Ambulance Services

Medical Necessity of Ambulance Services

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For payment to be made by Medicare the following coverage requirements must be met for ambulance transport:

1. The transport must be medically reasonable and necessary;
2. Transportation actually occurred;
3. The covered destination is local and;
4. The facility is appropriate to rendered the required care

Medicare ground ambulance transports are covered only to and from the following destinations:

- Hospitals;
- Critical access hospitals;
- Skilled nursing facilities;
- Beneficiaries home;
- Dialysis facilities for end-stage renal disease (beneficiaries who require dialysis);
- Physician office (limited coverage as follows):
- When the transport is en route to a Medicare-covered destination and the ambulance stops because of the beneficiary's dire need for professional attention and immediately thereafter, the ambulance continues to the covered destination.

There may be times when the ambulance provider/supplier feels that Medicare might not cover your ambulance transport based on medical necessity. Meaning: that other means of transportation could have

transported you safely without endangering your life. As a courtesy, an ambulance provider may give you an ABN to notify you that Medicare will not cover the transport and you will be responsible for payment of the transport. Ambulance providers/suppliers are not required to issue an ABN when the ambulance transport is not deemed medically necessary.

Medicare does not pay for ambulance services when transportation does not occur to a covered destination. If you call the ambulance and then refuse to be transported, the ambulance provider cannot bill Medicare and may bill you for their services.

If you request the ambulance provider/supplier to submit a claim to Medicare for the ambulance transport, the provider will submit the line item for ambulance transport with a GY modifier. The GY modifier notifies the Medicare system that the service is not covered. When the claim processes, the line item with the GY modifier will deny. You will receive notification of the denial via a remittance advice notice or Medicare summary notice, and will be responsible for the charges.

What You Can Do

If you feel that your claim should have been paid by Medicare, you have the right to an appeal. You may request your ambulance provider submit an appeal on your behalf or you may appeal the denial with Medicare. Appeals must be filed within 120 days from the date of the denial. Appeals information and forms can be found on our website.

Nearest Appropriate Facility: GY Modifier

Medicare will only cover ambulance services to the nearest appropriate medical facility that's able to give you the medical care you need. If you choose to be transported to a facility farther away, Medicare's payment will be based on the charge to the closest appropriate facility. Mileage to the more distant facility will be your responsibility.

When an ambulance provider/supplier deems that you were transported to a facility that is beyond the closest appropriate facility they will notify Medicare of the excessive mileage by billing the additional miles with HCPCS code A0888 with a GY modifier.

For example, if the nearest appropriate facility to provide care is ten miles away, however you request that the ambulance transport you to a facility that is 25 miles away. The 15 miles will be billed with A0888 to indicate the miles beyond the closest appropriate facility. The base ambulance rate and covered miles will be paid by Medicare as long as all program requirements are met. You will be responsible for payment of the 15 miles beyond the closest appropriate facility.

When determining the nearest appropriate facility it is important to keep in mind the nearest appropriate facility is the facility that is capable of providing the medical care to treat your condition. The fact that your physician does not treat patients at a particular facility does not disqualify the hospital from being the closet appropriate facility. If you choose a more distant hospital because you want a particular physician or facility, you will be responsible for the mileage beyond the closest appropriate facility.

What You Can Do

Talk to your physician prior to ambulance transports between facilities. Ask your physician why you are being transferred to another facility, and if it is the closest appropriate facility to provide care.

If you feel that your claim should have been paid by Medicare, you have the right to an appeal. You may have your ambulance provider submit an appeal on your behalf or you may appeal the denial with Medicare. Appeals must be filed within 120 days from the date of the denial. Appeals information and forms can be found on our website.

Coverage of Rural Air Ambulance Services

Section 415 of the Medicare Modernization Act of 2003 provides coverage for rural air ambulance services that are reasonable and necessary and ordered by qualified personnel.

Medicare considers the following personnel qualified to order air ambulance services:

- Physician
- Registered nurse practitioner (from the transferring hospital)
- Physician assistant (from the transferring hospital)
- Paramedic or emergency medical technician (EMT) (at the scene), and
- Trained first responder (at the scene)

The reasonable and necessary requirement for rural air ambulance transport may be "deemed" to be met when the service is provided pursuant to an established state or regional EMS agency protocol. The Secretary of the Department of Health and Human Services, which administers Medicare through the CMS, has delegated responsibility for approval of the protocols to local MACs.

