Capital BLUE

NETWORK REIMBURSEMENT POLICY

POLICY TITLE	Ambulance Services
POLICY NUMBER	NR-30.024

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I. DESCRIPTION/BACKGROUND TOP

This policy documents the billing requirements and reimbursement methodology applied to ambulance services.

II. DEFINITIONS TOP

American Medical Association (AMA) – An organization whose missions is to promote the science and art of medicine and the betterment of public health. The AMA speaks out on issues important to patients and the nation's health and exercises a strong advocacy agenda on behalf of patients and providers. The AMA is also committed to providing timely information on matters important to the health of America and includes the development and promotion of standards in medical practice, research and education.

Centers for Medicare and Medicaid Services (CMS) –The current name of the government agency which administers Medicare.

Current Procedural Terminology (CPT) – A set of codes, descriptions, and guidelines intended to describe procedures and services performed by physicians and other health care professionals. Each procedure or service is identified with a five-digit code. The use of CPT codes simplifies the reporting of procedures and services.

Healthcare Common Procedure Coding System (HCPCS) - A national standard, alphanumeric coding system established by the Centers for Medicare and Medicaid Services. It standardizes billing and payment for certain covered services (e.g. medical supplies, prosthetics and durable medical equipment). HCPCS Level I codes are copyrighted by the American Medical Association (CPT). Level II codes are five-position alphanumeric codes maintained jointly by the Alpha-Numeric Panel (consisting

of the Centers for Medicare and Medicaid Services (CMS), the Health Insurance Association of America, and the BlueCross and BlueShield Association). The American Dental Association copyrights the D-code series in Level II HCPCS.

APPROPRIATE FACILITIES is defined as that institution that is generally equipped to provide hospital care necessary to manage the illness or injury of the member. It is the institution, its equipment, its personnel and its capability to provide the services necessary to support the required medical care that determine whether it has appropriate facilities.

BASIC LIFE SUPPORT AMBULANCE (BLS) is the delivery of pre-hospital or inter-hospital emergency medical care and the management of illness and injury, such as administration of oxygen and first aid (e.g., splinting of fractures, pressure bandages, and cardio-pulmonary resuscitation).

ADVANCED LIFE SUPPORT (ALS) is the delivery of pre-hospital or inter-hospital emergency medical care for serious illness or injury. ALS includes the administration of intravenous therapy, cardiac (EKG) monitoring, and defibrillation of the heart.

MEDICAL EMERGENCY - A medical condition with acute symptoms of such severity that:

- Care is sought as soon as possible after the medical condition becomes evident to the member or the member's parent or guardian;
- The emergency involves the sudden onset of a medical condition that manifests itself by acute symptoms of sufficient severity or severe pain, such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:
- Undo risk to the health of the *member*, or, with respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy;
- Serious impairment to bodily functions, or
- Serious dysfunction of any bodily organ or part.

III. POLICY

This policy addresses general guidelines applicable to reimbursement for ambulance services. It should be used as a reference source in conjunction with the member's benefits, the Provider's Agreement with Capital and any applicable ambulance billing guidelines that can be found in the Provider Manual.

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Capital covers emergent and non-emergent ground ambulance services provided by a state licensed ambulance provider. All ambulance services are subject to the criteria set forth in the Medical Policy.

IV. AMBULANCE TRANSPORTATION SERVICES

Reimbursement for ambulance providers rendering ground transportation services will be established with an all-inclusive base rate which includes all supplies rendered as a part of the routine service, along with a separate amount that is payable for mileage.

Ambulance providers should report the appropriate code reflecting the ground transportation services rendered with a separate charge for mileage. For services to be considered covered the use of the following codes is necessary:

Code	Description
A0425	Ground mileage, per statute mile
A0426	Ambulance service, advanced life support, non-emergency transport, level 1 (ALS1)
A0427	Ambulance service, advanced life support, emergency transport, level 1 (ALS1-emergency)
A0428	Ambulance service, basic life support, non-emergency transport, (BLS)
A0429	Ambulance service, basic life support, emergency transport, (BLS-emergency)
A0433	Advanced life support, level 2 (ALS2)
A0434	Specialty care transport (SCT)
A0998	Ambulance response and treatment, no transport
A0999	Unlisted ambulance service (complete narrative description required, payment can be made on an individual consideration basis)

There will be no additional reimbursement for ambulance services billed in addition to the base rate, any such services will be considered as an integral part of the actual transportation service.

