Payment Policy: Prepayment Ambulance Services Policy

Reference Number: CC.PP.153
Product Types: All
Last Review Date: 5/2021

Coding Implications
Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Policy Overview

Ambulance emergency services are deemed necessary when a patient's condition is an emergency that renders the patient unable to be safely transported to the hospital in a moving vehicle (other than an ambulance) for time required to complete the transport. Emergency ambulance services are services provided after the sudden onset of a medical condition. Acute signs or symptoms of sufficient severity must manifest the emergency medical condition such that the absence of immediate medical attention could reasonably be expected to result in placing the patient's health in serious jeopardy, cause serious impairment to bodily functions, or cause serious dysfunction of any body organ or part.

According to CMS policy, certain emergency and non-emergency ground ambulance services require a diagnosis indicating the medical condition of the patient. The diagnosis justifies the need for that transportation and further justifies that any other transportation means is medically contraindicated.

Transportation services included in this policy as covered and medically necessary are as follows:

- A0425 (Ground mileage, per statute mile)
- A0426 (ALS, non-emergency, level 1)
- A0427 (ALS, emergency, level 1)
- A0428 (BLS, non-emergency)
- A0429 (Ambulance service, basic life support, emergency transport (BLS emergency)
- A0433 (Advanced life support, level 2 (ALS 2)
- A0434 (Specialty care transport (SCT)

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Diagnosis included in this policy as covered and medically necessary are as follows:

- Bed confinement status (ICD-10 code Z74.01)
- Dependence on other enabling machines and devices (ICD-10 code Z99.89)
- Dependence on respirator (ventilator) status (ICD-10 code Z99.11)
- Dependence on supplemental oxygen (ICD-10 code Z99.81)
- Need for continuous supervision (ICD-10 code Z74.3)
- Other specified health status (ICD-10 code Z78.9)
- Physical restraint status (ICD-10 code Z78.1)

The presence of one the listed diagnosis is intended to indicate that the policy conditions have been met; absence of these diagnosis codes may result in a denial.

Application

Coverage of Ambulance Services & Documentation Requirements

The Centers of Medicaid and Medicare (CMS) state that ambulance transportation is covered when the patient's condition requires the vehicle itself or the specialized services of the trained ambulance personnel. A requirement of coverage is that the needed services of the ambulance personnel were provided and clear clinical documentation validates their medical need and their provision in the record of the service (usually the trip/run sheet).
To be covered, ambulance services must be medically necessary and reasonable. Medical necessity is established when the patient's condition is such that use of any less medically comprehensive method of transportation is contraindicated. In any case in which some means of transportation other than an ambulance could be used without endangering the individual's health, no payment may be made for ambulance services.

Reimbursement

Appropriate Designation of Level of Service

The need for emergency transport is justified based on the condition of the patient. Emergency transport services are appropriate when the condition of the patient requires immediate response by the ambulance provider. ALS or BLS transport services, whether for emergency or non-emergency services, are expected to be billed with an appropriate diagnosis indicating the condition of the patient and the need for either basic or advanced life support services.

CMS has developed guidelines that outline which diagnoses are appropriate for Advanced Life Support (ALS) and Basic Life Support (BLS) services. These guidelines are further subdivided

into diagnoses that are appropriate for emergency and non-emergency transport. WellCare will generally apply these same guidelines when approving coverage for the various levels of ambulance transport. If the diagnoses supplied do not justify the patient's need for life support services, payment may be denied.

CMS Medical Conditions List can be found at
http://www.cms.hhs.gov/manuals/downloads/clm104c15.pdf

When submitting a claim for payment, it is essential that providers supply claims information that will substantiate (1) the patient's need to be transported by ambulance versus other forms of transportation, and (2) the level of service utilized. In all cases, the appropriate documentation must be kept on file and presented upon request. Neither the presence nor absence of a signed physician's order for an ambulance transport necessarily justifies the transport as medically necessary.

Coding and Modifier Information

This payment policy references Current Procedural Terminology (CPT®). CPT® is a registered trademark of the American Medical Association. All CPT® codes and descriptions are copyrighted 2020, American Medical Association. All rights reserved. CPT codes and CPT descriptions are from current manuals and those included herein are not intended to be all-inclusive and are included for informational purposes only. Codes referenced in this payment policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.
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HCPCS Code	Descriptor
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)
A0433	Advanced life support, level 2 (ALS 2)
A0434	Specialty care transport (SCT)

Modifier	Descriptor
NA	NA

ICD 10 Codes	Descriptor
Z74.01	Bed confinement status
Z74.3	Need for continuous supervision
Z78.1	Physical restraint status
Z78.9	Other specified health status
Z99.11	Dependence on respirator [ventilator] status
Z99.81	Dependence on supplemental oxygen

Definitions

Advanced Life Support (ALS) - Advanced life support (ALS) refers to the medical procedures for sustaining life including the advanced diagnosis and protocol-driven treatment of a patient in the field such as defibrillation, airway management, and administration of medications. Generally, ALS is performed by emergency medical technicians-paramedics and other qualified health professionals.

Basic Life Support (BLS) - Basic Life Support (BLS) means emergency first aid and cardiopulmonary resuscitation procedures which, at a minimum, include recognizing respiratory and cardiac arrest and starting the proper application of cardiopulmonary resuscitation to maintain life without invasive techniques until the victim may be transported or until advanced life support is available

Additional Information
NA

Related Documents or Resources
NA

References

1. Local Coverage Determination (LCD): Ambulance Services (Ground Ambulance) (L35162). Retrieved March 17, 2020 from https://www.cms.gov/medicare-coverage-database/details/lcd-details.aspx?LCDId=35162&ver=61&DocID=L35162&bc=KAAAAAgAAAAA&
2. Medicare Claims Processing Manual Chapter 15-Ambulance. Retrieved March 17, 2020 from https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c15.pdf

Revision History	
6/25/2019	Initial policy draft
5/17/2021	Annual review completed with conversion to Centene corporate template

Important Reminder

For the purposes of this payment policy, "Health Plan" means a health plan that has adopted this payment policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any other of such health plan's affiliates, as applicable.

The purpose of this payment policy is to provide a guide to payment, which is a component of the guidelines used to assist in making coverage and payment determinations and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage and payment determinations and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable plan-level administrative policies and procedures.

This payment policy is effective as of the date determined by Health Plan. The date of posting may not be the effective date of this payment policy. This payment policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this payment policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. Health Plan retains the right to change, amend or withdraw this payment policy, and additional payment policies may be developed and adopted as needed, at any time.

This payment policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members. This payment policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this policy are independent contractors who exercise independent judgment and over whom Health Plan has no control or right of control. Providers are not agents or employees of Health Plan.

 Providers, members and their representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers, members and their representatives agree to be bound by such terms and conditions by providing services to members and/or submitting claims for payment for such services.

Note: For Medicaid members, when state Medicaid coverage provisions conflict with the coverage provisions in this payment policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this payment policy.

Note: For Medicare members, to ensure consistency with the Medicare National Coverage Determinations (NCD) and Local Coverage Determinations (LCD), all applicable NCDs and

LCDs should be reviewed prior to applying the criteria set forth in this payment policy. Refer to the CMS website at http://www.cms.gov for additional information.