

Whitney's Take:

I get many questions about ambulance transportation and what Medicare will and will not pay for. Here is a good summary put together by the Center for Medicare Advocacy that covers most questions.



Ambulance Coverage

- The ambulance transportation must be provided by a Medicare-certified provider.
- The ambulance transportation is **medically necessary** as the patient's condition means other forms of transportation are contraindicated.
- The individual needs both the ambulance transportation itself and the level of services provided by the skilled ambulance staff.
- Certain **“origin and destination requirements”** must be met: Medicare only covers ambulance transportation to or from certain destinations:
 - Hospital
 - Skilled Nursing Facility (SNF)
 - The individual's home
 - Dialysis facility for End Stage Renal Disease (ESRD) who require dialysis.
- **THE TRANSPORT MUST BE TO THE NEAREST FACILITY THAT IS ABLE TO PROVIDE THE NECESSARY DIAGNOSTIC AND/OR THERAPEUTIC SERVICES.**
- Nonemergency transportation by ambulance **generally requires a physician certification** that the ambulance transportation is **medically necessary**.
- In non-emergencies, if the service is NOT medically necessary, the provider may be required to provide advance written notice that Medicare will not cover the transportation even if other requirements are met. If coverage is denied because the transportation does not meet the “origin and destination” requirements, advance written notice is not required.
- **“Rural Area” Provision:** Paramedic intercept services are generally not covered unless the service is furnished in a “rural area” as defined by Medicare, **the paramedic intercept service has a contract with one or more volunteer ambulance services**, and the service is **medically necessary**.



Transportation Medicare does NOT pay for:

- Medicare does not pay for transportation from the individual's home to the individual's physician/provider's office.
- Medicare does not cover wheelchair van transportation.

Billing issues

- If the individual is an inpatient at a hospital or skilled nursing facility on the day of the ambulance transportation, the transportation should be arranged by and billed to the inpatient facility.
- If the patient is enrolled in hospice and the ambulance transportation is related to terminal illness, it should be arranged by and billed to the hospice provider.

See the next page for Important Information

Definition of Medically Necessary

We highlighted the term **medically necessary** in the ambulance document because it has a very specific meaning in government documents:

According to HealthCare.gov, medically necessary services are defined as “health care services or supplies that are needed to diagnose or treat an illness, injury, condition, disease, or its symptoms – and that meet accepted standards of medicine.”

The Centers for Medicare & Medicaid Services (CMS) provides further detail regarding medically necessary services as they apply to your Medicare coverage.

According to CMS, medically necessary services or supplies:

Are proper and needed for the diagnosis or treatment of your medical condition.

Are provided for the diagnosis, direct care, and treatment of your medical condition.

Meet the standards of good medical practice in the local area and are not mainly for the convenience of you or your doctor.

If you have questions about ambulance transportation or any other Medicare issue, call us at 334-240-4680 and ask for ADRC.

Or you can email: caac.adrc@caac-al.org

This material was compiled by:



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