Transportation Services

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➲ Terms and Conditions

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Related Medicare Advantage Reimbursement Policy

- Medicare Physician Fee Schedule Status Indicator, Professional

Related Medicare Advantage Coverage Summary

- Ambulance Services

Policy Summary

➲ See Purpose

Overview

Medicare covers ambulance services only if they are furnished to a beneficiary whose medical condition is such that use of any other means of transportation is contraindicated. A beneficiary whose condition permits transport in any type of vehicle other than an ambulance would not qualify for services under Medicare. The beneficiary's condition at the time of the transport is the determining factor in whether medical necessity is met.

Guidelines

Emergency Ambulance Services (Ground)

Emergency response means responding immediately at the BLS or ALS1 level of service to a 911 call or the equivalent in areas without a 911 call system. An immediate response is one in which the ambulance provider or supplier begins as quickly as possible to take the steps necessary to respond to the call. Medicare will cover emergency ambulance services when the services are medically necessary, meet the destination limits of closest appropriate facilities, and are provided by an ambulance service that is licensed by the state.

Medical Reasonableness

Medical reasonableness is established if the beneficiary's condition is an emergency and the beneficiary is unable to go to the hospital by other means. An emergency means services provided after the sudden onset of a medical condition, manifesting itself by acute signs or symptoms of sufficient severity such that the absence of immediate medical attention could reasonably be expected to result in the following: placing the beneficiary's health in serious jeopardy; serious impairment to bodily functions; or serious dysfunction of any bodily organ or part.

Examples of emergency situations are: (Note: This list is not all inclusive.)

- Injury resulting from an accident, or illness with acute symptoms. Examples are hemorrhage, shock, chest pain, acute neurological symptoms or respiratory distress.
- The beneficiary requires restraints by a professionally trained ambulance attendant as a means of preventing injury either to the beneficiary or to another person. A description of why restraints are necessary is required. Such descriptions may include narrative describing specific violent or psychotic acts, frequency/severity/predictability of seizure activity, or a

precise description of the risk to safety that unrestrained and unsupervised transport would create. A sole diagnosis of senility, forgetfulness, or Alzheimer's does not qualify.
- Oxygen is required by the beneficiary during transport. The administration of oxygen itself does not satisfy the requirement that the beneficiary needed oxygen. Documentation should reflect the need such as hypoxemia, syncope, airway obstruction, and chest pain. Ambulance transport is not medically necessary if the only reason for the ambulance service is to provide oxygen during transport, and the beneficiary has a portable oxygen system available.
- Immobilization of the beneficiary is necessary because of a suspected fracture, a compound fracture, severe pain, the need for pain medication, or suspicion of neurological injury.
- A transfer is made of a beneficiary between institutions for necessary services not available at the transferring institution and the beneficiary meets any of the criteria 1-4 above. Examples are beneficiaries with cardiac disease requiring cardiac catheterization or coronary bypass not available at the transferring institution.

Destination

An ambulance transport is covered to the nearest appropriate facility to obtain necessary diagnostic and/or therapeutic services (such as a CT scan or cobalt therapy) as well as the return transport. In addition to all other coverage requirements, this transport situation is covered only to the extent of the payment that would be made for bringing the service to the patient.

Medicare covers ambulance transports (that meet all other program requirements for coverage) only to the following destinations:
- Hospital
- Critical Access Hospital (CAH)
- Skilled Nursing facility (SNF)
- From a SNF to the nearest supplier of medically necessary services not available at the SNF where the beneficiary is a resident and not in a covered Part A stay, including the return trip
- Beneficiary's home
- Dialysis facility for ESRD beneficiary who requires dialysis

A physician's office is not a covered destination. However, under special circumstances an ambulance transport may temporarily stop at a physician's office without affecting the coverage status of the transport.

Transfer Site (Airport/Helicopter)

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

Non-Emergency (Scheduled) Ambulance Service (Ground)

For non-emergency ambulance transportation, transportation by ambulance is appropriate if the beneficiary is bed-confined and it is documented that the beneficiary's medical condition is such that other methods of transportation are contraindicated, or if his or her medical condition, regardless of bed-confinement, is such that transportation by ambulance is medically required.

