

# Medicare Ambulance Transport: Comprehensive Policy and Coverage Briefing

## Executive Summary

The Medicare ambulance benefit is defined strictly as a transportation benefit. Coverage and reimbursement are predicated on the actual provision of transport to a Medicare beneficiary; without transport, no payable service exists. This briefing synthesizes the regulatory requirements for vehicle and crew standards, the criteria for medical necessity, and the complex distinctions between Part A "under arrangement" services and separately billable Part B services.

### Critical Takeaways:

- **Medical Necessity:** Coverage is established only when other methods of transportation are contraindicated by the patient's condition.
- **Destination Requirements:** Transports are generally limited to the nearest appropriate facility (Hospital, CAH, SNF, home, or dialysis facility).
- **Payment Levels:** Reimbursement is based on the level of medically necessary service actually furnished (BLS, ALS1, ALS2, or SCT), regardless of the vehicle type used.
- **Inpatient Status (Part A vs. Part B):** Ambulance services provided to beneficiaries in inpatient status (Hospital, CAH, or SNF) for specialized care are often "under arrangement" and included in the provider's Part A claim rather than being separately billable under Part B.

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## I. Vehicle and Crew Requirements

All ambulance providers and suppliers must meet specific standards to qualify for Medicare reimbursement.

### 1. The Vehicle

Any vehicle used must be designed and equipped for medical emergencies or transporting beneficiaries with acute conditions.

- **Compliance:** Must adhere to State and local licensing and certification laws.
- **Minimum Equipment:** Includes a stretcher, linens, emergency supplies, oxygen equipment, warning lights, sirens, and telecommunications (two-way radio or wireless phone).
- **Supplies:** Customary care items (e.g., backboards, splints) are considered part of the transport and are not separately reimbursed.

## 2. Crew Staffing Standards

Staffing requirements vary by the level of service provided:

Service Level	Minimum Staffing	Certification Requirements
<b>Basic Life Support (BLS)</b>	At least two people	At least one must be certified as an EMT-Basic and authorized to operate all onboard equipment.
<b>Advanced Life Support (ALS)</b>	At least two people	At least one must meet BLS requirements; at least one must be certified as an EMT-Intermediate or EMT-Paramedic to perform ALS services.

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## II. Medical Necessity and Reasonableness

Medicare coverage requires that the transport be both medically necessary and reasonable.

### 1. Establishing Necessity

Medical necessity is confirmed when any other method of transportation would endanger the individual's health.

- **Contraindication:** If the patient could have been moved by other means without endangering their health, the service is not covered, even if other transportation was unavailable.
- **Physician Orders:** The presence or absence of a physician's order does not, by itself, prove or disprove medical necessity.
- **Bed-Confinement:** Medicare presumes necessity if a beneficiary is "bed-confined," defined as:
  - Unable to get up from bed without assistance.
  - Unable to ambulate.
  - Unable to sit in a chair or wheelchair.
  - *Note:* Bed-confinement is a factor in determining if other transport is contraindicated, but is not the sole requirement for coverage.

### 2. Presumed Necessity Scenarios

MACs (Medicare Administrative Contractors) may presume necessity if documentation indicates the patient:

- Required restraint to prevent injury.
- Was unconscious or in shock.
- Required oxygen or emergency treatment during transport.
- Exhibited signs of acute stroke, cardiac distress, or respiratory distress.

- Had a fracture that had not been set.
  - Was experiencing severe hemorrhage.
  - Could only be moved by stretcher.
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### **III. Coverage and Destination Rules**

Medicare generally only covers local transportation to the nearest appropriate facility.

#### **1. Covered Destinations**

Transports are limited to:

- Hospitals or Critical Access Hospitals (CAH).
- Skilled Nursing Facilities (SNF).
- The beneficiary's home.
- Dialysis facilities (for ESRD patients requiring dialysis).
- **Physician's Office Exception:** Generally not a covered destination. However, a transport may stop at a physician's office for "dire need of professional attention" while en route to a covered destination without losing coverage.

