REIMBURSEMENT POLICY

Ambulance Services

Active

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Description

This policy addresses coverage and reimbursement for ambulance services including ground and air ambulance transports.

Definitions

Ambulance services include transport by ground or air.

Ground ambulance transports include the following:

- **Basic Life Support (BLS)** – Includes the provision of medically necessary supplies and services and BLS ambulance transportation, as defined by the State where the transport is provided.
- **Advanced Life Support, Level 1 (ALS1)** – Includes the provision of medically necessary supplies and services and the provision of an ALS assessment or at least one ALS intervention. An ALS intervention is a procedure that must be performed by an emergency medical technician-intermediate (EMT-Intermediate) or an EMT-Paramedic in accordance with State and local laws.
- **Advanced Life Support, Level 2 (ALS2)** – Includes the provision of medically necessary supplies and services and:
  - At least three separate administrations of one or more medications by intravenous push/bolus or by continuous infusion (excluding crystalloid fluids);
  - or
  - At least one of the following procedures:
    - Manual defibrillation/cardioversion
    - Endotracheal intubation
    - Central venous line
    - Cardiac pacing
    - Chest decompression
    - Surgical airway or
    - Intraosseous line
- **Specialty Care Transport (SCT)** – Includes the provision of medically necessary supplies and services at a level of service beyond the scope of an EMT-Paramedic. SCT is the interfacility transportation of a critically ill or injured beneficiary that is necessary because the beneficiary's condition requires ongoing care furnished by one or more

professionals in an appropriate specialty (such as emergency or critical care nursing, emergency medicine, respiratory or cardiovascular care, or a paramedic with additional training):

- **Paramedic Intercept (PI)** – Refers to an entity that provides ALS services but does not supply the ambulance transport. PI may be required when only a BLS level of service is provided and the beneficiary requires an ALS level of service (such as electrocardiogram monitoring, chest decompression, or intravenous therapy).

Air Ambulance is defined as follows:

- **Air Ambulance Transport** – Includes the provision of medically necessary supplies and services to a beneficiary transported by fixed wing (airplane) or rotary wing (helicopter) aircraft as defined by the State where the transport is provided.

Policy Statement

The ambulance transport benefit covers a medically necessary transport of a beneficiary by ground or air ambulance to the nearest appropriate facility that can treat his or her condition when any other methods of transportation are contraindicated.

An emergency response is one that the ambulance responds to immediately.

Ambulance Providers

An ambulance provider may be an independent ambulance supplier or a hospital-based ambulance service.

- **Independent Ambulance Supplier**: An ambulance supplier may be a licensed, independently owned and operated ambulance service company that is enrolled as an independent ambulance supplier. These providers bill their services on a professional claim (837P).
- **Hospital-based Ambulance Provider**: A hospital-based ambulance provider is owned and/or operated by a hospital and provides ambulance services as an adjunct to its institutional-based operations. Services by these providers are billed on an institutional claim (837I).

Covered Destinations

Ground Ambulance Transport

Ground ambulance transports are covered only to and from the following destinations and not from other locations:

- Hospitals
- Beneficiary's home:
  - Transport **to** the beneficiaries' home is not covered unless covered under the member's contract
- Physicians' office, only as follows:
  - The transport is enroute to a covered destination
  - The ambulance stops because of the beneficiary's dire need for professional attention and
  - Immediately thereafter, the ambulance continues to the covered destination

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Air Ambulance Transport

Air ambulance transports are covered only to an acute care hospital. Air ambulance transports to the following destinations are **not** covered:

- Nursing facilities
- Physicians' offices and
- Beneficiary's home

Coverage Requirements

Ground Ambulance Transports

The following coverage requirements apply to ground ambulance transports:

1) The transport is medically reasonable and necessary
    - The transport must meet the following requirements:
        - Due to the beneficiary's condition, the use of any other method of transportation is contraindicated and
        - The purpose of the transport is to obtain a covered service or to return from obtaining such service.
2) The destination is local
    - As a general rule, the ground ambulance transport destination must be local, which means that only mileage to the nearest appropriate facility equipped to treat the beneficiary is covered.
3) The facility is appropriate
    - Some circumstances that may justify ground ambulance transport to a more distant institution include:
        - The beneficiary's condition requires a higher level of trauma care or other specialized service that is only available at the more distant hospital. A specialized service is a covered service that is not available at the facility where the beneficiary is a patient and
        - No beds are available at the nearest institution.