Three criteria determine whether a beneficiary has Medicare coverage for non-emergency (scheduled) ambulance services:
- Only when transportation by any other means of transportation is contraindicated by the medical condition of the beneficiary
- Only to specific destinations; and
- Only when certified as medically necessary by a physician directly responsible for the beneficiary's care

Note: All three of the above criteria must be met.

Medical Reasonableness

Ambulance transport in non-emergency situations must meet medical necessity guidelines.
- Medical reasonableness is established for non-emergency ambulance services when the beneficiary's condition is such that the use of any other method of transportation (such as: taxi, private car, wheelchair van, or other type of vehicle) is

contraindicated. If the condition contraindicating other means of transportation is "bed confined", the beneficiary must meet the following criteria of "bed confined." The beneficiary is:
    - Unable to get up from bed without assistance
    - Unable to ambulate; and
    - Unable to sit in a chair or wheelchair

    Note: All three components must be met in order for the beneficiary to be considered "bed-confined." It does not include a beneficiary who is restricted to bed rest on a physician's instructions due to a short-term illness. Bed confinement, by itself, is neither sufficient nor is it necessary to determine the coverage for Medicare ambulance benefits. It is simply one element of the beneficiary's condition that may be taken into account in the intermediary's determination of whether means of transport other than an ambulance were contraindicated. Examples of situations in which beneficiaries are bed confined and cannot be moved by wheelchair, but must be moved by stretcher include:
    - Contractures creating non-ambulatory status and the beneficiary cannot sit
    - Severe generalized weakness
    - Severe vertigo causing inability to remain upright
    - Immobility of lower extremities (beneficiary in spica cast, fixed hip joints, or lower extremity paralysis) and unable to be moved by wheelchair
- If some means of transportation other than an ambulance (such as: private car, wheelchair van, etc.) could be utilized without endangering the individual's health, whether or not such other transportation is actually available, no payment may be made for ambulance service.
- If transportation is for the purpose of receiving an excluded service (such as a routine dental examination) then the transportation is also excluded even if the beneficiary could only have gone by ambulance.
- If transportation is for the purpose of receiving a service that could have been safely and effectively provided in the point of origin then the transport is not covered even if the beneficiary could only have gone by ambulance. Examples include (a) A transport from a residence to a hospital for a service that can be performed more economically in the beneficiary's home, and (b) A transport of a skilled nursing facility beneficiary to a hospital or to another SNF for a service that can be performed more economically in the first SNF.

Ambulance transportation for services excluded from SNF consolidated billing must meet the criteria as reasonable and necessary (i.e. other means contraindicated).

Emergency Air Ambulance Transportation

Emergency response means responding immediately at the BLS or ALS1 level of service to a 911 call or the equivalent in areas without a 911 call system. An immediate response is one in which the ambulance supplier begins as quickly as possible to take the steps necessary to respond to the call. Medically appropriate air ambulance transportation either by means of a helicopter or fixed wing aircraft is a covered service regardless of the state or region in which it is rendered only if the beneficiary's medical condition required immediate and rapid ambulance transportation that could not have been provided by land ambulance, or either:

- The point of pick-up is inaccessible by land vehicle (this condition could be met in Hawaii, Alaska, and in other remote or sparsely populated areas of the continental United States), or
- Great distances or other obstacles (for example, heavy traffic) are involved in getting the patient to the nearest hospital with appropriate facilities as described in this policy.

Medical Reasonableness for Emergency Air Ambulance Transportation

Medical reasonableness is only established when the beneficiary's condition is such that the time needed to transport a beneficiary by land, or the instability of transportation by land, poses a threat to the beneficiary's survival or seriously endangers the beneficiary's health. These conditions may include, but are not limited to:

- Intracranial bleeding - requiring neurosurgical intervention;
- Cardiogenic shock;
- Burns requiring treatment in a Burn Center;
- Conditions requiring treatment in a Hyperbaric Oxygen Unit;
- Multiple severe injuries; or
- Life-threatening trauma.