CMS defines "established" to mean those protocols that have been reviewed and approved by the state EMS agencies or have been developed according to state EMS umbrella guidelines. Submission of protocols for review and subsequent approval by the MAC will "deem" that the reasonable and necessary requirement for rural air ambulance transport has been met by the provider.

Providers that anticipate rural air ambulance transports pursuant to such a protocol may submit their written protocol to their MAC for review and approval in advance.

Providers may submit protocols for review as follows:

Jurisdiction 6 Providers:

National Government Services, Inc.
Attn: Air Ambulance Protocol Approval Request
P.O. Box 7108
Indianapolis, IN 46207-7108

Providers will be notified of all protocol review decisions in writing within 30 days of receipt by National Government Services, Inc.

Please include a contact name, telephone number and address with your submissions. Review decisions will be mailed to this address.

Please review CMS MLN Matters article #MM3571 for additional information pertaining to this requirement.

Related Content

- CMS IOM Publication 100-08, *Medicare Program Integrity Manual,* Chapter 6, Section 6.4.2
- CMS MLN Matters article #MM3571

Ambulance Transports Included in SNF Consolidated Billing

Transport Description	Medical Necessity Met	Ambulance Billing Modifiers and Other Considerations	Who is Responsible for Payment?	Reference(s)
SNF to SNF **Note**: The day of departure from SNF 1 is a covered Part A day (to which consolidated billing would apply) only if the beneficiary's admission to SNF 2 occurs	YES	The first character (origin) of any HCPCS ambulance modifier is N (SNF), the second character (destination) of the HCPCS ambulance modifier is N (SNF) and the patient status is 03. An ambulance trip that is medically necessary to effect this type of SNF-to-SNF transfer would be bundled back to SNF 1, as in this specific situation the beneficiary would continue to be considered a "resident" of SNF 1	SNF 1-Transferring SNF	• CMS IOM Publication 100-04, Claims Processing Manual, Chapter 6 Section 20.3.1 - Ambulance Services (500 KB) • 42 CFR 409.27(c) Other services generally provided by (or under arrangements made by) SNFs

by midnight of the day of departure.		for CB purposes up until the actual point of admission to SNF 2 For example, a SNF-to-SNF transfer would be considered reasonable and necessary in a situation where needed care is unavailable at the originating SNF, thus necessitating a transfer to the receiving SNF in order to obtain that care.		
SNF to SNF **Note**: The day of departure from SNF 1 is a covered Part A day (to which consolidated billing would	NO	The first character (origin) of any HCPCS ambulance modifier is N (SNF), the second character (destination) of the HCPCS ambulance modifier is N (SNF) and the patient status is 03.	Beneficiary	CMS IOM Publication 100-04, Claims Processing Manual, Chapter 6 Section 20.3.1 - Ambulance Services (500 KB)

apply) only if the beneficiary's admission to SNF 2 occurs by midnight of the day of departure.		A SNF-to-SNF transfer that is prompted by non-medical considerations (such as a patient's personal preference to be placed in the receiving SNF) is not considered reasonable and necessary for diagnosing or treating the patient's condition and, thus, would not be bundled back to the originating SNF.		
Ambulance transports to or from a diagnostic or therapeutic site other than a hospital or renal dialysis facility (e.g., an independent diagnostic testing	YES	The ambulance transport is included in the SNF PPS rate if the first or second character (origin or destination) of any HCPCS code ambulance modifier is "D" (diagnostic or therapeutic site other than "P" or "H"), and the other	SNF	CMS IOM Publication 100-04, Claims Processing Manual, Chapter 6 Section 20.3.1 - Ambulance Services (500 KB)

facility (IDTF), cancer treatment center, radiation therapy center, wound care center, etc.)		modifier (origin or destination) is “N” (SNF).		
SNF Part A resident to a physician’s office (round trip)	YES	First or second character (origin or destination) of any HCPCS code ambulance modifier is “P” (physician’s office), and the other modifier (origin or destination) is “N” (SNF)	SNF	• CMS IOM Publication 100-04, Claims Processing Manual, Chapter 6 Section 20.3.1 - Ambulance Services (500 KB) • 42 CFR Section 409.27 (c) Other services generally provided by (or under arrangements made by) SNFs

