Medicare Coverage Overview

Medicare covers non-emergency scheduled ambulance service which is medically necessary.

Here are the Who, When, and Where:

WHO? A patient with at least ONE of the following conditions:

- Is bed confined or requires restraint
- Is too weak or ill to be moved any other way
- Is an invalid with poor significant medical history (e.g. stroke or paralysis, poor heart condition, later stages of diabetes, terminal cancer, severe renal failure…)
- Is confused about or not aware of surroundings (due to sedation, dementia, Alzheimer's, stroke…)
- Must remain immobile due to fracture or fear of fracture

WHEN? When he or she is admitted or discharge or when transportation is needed for diagnostic or therapeutic procedures not available at the present facility. These include but are not limited to the following. If in doubt, please call us.

- Chemotherapy, CAT scans, dialysis, MRIs, radiation, ultrasound, X-rays, etc.
- Treatment of decubitus ulcers
- Surgeries and pre/post surgical diagnostic testing

WHERE?

- From hospital to hospital (higher level of care) nursing facility or residence.
- From nursing facility to hospital, or out-patient clinic
- From physician's office to hospital
- From private residence to hospital

Medicare does NOT cover

- Wheelchair or courtesy transports
- Transports for routine medical exams
- Patients residence to physician's office

If you need clarification on any transport or assistance with financial arrangements, please contact any of our friendly Customer Service Representatives. Each Representative is well versed on Medicare, Medicaid, and Private Insurance. They can assist you with getting your transport approved or offer viable alternatives. Remember, our team is dedicated to serving you.

Medicare Coverage Frequently Asked Questions

Question: When will Medicare pay for an Ambulance?

Answer: When it's medically necessary, not just for convenience

The Balanced Budget Act of 1997 set federal reimbursement rates and rules under which ambulance services are reimbursed. Medicare will generally pay for emergency and non-emergency basic life support (BLS), advanced life support (ALS), and specialty-care transport, but only when these transports are deemed necessary and reasonable. Ambulance services are considered necessary and reasonable under Medicare guidelines when the beneficiary's medical condition is such that other means of transportation are contra-indicated.

Section 1861 of the Balanced Budget Act says:

"Ambulance services are not covered or paid by Medicare if other modes of transportation (i.e. automobile, taxi, wheelchair van, etc.) could have been used by the beneficiary without endangering his or her health. If the decision to use an ambulance service is based on the convenience of the beneficiary, the beneficiary's family, or some other element of personal preference, Medicare coverage is not available."

Caution: A patient's condition may meet medical-necessity criteria, but the reason for the ambulance must also be deemed reasonable and necessary. A trip to the pharmacy, for example, is medically necessary, but making that trip in an ambulance is not.

Examples that meet medical necessity guidelines:

- Post-hip fracture with physician's order to remain supine
- Needs to remain immobile due to possible fracture or splinting requirement
- Contracture of lower limbs (describe the severity)
- Facility transfer for higher level of care
- Examples that are NOT reasonable and necessary
- Foley catheter replacement
- Transport for convenience of patient, family or physician

Medicare requires a Physician Certification Statement for reimbursement, a form that documents the medical need for an ambulance signed by a physician or nurse. A version of this from can be downloaded from our website.

For more information, go to the Medicare website at www.cms.hhs.gov