Destination

When all other program requirements for coverage are met, air ambulance transports are covered only to an acute care hospital. Air ambulance transports to these destinations are not covered:

- Nursing facilities
- Physicians' offices
- Beneficiaries' homes

Appropriate Facilities

The term "appropriate facilities" means that the institution is generally equipped to provide the needed hospital or skilled nursing care for the illness or injury involved. 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.

The fact that a more distant institution is better equipped, either qualitatively or quantitatively, to care for the patient does not warrant a finding that a closer institution does not have "appropriate facilities." Such a finding is warranted, however, if the beneficiary's condition requires a higher level of trauma care or other specialized service available only at a more distant hospital. In addition, a legal impediment barring a patient's admission would permit a finding that the institution did not have "appropriate facilities." For example, the nearest appropriate specialty hospital may be in another State and that State's law precludes admission of nonresidents.

An institution is also not considered an appropriate facility if there is no bed available.

Note: If the transport is for the purpose of receiving a non-covered service, then the transport is also non-covered, even if the destination is an appropriate facility.

Ambulance Service to a Physician's Office

Ambulance service to a physician's office is covered only under the following circumstances:

- The ambulance transport is en route to a Medicare covered destination.
- During the transport, the ambulance stops at a physician's office, because of the beneficiary's dire need for professional attention, and immediately thereafter, the ambulance continues to a covered destination.

In such cases, the beneficiary will be deemed to have been transported directly to a covered destination and payment may be made for a single transport and the entire mileage of the transport, including any additional mileage traveled because of the stop at the physician's office.

Physician Certification & Order

Ambulance transport providers or suppliers must obtain a written order from the attending physician for all nonemergency, scheduled repetitive ambulance services and a written statement from the physician certifying the medical necessity of the ambulance services. Requirements for non-emergency ambulance transportation include:

- The order and certification must be dated no earlier than 60 days in advance of the transport, for repetitive beneficiaries whose transportation is scheduled in advance.
- For residents in facilities who are under the direct care of a physician, written orders from the patient's attending physician certifying medical necessity can be obtained within 48 hours after the transport.
- The physician order may be signed by a physician assistant (PA), nurse practitioner (NP), or clinical nurse specialist (CNS) (where all applicable state licensure or certification requirements are met).
- For unscheduled non-emergency transports, a registered nurse (RN) or discharge planner who is employed by the beneficiary's attending physician or the hospital or facility where the patient is being treated may sign a physician certification statement on oral orders from the physician or other qualified practitioner (i.e., PA, NP, CNS). The physician must later countersign the written order.
- The ambulance supplier is responsible for obtaining the signed written order and certification with the appropriate signatures as expeditiously as possible, and must obtain the signed order before billing for the service.
- If the ambulance supplier is unable to obtain the written order and certification with appropriate signatures within 21 calendar days following the date of the service, the supplier may bill only if there is documentation of good faith effort to obtain the order and certification.

- A physician order is not required prior to emergency transports or unscheduled transports of a beneficiary residing at home or in a facility, who is not under the direct care of a physician.

When the transport involves a ground ambulance and an air ambulance, both services may be reimbursed if both are medically necessary.

Note: It is important to note that the presence of the signed physician certification statement does not necessarily demonstrate that the transport was medically necessary. The ambulance provider or supplier must meet all coverage criteria in order for payment to be made.

Documentation Requirements

In all cases, the appropriate documentation must be kept on file and, upon request, presented to the contractor. It is important to note that 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. The ambulance service must meet all program coverage criteria in order for payment to be made.

- IOM Pub 100-01, Medicare General Information, Eligibility, and Entitlement Manual, chapter 4 - Physician Certifications and Recertification of Services, contains specific information on supplier requirements for ambulance certification.
- IOM Pub. 100-08, Medicare Program Integrity Manual, chapter 6 - Medicare Contractor Medical Review Guidelines for Specific Services contains information on medical review instructions of ambulance services.

Utilization Guidelines

Multiple patient transports - a single payment allowance for mileage will be prorated by the number of beneficiaries onboard.

Down coding from air to ground is an §1862 (a)(1)(A) denial.

