present it to the contractor. The presence of the signed physician certification statement does not alone demonstrate that the ambulance transport was medically necessary. All other program criteria must be met in order for payment to be made.

(3) Special rule for nonemergency ambulance services that are either unscheduled or that are scheduled on a nonrepetitive basis. Medicare covers medically necessary nonemergency ambulance services that are either unscheduled or that are scheduled on a nonrepetitive basis under one of the following circumstances:

(i) For a resident of a facility who is under the care of a physician if the ambulance provider or supplier obtains a written order from the beneficiary’s attending physician, within 48 hours after the transport, certifying that the medical necessity requirements of paragraph (d)(1) of this section are met.

(ii) For a beneficiary residing at home or in a facility who is not under the direct care of a physician. A physician certification is not required.

(iii) If the ambulance provider or supplier is unable to obtain a signed physician certification statement from the beneficiary’s attending physician, a signed certification statement must be obtained from either the physician assistant (PA), nurse practitioner (NP), clinical nurse specialist (CNS), registered nurse (RN), or discharge planner, who has personal knowledge of the beneficiary’s condition at the time the ambulance transport is ordered or the service is furnished. This individual must be employed by the beneficiary’s attending physician or by the hospital or facility where the beneficiary is being treated and from which the beneficiary is transported. Medicare regulations for PAs, NPs, and CNSs apply and all applicable State licensure laws apply; or,

(iv) If the ambulance provider or supplier is unable to obtain the required certification within 21 calendar days following the date of the service, the ambulance supplier must document its attempts to obtain the requested certification and may then submit the claim. Acceptable documentation includes a signed return receipt from the U.S. Postal Service or other similar service that evidences that the ambulance supplier attempted to obtain the required signature from the beneficiary’s attending physician or other individual named in paragraph (d)(3)(iii) of this section.

(v) In all cases, the provider or supplier must keep appropriate documentation on file and, upon request, present it to the contractor. The presence of the signed certification statement or signed return receipt does not alone demonstrate that the ambulance transport was medically necessary. All other program criteria must be met in order for payment to be made.

(e) Origin and destination requirements. Medicare covers the following ambulance transportation:

(1) From any point of origin to the nearest hospital, CAH, or SNF that is capable of furnishing the required level and type of care for the beneficiary’s illness or injury. The hospital or CAH must have available the type of physician or physician specialist needed to treat the beneficiary’s condition.

(2) From a hospital, CAH, or SNF to the beneficiary’s home.

(3) From a SNF to the nearest supplier of medically necessary services not available at the SNF where the beneficiary is a resident, including the return trip.

(4) For a beneficiary who is receiving renal dialysis for treatment of ESRD, from the beneficiary’s home to the nearest facility that furnishes renal dialysis, including the return trip.

(f) Specific limits on coverage of ambulance services outside the United States. If services are furnished outside the United States, Medicare Part B covers ambulance transportation to a foreign hospital only in conjunction with the beneficiary’s admission for medically necessary inpatient services as specified in subpart H of part 424 of this chapter.

§ 410.41 Requirements for ambulance suppliers.

(a) Vehicle. A vehicle used as an ambulance must meet the following requirements:
§ 410.42 Limitations on coverage of certain services furnished to hospital outpatients.

(a) General rule. Except as provided in paragraph (b) of this section, Medicare Part B does not pay for any item or service that is furnished to a hospital outpatient (as defined in § 410.2) during an encounter (as defined in § 410.2) by an entity other than the hospital unless the hospital has an arrangement (as defined in § 409.3 of this chapter) with that entity to furnish that particular service to its patients. As used in this paragraph, the term “hospital” includes a CAH.

(b) Exception. The limitations stated in paragraph (a) of this section do not apply to the following services:

(1) Physician services that meet the requirements of § 415.102(a) of this chapter for payment on a fee schedule basis.

(2) Physician assistant services, as defined in section 1861(s)(2)(K)(i) of the Act.

(3) Nurse practitioner and clinical nurse specialist services, as defined in section 1861(s)(2)(K)(ii) of the Act.

(4) Certified nurse mid-wife services, as defined in section 1861(gg) of the Act.

(5) Qualified psychologist services, as defined in section 1861(ii) of the Act.

(6) Services of an anesthetist, as defined in § 410.69.

(7) Services furnished to SNF residents as defined in § 411.15(p) of this chapter.

[65 FR 18536, Apr. 7, 2000]

§ 410.43 Partial hospitalization services: Conditions and exclusions.

(a) Partial hospitalization services are services that—

(1) Are reasonable and necessary for the diagnosis or active treatment of the individual’s condition;

(2) Are reasonably expected to improve or maintain the individual’s condition and functional level and to prevent relapse or hospitalization;

(3) Are furnished in accordance with a physician certification and plan of...