

Ambulance Services

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[Instructions for Use](#)

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Coverage Rationale

Indications for Coverage

Air Ambulance

As a general guideline, when it would take a ground ambulance 30-60 minutes or more to transport a member whose medical condition at the time of pick-up required immediate and rapid transport due to the nature and/or severity of the member's illness/injury, air transportation may be appropriate.

Air ambulance transportation should meet the following criteria:

- The member's destination is an acute care hospital; and
- The member's condition is such that the ground ambulance (basic or advanced life support) would endanger the member's life or health; or
- Inaccessibility to ground ambulance transport or extended length of time required to transport the member via ground ambulance transportation could endanger the member; or
- Weather or traffic conditions make ground ambulance transportation impractical, impossible, or overly time consuming

Emergency Ambulance (Ground, Water, or Air)

Coverage includes Emergency ambulance transportation (including wait time and treatment at the scene) by a licensed ambulance service from the location of the sudden illness or injury, to the nearest hospital where Emergency Health Care Services can be performed.

The following Emergency ambulance services are covered:

- Ground ambulance or air ambulance transportation requiring basic life support or advanced life support
- Supplies that are needed for advanced life support or basic life support to stabilize a member's medical condition
- Treatment at the scene (paramedic services) without ambulance transportation
- Wait time associated with covered ambulance transportation
- Transportation to a hospital that provides a required higher level of care that was not available at the original hospital

Non-Emergency Ambulance (Ground or Air) Between Facilities

Coverage includes non-Emergency ambulance transportation by a licensed ambulance service (either ground or air ambulance, as UnitedHealthcare determines appropriate) between facilities only when the transport meets one of the following:

- From an out-of-Network Hospital to the closest Network Hospital when Covered Health Care Services are required
- To the closest Network Hospital or facility that provides the required Covered Health Care Services that were not available at the original Hospital or facility
- From a Short-Term Acute Care Facility to the closest Network Long-Term Acute Care Facility (LTAC), Network Inpatient Rehabilitation Facility, or other Network Sub-Acute Facility where the required Covered Health Care Services can be delivered
- When the member's condition requires treatment at another facility and another mode of transportation would endanger the member's medical condition

The applicable benefit level for eligible non-Emergency ambulance transportation depends on the member pick-up location (origin) as follows:

- If the member is inpatient and is transported from a hospital to another hospital or inpatient facility, coverage levels for these ambulance services may vary.
- If the member is in a sub-acute setting and is transported to an outpatient facility and back (outpatient hospital, outpatient facility, or physician's office), these ambulance services are covered under the benefits that apply to that sub-acute setting. For example, if the member is at a Skilled Nursing Facility, the ambulance transport to an outpatient facility (dialysis facility or radiation whether or not it is attached to a hospital) and back is covered under the Skilled Nursing Facility/Inpatient Rehabilitation Facility Services section of the COC.

Pre-Service Notification Requirements for Non-Emergency Ambulance

- If UnitedHealthcare initiates the non-Emergency ambulance transportation, member notification is not required.
- If UnitedHealthcare does not initiate the non-Emergency ambulance transportation, certain plans may require the member or the provider to call in for notification.
- Provider notification requirements are not addressed by this document.

Out-of-Network Ambulance (Emergency)

If the ambulance transportation is covered, the benefit level for out-of-Network Emergency ambulance (ground, water, or air) is covered at the Network level of deductible and coinsurance.

Coverage Limitations and Exclusions

The following services are not eligible for coverage:

- Ambulance services from providers that are not properly licensed to be performing the ambulance services rendered.
- Air ambulance transportation that does not meet the covered indications in the [Air Ambulance](#) criteria listed above.
- Non-ambulance transportation. Non-ambulance transportation is not covered even if rendered in an Emergency situation. Examples include but are not limited to:
 - Commercial or private airline or helicopter
 - A police car ride to a hospital
 - Medi-van or wheel-chair van transportation
 - Taxi ride, bus ride, rideshare services such as Lyft and Uber, etc.
- Ambulance transportation when other mode of transportation is appropriate. Except as indicated under the [Indications for Coverage](#) section above, ambulance services when transportation by other means would not endanger the member's health are not covered.
- Ambulance transportation to a home, residential, domiciliary or custodial facility is not covered.
- Ambulance transportation that violates the notification criteria listed in the [Indications for Coverage](#) section above.
- Ambulance transportation for member convenience or other miscellaneous reasons for member and/or family. Examples include but are not limited to:
 - Member wants to be at a certain hospital or facility for personal/preference reasons
 - Member is in foreign country, or out of state, and wants to come home for a surgical procedure or treatment (this includes those recently discharged from inpatient care)
 - Member is going for a routine service and is medically able to use another mode of transportation
 - Member is deceased and family wants transportation to the coroner's office or mortuary
- Ambulance transportation deemed not appropriate. Examples include but are not limited to:
 - Hospital to home
 - Home to physician's office

- Home (e.g., residence, nursing home, domiciliary or custodial facility) to a hospital for a scheduled service
- If the member is at a Skilled Nursing Facility/Inpatient Rehabilitation Facility and has met the annual day/visit limit on Skilled Nursing Facility/Inpatient Rehabilitation Facility Services, ambulance transports (during the non-covered days) are not eligible.

Documentation Requirements

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 documentation requirements outlined below are used to assess whether the member meets the clinical criteria for coverage but do not guarantee coverage of the service requested.

HCPSC Codes*	Required Clinical Information
Air Ambulance and Non-Emergency Transport (Ground or Air)	
A0430 A0431 A0435 A0436	<p>Medical notes documenting all of the following:</p> <ul style="list-style-type: none"> ● Date of service ● Ordering physician's name and phone number (if request is made to Air Ambulance provider) ● Physician order and documentation by explaining the reason for Air Ambulance transport ● Any additional equipment or personnel needed for transport ● Member's diagnosis and chief complaint ● Members current condition (clinical summary) including: <ul style="list-style-type: none"> ○ Co-morbidities ○ Current functional limitations ○ Description of members inpatient (IP) stay and progress if applicable ● Where member is traveling from (facility name & contact name/phone number) ● Where member is traveling to (facility name & contact name/phone number) ● Mileage (one-way) for transport including air mileage and land mileage for transport

*For code descriptions, see the [Applicable Codes](#) section.

Definitions

The following definitions may not apply to all plans. Refer to the member specific benefit plan document for applicable definitions.

Covered Health Care Service(s): Health care services, including supplies or Pharmaceutical Products, which UnitedHealthcare determines to be all of the following:

- Provided for the purpose of preventing, evaluating, diagnosing or treating a Sickness, Injury, Mental Illness, substance-related and addictive disorders, condition, disease or its symptoms.
- Medically Necessary.
- Described as a Covered Health Care Service in the *Certificate of Coverage* under *Section 1: Covered Health Care Services* and in the *Schedule of Benefits*.
- Not excluded in the *Certificate of Coverage* under *Section 2: Exclusions and Limitations*.

Emergency: A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) so 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:

- Placing the health of the Covered Person (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

Emergency Health Care Services: Services that are required to stabilize or begin treatment in an Emergency. Emergency Health Care Services must be received on an outpatient basis at a Hospital or Alternate Facility.

Long-Term Acute Care Facility (LTAC): A facility or Hospital that provides care to people with complex medical needs requiring long-term Hospital stay in an acute or critical setting.

Medically Necessary: Health care services that are all of the following as determined by UnitedHealthcare or our designee:

- In accordance with Generally Accepted Standards of Medical Practice.
- Clinically appropriate, in terms of type, frequency, extent, service site and duration, and considered effective for your Sickness, Injury, Mental Illness, substance-related and addictive disorders, disease or its symptoms.
- Not mainly for the member’s convenience or that of the member’s doctor or other health care provider.
- Not more costly than an alternative drug, service(s), service site or supply that is at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of the member’s Sickness, Injury, disease or symptoms.