Aspirin alone does not qualify to validate as an indicator that an ALS-2 level has been supplied. Oxygen alone, even at high flow rates, does not qualify to validate as an indication that an ALS-2 level has been supplied. Administration of IV fluids even with a fluid challenge does not qualify to validate as an indication that an ALS-2 level has been supplied.

Nitroglycerin administered as an assist to the beneficiary's own nitroglycerin does not qualify to validate as an indication ALS-2 level has been supplied. Nitroglycerin administered intravenously from the ambulance stock under a physician's telephonic order, or standing orders does qualify as an indication (as one of three medications) that an ALS-2 level has been supplied.

Multiple arrivals - when multiple units respond to a call for services the entity that provides the transport for the beneficiary should be the only provider billing the service.

Billing for Ground Ambulance Services when the Beneficiary is Pronounced Deceased

Some ambulance providers are incorrectly billing for transports for deceased beneficiaries. According to Pub. 100-02, Chapter 10, Section 10.2.6, reimbursement of ambulance services provided to a deceased Medicare beneficiary depends on when the beneficiary is pronounced deceased by an individual authorized to do so.

- If the beneficiary is pronounced deceased at the scene by an authorized individual after the ambulance is dispatched and prior to loading, the claim is billed with a QL modifier and no mileage is billed.
- If the beneficiary is dead at the scene but has not been pronounced by an authorized individual, services are not paid unless the ambulance waits at the scene for an authorized individual to arrive and pronounce death. The claim is billed with a QL modifier and no mileage is billed.
- Medicare reimbursement for the above situations is based on the appropriate Basic Life Support rate using HCPCS codes A0428 or A0429.
- When the beneficiary is dead at the scene but has not been pronounced by an authorized individual and the ambulance transports the body to the hospital for pronouncement of death, services are billed and reimbursed at the appropriate level of service furnished.
- If the beneficiary is pronounced deceased by an authorized individual prior to ambulance being dispatched no payment is made.

Billing Procedures When Patient Refuses Transport

Refusal of transport (Procedure code A0998 definition-"Ambulance response and treatment, no transport") is statutorily excluded from Medicare coverage and, therefore, is not payable when billed to Medicare.

Note: Noridian jurisdiction requires different billing for this service please see the following for further instruction; Noridian Billing Procedures When Patient Refuses Transport

Limitations

Medicare does not cover the following services:

- Transportation in Ambi-buses, ambulettes (Mobility Assistance Vehicle (MAV)), Medi-cabs, vans, privately owned vehicles, taxicabs
- Transportation via Mobile Intensive Care Unit (MICU) (if billed under Part A)
- Parking fees
- Tolls for bridges, tunnels and highways

The IOM Publication 100-04, Chapter 15, Section 40 states: See https://www.cms.gov/Center/Provider-Type/Ambulances-Services-Center.html for a medical conditions list and instructions to assist ambulance providers and suppliers to communicate the patient's condition to Medicare contractors, as reported by the dispatch center and as observed by the ambulance crew. Use of the medical conditions list does not guarantee payment of the claim or payment for a certain level of service.

In addition to reporting one of the medical conditions on the claim, one of the transportation indicators may be included on the claim to indicate why it was necessary for the patient to be transported in a particular way or circumstance. The provider or supplier will place the transportation indicator in the “narrative” field on the claim. Information on the appropriate use of transportation indicators is also available at https://www.cms.gov/Center/Provider-Type/Ambulances-Services-Center.html

Effective January 1, 2006, items and services which include but are not limited to oxygen, drugs, extra attendants, supplies, EKG, and night differential are no longer paid separately for ambulance services. This occurred when CMS fully implemented the Ambulance Fee Schedule, and therefore, payment is based solely on the ambulance fee schedule.

Applicable Codes

The following list(s) of procedure and/or diagnosis codes is provided for reference purposes only and may not be all inclusive. Listing of a code in this guideline does not imply that the service described by the code is a covered or non-covered health service. Benefit coverage for health services is determined by the member specific benefit plan document and applicable laws that may require coverage for a specific service. The inclusion of a code does not imply any right to reimbursement or guarantee claim payment. Other Policies and Guidelines may apply.