Ground Ambulance Coding

Ground ambulance transport and mileage services are reported using codes A0225, A0426-A0429, A0432-A0434, A0888, A0998, A0999, T2007.

The appropriate two digit origination and destination modifier must be reported. See the *Procedure Modifiers – Transportation Services* code list later in this policy.

Air Ambulance Transports

The following coverage requirements apply to air ambulance transports:

1) The transport is medically reasonable and necessary:
    - The transport must meet the following requirements:
        - The beneficiary's medical condition requires immediate and rapid ambulance transport

  - It cannot be furnished by BLS or ALS ground ambulance transport because one of the following poses a threat to the beneficiary's survival or seriously endangers his or her health:
    - The point-of-pick-up (POP) is not accessible by ground vehicle. The POP is the location of the beneficiary at the time he or she is placed on board the ambulance.
    - The distance to the nearest appropriate facility or the time a ground ambulance transport will take (generally more than 30–60 minutes) or
    - The instability of ground transportation.

2) The destination is local:
   - As a general rule, the air ambulance transport destination must be local, which means that only mileage to the nearest appropriate facility equipped to treat the beneficiary is covered.
3) The facility is appropriate.
   - An appropriate facility is an acute care hospital that is generally equipped to provide the needed hospital or skilled nursing care for the beneficiary's illness or injury. An appropriate hospital must have a physician or a physician specialist available to provide the necessary care required to treat the beneficiary's condition.
   - Some circumstances that may justify air ambulance transport to a more distant institution include:
     - The beneficiary's condition requires a higher level of trauma care or other specialized service that is only available at the more distant hospital. A specialized service is a covered service that is not available at the facility where the beneficiary is a patient; and
     - No beds are available at the nearest institution.

Air Ambulance Coding

Air ambulance transport and mileage services are reported based on whether the air transport is fixed wing or rotary wing.

- Fixed wing transport is reported as A0430 and A0435 for mileage.
- Rotary wing transport is reported as A0431 and A0436 for mileage.

The appropriate two digit origination and destination modifier must be reported. See the *Procedure Modifiers – Transportation Services* code list later in this policy.

Mileage

Generally, each ambulance trip will require two lines of coding, e.g., one line for the service and one line for the mileage.

Charges for mileage must be based on loaded mileage only, e.g., from the pickup of a patient to his/her arrival at destination.

Mileage is reported under the codes A0380, A0425, A0888 or A0998. Units reflect miles traveled.

Statute Miles vs. Nautical Miles

A statute mile is 5,280 feet in length. A nautical mile is 6,076.11549 feet in length.

- To convert from nautical to statute miles, the factor 1.15 may be used.

The air ambulance mileage rate is calculated per actual loaded (patient onboard) miles flown and is expressed in statute miles (not nautical miles).

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Pronounced Dead Before Arrival

In the case where the beneficiary was pronounced dead after the ambulance is called but before the ambulance arrives at the scene, payment may be made for a BLS service if a ground vehicle is dispatched or at the fixed wing or rotary wing base rate, as applicable, if an air ambulance is dispatched.

Mileage would not be allowed. Providers should report code A0428. The provider must also report modifier QL instead of the origin and destination modifier. In addition to the QL modifier, report modifier QM or QN.

Waiting time

Waiting time is a charge that an ambulance service company makes for time spent while waiting for the patient. Ambulance companies usually consider that the total time involved in picking up a patient and transporting the patient to the destination involves some waiting time. This waiting time is not a separate identifiable part of the charge rate for a covered ambulance service and therefore, is not reimbursable as a separate charge unless the waiting time is extraordinarily long and constitutes unusual circumstances.

