BlueCross BlueShield Minnesota

COMMERCIAL REIMBURSEMENT POLICY

Ambulance Services

Active

Policy Number: General Coding – 069
Policy Title: Ambulance Services
Section: General Coding
Effective Date: 11/01/23

Description

This policy addresses coding and reimbursement for ground and air ambulance services.

Definitions

Ground Ambulance Transport: A specially equipped vehicle designed and supplied with materials and devices to provide life-saving and supportive treatments or interventions.

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

Policy Statement

Ambulance Providers

Services may be provided by 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). 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.

Procedure Modifiers

Most modifiers that are used on claims for ambulance services are created by combining two alpha characters. Each alpha character, except for 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 also several two-digit modifiers 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

Mileage
Generally, each ambulance trip will require two lines of coding:

- One line for the service
- One line for the mileage (reported with units to reflect miles)

Charges for mileage must be based on loaded mileage only, e.g., from the pickup of a patient to the arrival at the destination. Mileage is reported with the following codes:

Code	Ground	Air
A0380	X	
A0390	X	
A0425	X	
A0435		X
A0436		X
A0888	X	X

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).

Pronounced Dead Before Arrival
In the case where the patient 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. Refer to *Procedure Modifiers* section.

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 patient's 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.

Items not separately reimbursed
In alignment with Centers for Medicare and Medicaid Services (CMS), items and services which include but are not limited to oxygen, drugs, extra attendants, supplies, EKG, and night differential are not reimbursed separately for ambulance services. If billed separately, the items will be denied as included in the base rate.
These services are reported under A0382, A0384, A0392, A0394, A0396, A0398, A0420, A0422, A0424, S9960, or S9961.

Zip Codes
For air ambulance services, the point of pickup (POP) determines the basis for payment and is reported by using the five-digit ZIP Code.

Air ambulance providers 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).

Documentation Submission

Documentation must identify and describe the services performed. If a denial is appealed, this documentation must be submitted with the appeal.

Coverage

Eligible services will be subject to the subscriber benefits, applicable 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 the 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 paid 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 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 subscriber 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:	A0225	A0380	A0382	A0384	A0390	A0392	A0394
	A0396	A03898	A0420	A0422	A0424	A0425	A0426
	A0427	A0428	A0429	A0430	A0431	A0432	A0433
	A0434	A0435	A0436	A0888	A0998	A0999	S9960
	S9961						
Revenue Codes:	0540	0545					

Resources

HCPCS Manual - Healthcare Common Procedure Coding System Manual
Medicare Benefit Policy Manual Chapter 10 - Ambulance Services
Medicare Claims Processing Manual Chapter 15 - Ambulance

Policy History

10/18/2016	Initial Committee Approval
03/15/2017	Annual Policy Review
01/04/2021	Annual Policy Review
06/29/2021	Annual Policy Review
10/25/2022	Annual Policy Review
10/24/2023	Annual Policy Review