HCPCS Code	Description
A0382	BLS routine disposable supplies
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)
A0394	ALS specialized service disposable supplies; IV drug therapy
A0396	ALS specialized service disposable supplies; esophageal intubation
A0398	ALS routine disposable supplies
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)
A0425	Ground mileage, per statute mile
A0426	Ambulance service, advanced life support, nonemergency transport, level 1 (ALS 1)

HCPCS Code	Description
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	Non-covered ambulance mileage, per mile (e.g., for miles traveled beyond closest appropriate facility) (Non-Covered)
A0998	Ambulance response and treatment, no transport (Non-Covered)
A0999	Unlisted ambulance service

Coding Clarification: For ambulance service claims, institutional-based providers and suppliers must report an origin and destination modifier for each ambulance trip provided in HCPCS/Rates. Origin and destination modifiers used for ambulance services are created by combining two alpha characters. Each alpha character, with the exception of "X", represents an origin code or a destination code. The pair of alpha codes creates one modifier. The first position alpha code equals origin; the second position alpha code equals destination. Origin and destination codes and their descriptions are listed below.

Modifier	Description
D	Community mental health center, FQHC, RHC, urgent care facility, non-provider-based ASC or freestanding emergency center, location furnishing dialysis services and not affiliated with ESRD facility
E	Residential, domiciliary, custodial facility (other than 1819 facility) if the facility is the beneficiary's home
G	Hospital based ESRD facility
H	Alternative care site for hospital, including CAH, provider-based ASC, or freestanding emergency center
I	Site of transfer (e.g., airport or helicopter pad) between modes of ambulance transport
J	Freestanding ESRD facility
N	Alternative care site for SNF
P	Physician's office
R	Beneficiary's home
S	Scene of accident or acute event
X	Intermediate stop at physician's office on way to hospital (destination code only)

Revenue Code	Description
540	Ambulance
541	Supplies
542	Medical transport
543	Heart mobile
544	Oxygen
545	Air ambulance
546	Neonatal ambulance services
547	Pharmacy

Revenue Code	Description
548	Telephone transmission EKG
549	Other (ALS)

Definitions

Advanced Life Support, Level 1 (ALS1): Advanced life support, level 1 (ALS1) is the transportation by ground ambulance vehicle (as defined in section 10.1, above) and the provision of medically necessary supplies and services (as defined in section 10.2, above) including the provision of an ALS assessment by ALS personnel or at least one ALS intervention.

Advanced Life Support, Level 1 (ALS1): Emergency: When medically necessary, the provision of ALS1 services, as specified above, in the context of an emergency response, as defined below. Emergency response is a BLS or ALS1 level of service that has been provided in immediate response to a 911 call or the equivalent. An immediate response is one in which the ambulance provider/supplier begins as quickly as possible to take the steps necessary to respond to the call.

Advanced Life Support, Level 2 (ALS2): Advanced Life Support, level 2 (ALS2) is the transportation by ground ambulance vehicle and the provision of medically necessary supplies and services including (1) at least three separate administrations of one of more medications by intravenous (IV) push/bolus or by continuous infusion (excluding crystalloid fluids) or (2) ground ambulance transport, medically necessary supplies and services, and the provision of at least one of the ALS2 procedures listed: Manual defibrillation/cardioversion; Endotracheal intubation; Central venous line; Cardiac pacing; Chest decompression; Surgical airway; or Intraosseous line.

Basic Life Support: Basic life support (BLS) is transportation by ground ambulance vehicle (as defined in section 10.1, above) and the provision of medically necessary supplies and services (as defined in section 10.2, above), including BLS ambulance services as defined by the State. The ambulance vehicle must be staffed by at least two people who meet the requirements of the state and local laws where the services are being furnished, and at least one of the staff members must be certified at a minimum as an emergency medical technician-basic (EMT-Basic) by the state or local authority where the services are being furnished and be legally authorized to operate all lifesaving and life-sustaining equipment on board the vehicle. These laws may vary from State to State or within a State. For example, only in some jurisdictions is an EMT-Basic permitted to operate limited equipment onboard the vehicle, assist more qualified personnel in performing assessments and interventions, and establish a peripheral intravenous (IV) line.