Mileage Reimbursement

As a rule, only local transportation by an ambulance is covered, and therefore, only mileage to the nearest appropriate facility equipped to treat the member is covered.

Multiple Transports
Capital may provide coverage for more than one patient transported e.g., from the scene of a traffic accident. The billed amount should be prorated by the number of patients in the ambulance.

Ambulance claims for multiple transports with a single trip must be appropriately identified by the modifier 'GM. Additionally, when multiple patient transports are reported, the statement "multiple patients" and the number transported must be documented.

Multiple Unit Response
When multiple units respond to a call for services, payment will be made to the entity that provides the transport for the member. The transporting entity should bill for all services furnished.

Origin and Destination Modifier Requirements

HCPCS Level II codes for ambulance services must be reported with modifiers that indicate pick up origins and destinations. Origin and destination modifiers are created by combining two alpha characters. Each alpha character represents either an origin or destination. Each pair of alpha characters creates one modifier. The first position represents the origin, and the second the destination. The modifiers may be selected from the following list of modifiers that represent active origin and destination modifiers:

Origin / Destination	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 1819 facility)
G	Hospital based ESRD facility
H	Hospital
I	Site of transfer (e.g. airport or helicopter pad) between modes of ambulance transport
J	Freestanding ESRD facility
N	Skilled nursing facility
P	Physician's office
R	Residence
S	Scene of accident or acute event

Ambulance services that are submitted without a valid ambulance modifier combination for origin and destination will be rejected as incomplete billing.

V. DESTINATION

Emergent Ambulance Transportation maybe covered for services when;

- The circumstances leading up to the ambulance services qualify as a medical emergency; and
- The member is transported to the nearest acute care hospital with appropriate facilities for treatment of the injury or illness involved.

Non-Emergency Ambulance Transportation may be covered when there is documented evidence of the following;

- The member is bed confined and the patient's condition is such that other methods of transport are contraindicated; or
- The member's medical condition, regardless of bed confinement, is such that transportation by ambulance is medically required (see guidelines below.)

Guidelines- The following criteria may be useful in determining the medical requirement for non-emergent ambulance transport:

- Is the member's medical condition, at the time of transportation such that the member must be transported on a stretcher in an ambulance and transportation by any other means is contraindicated?
- Could the member be safely transported in a wheelchair van, stretcher van, car or taxi, without a medical attendant?
- Does the member require cardiac/hemodynamic monitoring or medication administration (including oxygen), which requires monitoring or adjustment while in transit?
- Does the member require skilled services of a paramedic or BLS ambulance personnel?
- Does the member have a benefit for non-emergency ambulance transport?

Residence

Transportation to a residence is only covered if the transport is to return from a

- Hospital; or
- Freestanding diagnostic/treatment facilities; and
- The member's condition at the time must meet the criteria set forth in this policy contained under section Non-Emergency Ambulance Transportation.

Inter-facility

Medical transportation services between hospitals or other applicable facilities (such as freestanding diagnostic treatment facilities or other acute hospitals) may be covered when all of the following conditions are met:

- The transport meets prior documented criteria;
- Services required to treat a member's condition are not available in the original facility;
- The member is transported to the most appropriate hospital or freestanding diagnostic/treatment facility that can provide the necessary service:
    - Alternate transportation is not feasible or reasonable.

Physician's Office

Ambulance service to a physician's office is not a covered benefit.

VI. AIR AMBULANCE

Emergent & Non-Emergent Air Ambulance Transport may be considered for reimbursement when ALL the following criteria are met:

- The member must be transported to the nearest acute care hospital with appropriate facilities for treatment of the injury or illness involved;
- The transport must be the result of a medical emergency;
- The vehicle and crew utilized for air ambulance transport must meet all applicable local, state, and federal regulatory certification and licensing requirements;
- The origin (point of pick-up) is an acute care facility (e.g., hospital, rehabilitation hospital) and is not otherwise precluded from eligibility in the member contract; and
- The destination is not precluded from eligibility in the member contract**.**

Air Ambulance provider should report the appropriate code reflecting the transportation services rendered with a separate charge for mileage. For services to be considered covered the use of the following codes is necessary:

Code	Description
A0430	**Transport one way, fixed wing**
A0431	**Rotor Base**
A0435	**Fixed wing mileage, per status mile**
A0436	**Rotor wing mileage, per status mile**

There will be no additional reimbursement for ambulance services billed in addition to the base rate, any such services will be considered as an integral part of the actual transportation service.