The reasonableness of the additional amount charged in any given instance must be determined based on knowledge of all the pertinent facts including:

- The customary additional charge, under the circumstances, of the physician or other person rendering the service
- The prevailing charging practices under such circumstances of physicians and other persons in the locality and
- The additional time spent, or expenses incurred by the physician or other person rendering the service.

Patient Transport Refusal or Treat but No Transport

In a situation where the ambulance responds and treats the beneficiary medical condition but provides no transport, either because the medical issue is resolved or the patient refused to be transported to a medical facility, code A0998 only may be reported. This service may be considered allowable; however, the patient’s condition and treatment must be documented.

Non-covered transports

Ambulance services, ground and air, are not covered under the following circumstances:

- Transports in which some other means of transportation could be used without endangering the beneficiary’s health, regardless of whether the other means of transportation is actually available.
- Transports to a more distant hospital solely to avail the beneficiary of the services of a specific physician or physician specialist.

Non-covered items

Items and services which include but are not limited to oxygen, drugs, extra attendants, supplies, EKG, and night differential are not paid separately for ambulance services. If billed separately, the items will be denied as included in the base rate.

These services are reported under A0384, A0392, A0420, A0422, A0424, S9960, S9961 and T2007

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Billing

Claims format

Independent ambulance suppliers bill on the ASC X12 837 professional claim transaction.

Institution-based ambulance providers bill on the ASC X12 837 institutional claim. Institutional claims are reported under revenue code 0540 (Ambulance; General Classification) or 0545 (Ambulance; Air Ambulance) with the appropriate HCPCS codes for transportation type and mileage.

HCPCS code definitions

HCPCS Code	Description of HCPCS Codes
A0021	Ambulance service, outside state per mile, transport (Medicaid only)
A0225	Ambulance service, neonatal transport, base rate, emergency transport, one way
A0380	BLS mileage (per mile)
A0384	BLS specialized service disposable supplies; defibrillation (used by ALS ambulances and BLS ambulances in jurisdictions where defibrillation is permitted in BLS ambulances)
A0392	ALS specialized service disposable supplies: defibrillation (to be used only in jurisdictions where defibrillation cannot be performed in BLS ambulances)
A0420	Ambulance waiting time (ALS or BLS), one-half (1/2) hour increments
A0422	Ambulance (ALS or BLS) oxygen and oxygen supplies, life sustaining situation
A0424	Extra ambulance attendant, ground (ALS or BLS) or air (fixed or rotary winged); (requires medical review)
A0425	Ground mileage, per statute mile
A0426	Ambulance service, advanced life support, nonemergency transport, level 1 (ALS 1)
A0427	Ambulance service, advanced life support, emergency transport, level 1 (ALS 1 - emergency)
A0428	Ambulance service, basic life support, nonemergency transport, (BLS)
A0429	Ambulance service, basic life support, emergency transport (BLS, emergency)
A0430	Ambulance service, conventional air services, transport, one way (fixed wing)
A0431	Ambulance service, conventional air services, transport, one way (rotary wing)
A0432	Paramedic intercept (PI), rural area, transport furnished by a volunteer ambulance company which is prohibited by state law from billing third-party payers
A0433	Advanced life support, level 2 (ALS 2)
A0434	Specialty care transport (SCT)
A0435	Fixed wing air mileage, per statute mile
A0436	Rotary wing air mileage, per statute mile
A0888	Noncovered ambulance mileage, per mile (e.g., for miles traveled beyond closest appropriate facility)
A0998	Ambulance response and treatment, no transport
A0999	Unlisted ambulance service
S9960	Ambulance service, conventional air services, nonemergency transport, one way (fixed wing)

S9961	Ambulance service, conventional air service, nonemergency transport, one way (rotary wing)
T2007	Transportation waiting time, air ambulance and nonemergency vehicle, one-half (1/2) hour increments

Procedure Modifiers - Transportation Services

Most modifiers that are used on claims for ambulance services are created by combining two alpha characters. Each alpha character, with the exception of X, represents an origin (source) code or a destination code. The pair of alpha codes creates one modifier:

- First position alpha code = origin
- Second position alpha code = destination

In addition to the single digit modifiers, there are several two-digit modifiers as well that may be reported as appropriate.