Basic Life Support (BLS) Emergency: When medically necessary, the provision of BLS services, as specified above, in the context of an emergency response (as defined below). Emergency response is a BLS or ALS1 level of service that has been provided in immediate response to a 911 call or the equivalent. An immediate response is one in which the ambulance provider/supplier begins as quickly as possible to take the steps necessary to respond to the call.

Fixed Wing Air Ambulance (FW): Fixed wing air ambulance is furnished when the beneficiary's medical condition is such that transport by ground ambulance, in whole or in part, is not appropriate. Generally, transport by fixed wing air ambulance may be necessary because the beneficiary's condition requires rapid transport to a treatment facility, and either great distances or other obstacles, e.g., heavy traffic, preclude such rapid delivery to the nearest appropriate facility. Transport by fixed wing air ambulance may also be necessary because the beneficiary is inaccessible by a ground or water ambulance vehicle.

Paramedic Intercept (PI): Paramedic Intercept services are ALS services provided by an entity that does not provide the ambulance transport. This type of service is most often provided for an emergency ambulance transport in which a local volunteer ambulance that can provide only basic life support (BLS) level of service is dispatched to transport a patient. If the patient needs ALS services such as EKG monitoring, chest decompression, or I.V. 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 patient.

This tiered approach to life saving is cost effective in many areas because most volunteer ambulances do not charge for their services and one paramedic service can cover many communities. Prior to March 1, 1999, Medicare payment could be made for these services, but could not be made directly to the intercept service provider; rather, Medicare payment could be made only when the claim was submitted by the entity that actually furnished the ambulance transport. In those areas where State

laws prohibited volunteer ambulances from billing Medicare and other health insurance, the intercept service could not receive payment for treating a Medicare beneficiary and was forced to bill the beneficiary for the entire service.

Paramedic intercept services furnished on or after March 1, 1999, are payable separate from the ambulance transport when all of the requirements in the following three conditions are met:

- The intercept service(s) is:
  - Furnished in a rural area (as defined below);
  - Furnished under a contract with one or more volunteer ambulance services; and
  - Medically necessary based on the condition of the beneficiary receiving the ambulance service.
- The volunteer ambulance service involved must:
  - Meet Medicare's certification requirements for furnishing ambulance services;
  - Furnish services only at the BLS level at the time of the intercept; and
  - Be prohibited by State law from billing anyone for any service.
- The entity furnishing the ALS paramedic intercept service must:
  - Meet Medicare's certification requirements for furnishing ALS services, and,
  - Bill all recipients who receive ALS paramedic intercept services from the entity, regardless of whether or not those recipients are Medicare beneficiaries.

For purposes of the paramedic intercept benefit, a rural area is an area that is designated as rural by a State law or regulation or that is located in a rural census tract of a metropolitan statistical area (as determined under the most recent version of the Goldsmith Modification). (The Goldsmith Modification is a methodology to identify small towns and rural areas within large metropolitan counties that are isolated from central areas by distance or other features). The current list of these areas is periodically published in the Federal Register.

See the Medicare Claims Processing Manual, Chapter 15, "Ambulance," §20.1.4 for payment of paramedic intercept services.

Rotary Wing Air Ambulance (RW): Rotary wing air ambulance is furnished when the beneficiary's medical condition is such that transport by ground ambulance, in whole or in part, is not appropriate. Generally, transport by rotary wing air ambulance may be necessary because the beneficiary's condition requires rapid transport to a treatment facility, and either great distances or other obstacles, e.g., heavy traffic, preclude such rapid delivery to the nearest appropriate facility. Transport by rotary wing air ambulance may also be necessary because the beneficiary is inaccessible by a ground or water ambulance vehicle.

Rural Air Ambulance Services: "Rural air ambulance service" means fixed wing and rotary wing air ambulance service in which the point of pick-up of the individual occurs in a rural area (as defined in Section 1886(d) (2) (D)) or in a rural census tract of a metropolitan statistical area (as determined under the most recent modification of the Goldsmith Modification, originally published in the Federal Register on February 27, 1992)) (57 Fed. Reg. 6725).

