneficiary is an inpatient at both providers (i.e., inpatient status at both the origin and the destination, and the providers share the same NPI but are located on different campuses) –</td>
</tr>
<tr>
<td>• The transport is not separately billable;</td>
</tr>
<tr>
<td>• The provider is responsible for payment; and</td>
</tr>
<tr>
<td>• All other combinations (i.e., outpatient-to-inpatient, inpatient-to-outpatient, and outpatient-to-outpatient) are separately billable.</td>
</tr>
<tr>
<td>If the point of origin is not a provider –</td>
</tr>
<tr>
<td>• 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</td>
</tr>
<tr>
<td>• Ambulance services are excluded from the 3-day preadmission payment window.</td>
</tr>
</tbody>
</table>

¹Campus 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 Centers for Medicare & Medicaid Services (CMS) Regional Office.
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