				• 42 CFR Section 410.40 Coverage of ambulance services (d)
SNF Part A resident to a physician's office (round trip)	NO	First or second character (origin or destination) of any HCPCS code ambulance modifier is "P" (physician's office), and the other modifier (origin or destination) is "N" (SNF) **Note**: Medicare does not provide any coverage at all under Part A or Part B for any non-ambulance forms of transportation, such as ambulette, wheelchair van, or litter van. In order for the Part A SNF benefit to cover	Beneficiary	CMS IOM Publication 100-04, Claims Processing Manual, Chapter 6 Section 20.3.1 - Ambulance Services (500 KB)

		transportation via ambulance, the regulations at 42 CFR 409.27(c) specify that the ambulance transportation must be medically necessary--that is, the patient’s condition is such that transportation by any means other than ambulance would be medically contraindicated.		

Ambulance Transports Excluded From SNF Consolidated Billing

When a Medicare beneficiary is a resident in a SNF under a Part A stay, not all ambulance transports are included in the PPS (prospective payment system) payment for a SNF. SNF consolidated billing includes those medically necessary ambulance trips that are furnished during the course of a covered Part A stay except for specific exclusions as indicated in the CMS IOM Publication 100-04, Medicare Claims Processing Manual, Chapter 6, Section 20.3.1—Ambulance Services.

In most cases, ambulance trips are excluded from consolidated billing when resident status has ended. The ambulance company then must bill the MAC (as appropriate) directly for payment. Listed below are specific circumstances under which a beneficiary may receive ambulance services that are covered by Medicare, but excluded from consolidated billing. The following ambulance services may be billed as Part B services to Medicare by the ambulance provider/supplier in the following situations only.

Note: All ambulance transports billed to the MAC for Part B payment must meet medical necessity and CMS ambulance program requirements.

Transport Description Ambulance Billing Modifiers Reference(s)

Ambulance transport to a SNF for admission The second character (destination) of any ambulance HCPCS modifier is N (SNF) other than modifier QN, and the date of service is the same as the SNF 21X admission date. CMS IOM Publication 100-04, Claims Processing Manual, Chapter 6, Section 20.3.1 - Ambulance Services

The ambulance trip is from the SNF after discharge, to the beneficiary's home

The first character (origin) of any HCPCS ambulance modifier is N (SNF), the second character (destination) of the HCPCS ambulance modifier is R (Residence), and date of ambulance service is the same date as the SNF through date. * Note: this includes beneficiaries discharged home to receive services from a Medicare-participating home health agency under a plan of care CMS IOM Publication 100-04, Claims Processing Manual, Chapter 6, Section 20.3.1 - Ambulance Services

The ambulance trip is to a hospital based or nonhospital based ESRD facility for the purpose of receiving dialysis and related services excluded from consolidated billing The first character (origin) of the HCPCS ambulance modifier is N (SNF), and the second character (destination) HCPCS ambulance modifier code is G (Hospital-based dialysis facility) or J (Non-hospital based dialysis facility)) for the purpose of receiving dialysis and related services excluded from consolidated billing. CMS IOM Publication 100-04, Claims Processing Manual, Chapter 6, Section 20.3.1 - Ambulance Services

The ambulance trip is from the SNF to a Medicare-participating hospital or a CAH for an inpatient admission The first character (origin) of the HCPCS ambulance modifier is N (SNF), and the second character (destination) of the HCPCS modifier is H CMS IOM Publication 100-04, Claims Processing Manual, Chapter 6, Section 20.3.1 - Ambulance Services

The ambulance trip follows a formal discharge or other departure from the SNF to any destination other than another SNF, and the beneficiary does not return to that or any other SNF by midnight of that same day The first character (origin) of the HCPCS ambulance modifier is- N (SNF) and the second character (destination) of the HCPCS modifier is a Medicare covered destination. CMS IOM Publication 100-04, Claims Processing Manual, Chapter 6, Section 20.3.1 - Ambulance Services

An ambulance trip that conveys a beneficiary to a hospital or CAH and back to the SNF for the specific purpose of receiving emergency or other excluded services Ambulance origin modifier- N (SNF) of H (hospital)

Ambulance destination modifier- N(SNF) or H (hospital) CMS IOM Publication 100-04, Claims Processing Manual, Chapter 6, Section 20.3.1 - Ambulance Services

Related Content

CMS IOM Publication 100-04, Medicare Claims Processing Manual, Chapter 6, Section 20.3.1—Ambulance Services

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