Specialty Care Transport (SCT): Specialty care transport (SCT) is the interfaculty transportation of a critically injured or ill beneficiary by a ground ambulance vehicle, including the provision of medically necessary supplies and services, at a level of service beyond the scope of the EMT-Paramedic. SCT is necessary when a beneficiary's condition requires ongoing care that must be furnished by one or more health professionals in an appropriate specialty area, for example, emergency or critical care nursing, emergency medicine, respiratory care, cardiovascular care, or an EMT-Paramedic with additional training.

References

CMS Local Coverage Determinations (LCDs) and Articles

LCD	Article	Contractor	Medicare Part A	Medicare Part B
L34549 Ambulance Services	A56468 Billing and Coding: Ambulance Services	Palmetto	AL, GA, TN, NC, SC, VA, WV	

LCD	Article	Contractor	Medicare Part A	Medicare Part B
L35162 Ambulance Services (Ground Ambulance)	A54574 Billing and Coding: Ambulance Services (Ground Ambulance)	Novitas	AR, CO, DC, DE, LA, MD, MS, NJ, NM, OK, PA, TX	AR, CO, DC, DE, LA, MD, MS, NJ, NM, OK, PA, TX
	A55096 Reminder Regarding Ambulance Transports – Dual Diagnoses (Provider Bulletin)			
L37697 Emergency and Non-Emergency Ground Ambulance Services	A57674 Billing and Coding: Emergency and Non-Emergency Ground Ambulance Services	First Coast	FL, PR, VI	FL, PR, VI
	A56130 Emergency and non-emergency ground ambulance services revision to the Part A and Part B LCD Retired 10/29/2021			
	A56070 Emergency and non-emergency ground ambulance services revision to the Part A and Part B LCD Retired 10/29/2021			
	A55975 Emergency and non-emergency ground ambulance services New Part A and Part B LCD Retired 10/29/2021			
N/A	A52588 Billing for Ground Ambulance Services when the Beneficiary Is Pronounced Deceased	First Coast	FL, PR, VI	
N/A	A52917 Rural Air Ambulance Service Protocols	Noridian	AK, AZ, ID, MT, ND, OR, SD, UT, WA, WY	

CMS Benefit Policy Manual

Chapter 10; § 10 - § 10.5 Ambulance Services through Joint Responses, § 20 Coverage Guidelines for Ambulance Service Claims and Beneficiary Signature Requirements, § 30-30.1.1 Implementation of Ambulance Fee Schedule and Ground Ambulance Services

CMS Claims Processing Manual

Chapter 1; § 10.1.4.5 Appeals of Denied Charges for Physicians and Ambulance Services in Connection with Foreign Hospitalizations
Chapter 15 Ambulance

CMS Transmittal(s)

Transmittal 115, Change Request 9032, Dated 11/30/2015, (Implementation of the Intravenous Immune Globulin (IVIG) demonstration - Processing)

MLN Matters

CMS MLN, Special Edition
Article MM7161, Air Ambulance Services
Article MM8408, Informational Unsolicited Response (IUR) or Reject for Ambulance SNF to SNF Transfer

UnitedHealthcare Commercial Policies

Ambulance Services
Emergency Health Services and Urgent Care Center Services

Other(s)

Ambulance Fee Schedule and Medicare Transports
Medicare Program Integrity Manual (Pub 100-08), Chapter 6, Section 6.4 Medical Review of Rural Air Ambulance Services
Medicare Program Integrity Manual (Pub 100-08), Chapter 13 Local Coverage Determinations
Title XVIII, Social Security Act:
Section 1833 (e) prohibits Medicare payment for any claim which lacks the necessary information to process the claim
Section 1861 (v)(1)(K)(ii) defines emergency service
Section 1861(s)(7) outlines Ambulance Service where the use of other methods of transportation is contraindicated by the individual's condition, but only to the extent provided in regulations
Sections 1861 (s) and (t) outline coverage for drugs and biologicals and services and supplies
Section 1862(a)(1)(A) allows coverage and payment for only those services that are considered to be medically reasonable and necessary

Guideline History/Revision Information

Revisions to this summary document do not in any way modify the requirement that services be provided and documented in accordance with the Medicare guidelines in effect on the date of service in question.