Non-emergency air and ground ambulance transport is NOT covered for the convenience of the member, family members/companions, or the provider treating the member.

VII. VEHICLE AND CREW REQUIREMENTS

Any vehicle used as an ambulance must be designed and equipped to respond to medical emergencies, and, in non-emergency situations, be capable of transporting members with acute medical conditions. The vehicle and crew utilized for ambulance transport must comply with state or local laws governing the licensing and certification of an emergency medical transportation. At a minimum, the ambulance must contain a stretcher, linens, emergency medical supplies, oxygen equipment, and other lifesaving emergency medical equipment and be equipped with emergency warning lights, sirens, and telecommunications equipment as required by state or local law. This should include, at a minimum, one two-way voice radio or wireless telephone.

In situations where a BLS (Basic Life Support) supplier provides the transport of the member and an ALS (Advanced Life Support) supplier provides a service that meets the definition of ALS intervention (e.g., ALS assessment, Paramedic Intercept services), the BLS supplier may bill the higher ALS rate, only if there is a written agreement between the BLS and ALS suppliers. Suppliers must provide a copy of the agreement or other such evidence (e.g., signed attestation) upon request.

VIII. PARAMEDIC INTERCEPT

Paramedic intercept service are ALS services provided by paramedics who are not part of the ambulance entity that is providing the actual member transportation. Paramedic services are to be considered part of the global when an ambulance service provides Advanced Life Support (ALS) services. However, Paramedic intercept services may be considered a covered service when the ambulance service provides only Basic Life Support services (BLS). This type of service is most often provided for an emergency ambulance transport in which a local volunteer ambulance that can provide only BLS level of service is dispatched to transport a member. If the member needs ALS services such as EKG monitoring, chest decompression, or IV therapy, another entity dispatches a paramedic to meet the BLS ambulance at the scene or once the ambulance is on the way to the hospital. The ALS paramedics then provide services to the member.

BILLING IN CASE OF PATIENT DEATH

Payment may be made for ambulance services when the ambulance responds to pick up a member, but the member is pronounced dead before being loaded onto the ambulance for transport. A pronouncement of death is valid only when made by an individual authorized under State law to make such a pronouncement. Additionally, no payment is made if the dispatcher received pronouncement of death and had sufficient time to abort the transport.

In the case of member death, the allowed amount is the appropriate base rate. No amount will be allowed for mileage that would have been allowed had the transport of a living member been completed.

To be eligible for reimbursement, claims that meet the above criteria must be submitted with a 'QL' modifier.

IX. NON-COVERED AND BUNDLED SERVICES

Capital does not cover the following items or services unless specifically outlined in the member's contract;

- Transportation by way of wheelchair vans, stretcher vans, ambi-buses, ambulates (Mobility Assistance Vehicle (MAV)), Medi-cabs, vans, privately owned vehicles, taxicabs, or other transport modalities where advanced or basic life support is unnecessary;
- Parking Fees;
- Tolls for bridges, tunnels, or highways.

Supplies are considered included in the payment for ambulance services and are not separately reimbursable. This includes, but is not limited to disposable supplies, oxygen, and protective garments.

Additional Services including cardiac monitoring, EKG, and pulse oximetry are considered included in the payment for ambulance services and are not separately reimbursable.

Ambulance Wait Time is included in the payment for ambulance services and is not separately reimbursable.

Extra Ambulance Attendant is not separately reimbursable. This service when billed in addition to the base rate will be denied as an integral part of the actual transportation.

Night Differential charges will not be reimbursed for ambulance transport services provided between the hours of 7pm and 7am, as it is considered an inherent part of the base rate for ambulance transport.

X. EXCLUSIONS

N/A **TOP**

XI. VARIATIONS

The existence of this reimbursement policy does not mean that this service is a covered benefit under the member's contract. Benefit determinations should be based in all cases on the applicable contract language. This reimbursement policy is intended to serve as a guide, other factors may influence reimbursement and in some cases may supersede this policy. The Provider should consult their Capital Provider Agreement for further details of their contractual obligations.

XII. REFERENCES

Ambulance Services (Ground Ambulance) (L35162)
Medicare Benefit Policy Manual Chapter 10 – Ambulance Services
Medicare Claims Processing Manual Chapter 15 - Ambulance
Capital BlueCross Ground Ambulance Transport Services -Medical Policy MP-3.009
Capital BlueCross Provider Manual