#### **2. Locality and Appropriate Facilities**

- **Locality:** The service area surrounding an institution where individuals normally travel for care.
  - **Appropriate Facility:** An institution equipped to provide the necessary care, including the availability of specialists.
    - A facility is *not* appropriate if no bed is available or if it lacks specialized equipment (e.g., dialysis or trauma care) needed for the patient's condition.
    - Preference for a specific physician or hospital is not a valid reason for transport to a more distant facility.
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### **IV. Part A vs. Part B: Institutional Billing and Packaging**

The responsibility for billing depends on the beneficiary's status and the nature of the transport.

#### **1. Separately Payable (Part B)**

Ambulance services are typically paid under Part B. This applies if:

- The origin or destination is the beneficiary's home.

- A beneficiary is discharged from one provider and admitted to another (the "transfer" is Part B).
- A beneficiary is on a Leave of Absence (LOA) from an inpatient stay.

## 2. Packaged/Under Arrangement (Part A)

If a beneficiary is an inpatient of a Hospital, CAH, or SNF, certain transports are covered under Part A as "patient transportation."

- **Inpatient Status Maintenance:** If an inpatient requires transport to another site for specialized care and returns while maintaining inpatient status, the hospital must bill for the services and reimburse the ambulance entity.
- **Non-Separately Billable Transports:**
  - Intra-campus transfers (between different departments or buildings of the same provider).
  - Transports between two providers sharing the same Medicare provider number and campus.

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## V. Definitions of Ground Ambulance Services

Reimbursement levels are strictly defined by the intervention provided during the transport.

- **BLS (Basic Life Support):** Includes medically necessary supplies and services as defined by the state.
- **ALS1 (Advanced Life Support, Level 1):** Includes an ALS assessment or at least one ALS intervention (procedures requiring an EMT-Intermediate or Paramedic).
- **ALS2 (Advanced Life Support, Level 2):** Requires ground transport and:
  - At least three separate administrations of IV medications (excluding crystalloid fluids like Saline or D5W); OR
  - Provision of at least one specific procedure, such as manual defibrillation, endotracheal intubation, central venous line, cardiac pacing, chest decompression, surgical airway, or prehospital blood transfusion.
- **SCT (Specialty Care Transport):** Interfacility transport of a critically ill/injured beneficiary requiring care beyond the scope of an EMT-Paramedic (e.g., nursing or respiratory care).
- **Paramedic Intercept (PI):** ALS services provided by an entity that does not provide the transport. This is most common in rural areas where volunteer BLS units meet a separate paramedic service.

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## VI. Air Ambulance Services

Air ambulance (Fixed Wing or Rotary Wing) is covered only when ground transport is contraindicated.

- **Medical Reasonableness:** Established if ground transport time (typically 30-60+ minutes) or instability endangers the beneficiary’s survival.
- **Examples for Justification:** Intracranial bleeding requiring neurosurgery, cardiogenic shock, severe burns, or life-threatening trauma.
- **Limitations:** If ground transport would have sufficed, payment is limited to the ground rate. Air transport is not covered to nursing facilities, physician offices, or homes.

## VII. Special Scenarios and Administrative Requirements

### 1. Effect of Beneficiary Death

Because the benefit requires transport, death prior to transport limits or eliminates payment.

Scenario	Ground Payment	Air Payment
<b>Death before dispatch</b>	None	None
<b>Death after dispatch, before loading</b>	BLS base rate (no mileage); use QL modifier	Base rate (no mileage); use QL modifier
<b>Death after loading/during transport</b>	Full level of service furnished	As if the beneficiary had not died

### 2. Multiple Patient Transport

- **Two Patients:** Medicare allows 75% of the base rate for each beneficiary and 50% of the total mileage for the trip.
- **Three or More Patients:** Each beneficiary’s allowance is 60% of the base rate; mileage is prorated by the number of patients.

### 3. Beneficiary Signatures

Medicare requires a signature for claim submission and accepting assignment.

- **Representative Signatures:** If the beneficiary is mentally or physically unable to sign, representatives (legal guardians, relatives, or institutional representatives) may sign.
- **Refusal to Sign:** If a beneficiary refuses to authorize a claim, the provider may bill the beneficiary directly for the full charge.