Date	Summary of Changes

11/10/2021	**Policy Summary**
	• Replaced references to "UnitedHealthcare" with "Medicare"
	Limitations
	• Added language to indicate, effective Jan.1, 2006, items and services which include but are not limited to oxygen, drugs, extra attendants, supplies, electrocardiogram (EKG), and night differential are no longer paid separately for ambulance services; this occurred when CMS fully implemented the Ambulance Fee Schedule, and therefore, payment is based solely on the ambulance fee schedule
	Applicable Codes
	• Updated description for:
	  ○ Modifier codes D, E, H, N, and R
	  ○ Revenue code 548
	• Removed notation indicating HCPCS codes A0382, A0384, A0392, A0394, A0396, A0398, A0420, A0422, and A0424 "cannot be billed separately"
	Supporting Information
	• Updated *References* section to reflect the most current information
	• Archived previous policy version MPG320.07

Purpose

The Medicare Advantage Policy Guideline documents are generally used to support UnitedHealthcare Medicare Advantage claims processing activities and facilitate providers' submission of accurate claims for the specified services. The document can be used as a guide to help determine applicable:

- Medicare coding or billing requirements, and/or
- Medical necessity coverage guidelines; including documentation requirements.

UnitedHealthcare follows Medicare guidelines such as NCDs, LCDs, LCAs, and other Medicare manuals for the purposes of determining coverage. It is expected providers retain or have access to appropriate documentation when requested to support coverage. Please utilize the links in the References section below to view the Medicare source materials used to develop this

resource document. This document is not a replacement for the Medicare source materials that outline Medicare coverage requirements. Where there is a conflict between this document and Medicare source materials, the Medicare source materials will apply.

Terms and Conditions

The Medicare Advantage Policy Guidelines are applicable to UnitedHealthcare Medicare Advantage Plans offered by UnitedHealthcare and its affiliates.

These Policy Guidelines are provided for informational purposes, and do not constitute medical advice. Treating physicians and healthcare providers are solely responsible for determining what care to provide to their patients. Members should always consult their physician before making any decisions about medical care.

Benefit coverage for health services is determined by the member specific benefit plan document* and applicable laws that may require coverage for a specific service. The member specific benefit plan document identifies which services are covered, which are excluded, and which are subject to limitations. In the event of a conflict, the member specific benefit plan document supersedes the Medicare Advantage Policy Guidelines.

Medicare Advantage Policy Guidelines are developed as needed, are regularly reviewed and updated, and are subject to change. They represent a portion of the resources used to support UnitedHealthcare coverage decision making. UnitedHealthcare may modify these Policy Guidelines at any time by publishing a new version of the policy on this website. Medicare source materials used to develop these guidelines include, but are not limited to, CMS National Coverage Determinations (NCDs), Local Coverage Determinations (LCDs), Medicare Benefit Policy Manual, Medicare Claims Processing Manual, Medicare Program Integrity Manual, Medicare Managed Care Manual, etc. The information presented in the Medicare Advantage Policy Guidelines is believed to be accurate and current as of the date of publication and is provided on an "AS IS" basis. Where there is a conflict between this document and Medicare source materials, the Medicare source materials will apply.

You are responsible for submission of accurate claims. Medicare Advantage Policy Guidelines are intended to ensure that coverage decisions are made accurately based on the code or codes that correctly describe the health care services provided. UnitedHealthcare Medicare Advantage Policy Guidelines use Current Procedural Terminology (CPT®), Centers for Medicare and Medicaid Services (CMS), or other coding guidelines. References to CPT® or other sources are for definitional purposes only and do not imply any right to reimbursement or guarantee claims payment.

*For more information on a specific member's benefit coverage, please call the customer service number on the back of the member ID card or refer to the Administrative Guide.