Medicare Pulls Back on Ambulance Services

How to Meet Medicare's Coverage Criteria

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If you have ever paid for an ambulance ride, you know it doesn't come cheap. Costs can range from hundreds into the thousands of dollars. Some companies will tack on additional charges for additional practitioners on board (critical care nurses, respiratory therapists, etc.), use of medical supplies (i.e. oxygen masks, bandages, dressings, ice packs, etc.) and mileage among other things.

The question is whether or not your insurance plan will pay for ambulance services when you need them. Medicare will but only sometimes. Even in covered situations, Medicare Part B will only pay 80 percent, leaving you with the rest.

Medicare Coverage for Emergency Situations

Defining medical necessity is the first step. An ambulance, in Medicare's eyes, is only indicated if there is no other safe means of transportation, you are being transported to receive care covered by Medicare and the ambulance company accepts assignment.

In a medical emergency, your health is at stake. Medicare will pay for ambulance services to the nearest medical facility that can offer the appropriate level of care. You cannot pick and choose which facility you want to go.[1]

For example, if you were having chest pain, you may need to have cardiac catheterization. If the closest hospital does not offer that service, Medicare will pay for the ambulance to drive you to the closest hospital that does.

Medicare Coverage for Non-Emergency Situations

For Medicare to approve coverage in non-emergency situations, certain conditions must be met.
You must require transportation to receive medical evaluation and/or treatment, you are confined to your bed and cannot travel by other means or you require medical care during the course of transport. Not having another means of transportation is not sufficient for Medicare to pay for services.

Common examples may occur if you need transportation to get dialysis or if you are staying in a skilled nursing facility and require medical care.

In these cases, a doctor's order may be required to prove that use of the ambulance is medically necessary.

How Medicare is Tightening the Reins

Medicare fraud may be more common than you may realize. A study by the Inspector General of the U.S. Department of Health and Human Services found that the Centers for Medicare and Medicaid overpaid more than $30 million on ambulance services to facilities where Medicare services were not performed and $17 million on transport to and from facilities not covered under the Medicare benefit. Worse than that, 20 percent of billing practices were found to be inappropriate.

Medicare is now testing a pre-approval process, known as a prior authorization, for non-emergency ambulance services in three states -- New Jersey, Pennsylvania, and South Carolina. If you use three ambulance rides, either within a 10-day period or once a week over three weeks, Medicare must pre-approve the fourth before you can receive the service again. The idea is to cut back on overuse or inappropriate use of ambulances.

This prior authorization requirement may expand to all states in 2017.

What You Can Do for Coverage

You have a right to speak up for yourself. If you feel an ambulance service should have been covered, you have the right to an appeal.

Sources

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