Code	Description
D	Diagnostic or therapeutic site other than ‘P’ or ‘H’ when these are used as origin codes
E	Residential, domiciliary, custodial facility (other than an 1819 facility)
G	Hospital based dialysis facility (hospital or hospital related)
H	Hospital
I	Site of transfer (e.g., airport or helicopter pad) between modes of ambulance transport
J	Non-hospital based dialysis facility
N	Skilled nursing facility (SNF) (1819 facility)
P	Physician’s office (includes HMO non-hospital facility, clinic, etc.)
R	Residence
S	Scene of accident or acute event
X	(Destination code only) Intermediate stop at physician’s office enroute to the hospital (includes HMO non-hospital facility, clinic, etc.)
QL	Patient pronounced dead after ambulance called
QM	Ambulance service provided under arrangement by hospital
QN	Ambulance service furnished directly to hospital
TN	Rural/outside providers’ customary service area
TP	Medical transport, unloaded vehicle
TQ	Basic life support transport by a volunteer ambulance provider

Zip Codes

The point of pickup (POP) determines the basis for payment and the POP is reported by its 5-digit ZIP Code.

Electronic billers are required to submit, in addition to the loaded ambulance trip’s origin information (e.g., the ZIP Code of the point of pickup), the loaded ambulance trip’s destination information (e.g., the ZIP code of the point of drop-off). Refer to the appropriate Implementation Guide to determine how to report the destination information.

Only the ZIP Code of the point of pickup will be used to adjudicate and price the ambulance claim, not the point of drop-off. However, the point of drop-off is an additional reporting requirement on version 5010 of the ASC X12 837 professional claim format.

RUCA (Rural Urban Commuting Area)

RUCA is applied by Blue Plus® when the claims reflect zip codes that fall into the RUCA areas.

Non-emergency transportation providers are not required to apply RUCA prior to the claim's submission. RUCA is applied following DHS and MN State Legislation around transportation.

Documentation Submission

Documentation must be on file for an ambulance transport furnished to the beneficiary. Documentation may be used to assess, among other things, whether the transport meets medical necessity, eligibility, coverage, benefit category, and any other criteria necessary for payment.

The presence (or absence) of a physician's order for a transport by ambulance does not necessarily prove (or disprove) whether the transport was medically necessary.

Coverage

Eligible services will be subject to the subscriber benefits, Blue Cross fee schedule amount and any coding edits.

The following applies to all claim submissions.
All coding and reimbursement is subject to all terms of the Provider Service Agreement and subject to changes, updates, or other requirements of coding rules and guidelines. All codes are subject to federal HIPAA rules, and in the case of medical code sets (HCPCS, CPT, ICD), only codes valid for the date of service may be submitted or accepted. Reimbursement for all Health Services is subject to current Blue Cross Medical Policy criteria, policies found in Provider Policy and Procedure Manual sections, Reimbursement Policies and all other provisions of the Provider Service Agreement (Agreement).

In the event that any new codes are developed during the course of Provider's Agreement, such new codes will be reimbursed according to the standard or applicable Blue Cross fee schedule until such time as a new agreement is reached and supersedes the Provider's current Agreement.

All payment for codes based on Relative Value Units (RVU) will include a site of service differential and will be calculated, if appropriate, using the appropriate facility or non-facility components, based on the site of service identified, as submitted by Provider.

Coding

The following codes are included below for informational purposes only, and are subject to change without notice. Inclusion or exclusion of a code does not constitute or imply member coverage or provider reimbursement.

CPT/HCPCS Modifier:	D	E	G	H	I	J	N
	P	R	S	X	QL	QM	QN
	TN	TP	TQ				
ICD-10 Diagnosis:	N/A						
ICD-10 Procedure:	N/A						
CPT/HCPCS:	A0021	A0225	A0380	A0384	A0392	A0420	A0422
	A0424	A0425	A0426	A0427	A0428	A0429	A0430
	A0431	A0432	A0433	A0434	A0435	A0436	A0888
	A0998	A0999	S9960	S9961	T2007		
Revenue Codes:	0540	0545					
Deleted Codes:	N/A						

Policy History

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