Generally Accepted Standards of Medical Practice are standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, relying primarily on controlled clinical trials, or, if not available, observational studies from more than one institution that suggest a causal relationship between the service or treatment and health outcomes.

If no credible scientific evidence is available, then standards that are based on Physician specialty society recommendations or professional standards of care may be considered. UnitedHealthcare has the right to consult expert opinion in determining whether health care services are Medically Necessary. The decision to apply Physician specialty society recommendations, the choice of expert and the determination of when to use any such expert opinion, shall be determined by UnitedHealthcare.

UnitedHealthcare develops and maintains clinical policies that describe the Generally Accepted Standards of Medical Practice scientific evidence, prevailing medical standards and clinical guidelines supporting UnitedHealthcare’s determinations regarding specific services. These clinical policies (as developed by UnitedHealthcare and revised from time to time), are available to Covered Persons through www.myuhc.com or the telephone number on the member’s ID card. They are also available to Physicians and other health care professionals on UHCprovider.com.

Short-Term Acute Care Facility: A facility or Hospital that provides care to people with medical needs requiring short-term Hospital stay in an acute or critical setting such as for recovery following a surgery, care following sudden Sickness, Injury, or flare-up of a chronic Sickness.

Sub-Acute Facility: A facility that provides intermediate care on short-term or long-term basis.

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.

Modifier	Location
Ambulance Modifiers	
Ambulance claims are billed with two of the following modifiers. The first modifier indicates the place of origin, and the second modifier indicates the destination.	
D	Diagnostic or therapeutic site other than ‘P’ or ‘H’
E	Residential, domiciliary, custodial facility (nursing home, not skilled nursing facility)
G	Hospital-based dialysis facility (hospital or hospital-related)
H	Hospital
I	Site of transfer (for example, airport or helicopter pad) between types of ambulance
J	Non-hospital-based dialysis facility
N	Skilled nursing facility (SNF)

Modifier	Location
Ambulance Modifiers	
Ambulance claims are billed with two of the following modifiers. The first modifier indicates the place of origin, and the second modifier indicates the destination.	
P	Physician's office (includes HMO non-hospital facility, clinic, etc.)
R	Residence
S	Scene of accident or acute event
X	Intermediate stop at physician's office en route to the hospital (includes HMO non-hospital facility, clinic, etc.) Note: Modifier X can only be used as a destination code in the second position of a modifier.

HCPCS Code	Description
Air Ambulance (Also see Air Ambulance Revenue Code 0545 below)	
A0430	Ambulance service, conventional air services, transport, one way (fixed wing)
A0431	Ambulance service, conventional air services, transport, one way (rotary wing)
A0435	Fixed wing air mileage, per statute mile
A0436	Rotary wing air mileage, per statute mile
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
Ground/Other Ambulance	
A0225	Ambulance service, neonatal transport, base rate, emergency transport, one way
A0380	BLS mileage (per mile)
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)
A0390	ALS mileage (per mile)
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); (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)
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)

HCPSC Code	Description
Ground/Other Ambulance	
A0998	Ambulance response and treatment, no transport
A0999	Unlisted ambulance service
S0207	Paramedic intercept, nonhospital-based ALS service (nonvoluntary), nontransport
S0208	Paramedic intercept, hospital-based ALS service (nonvoluntary), nontransport

Revenue Code	Description
0540	Ambulance; general classification
0541	Ambulance; supplies
0542	Ambulance; medical transport
0543	Ambulance; heart mobile
0544	Ambulance; oxygen
0545	Air ambulance
0546	Neo-natal ambulance
0547	Ambulance; pharmacy
0548	Ambulance; telephone transmission EKG
0549	Other ambulance

References

Medicare Benefit Policy Manual, Chapter 10 – Ambulance Services <http://www.cms.gov/manuals/Downloads/bp102c10.pdf>. Accessed June 4, 2020.

Guideline History/Revision Information

Date	Summary of Changes
08/01/2020	<p>Template Update</p> <ul style="list-style-type: none"> Reformatted policy; transferred content to new template <p>Definitions</p> <ul style="list-style-type: none"> Added definition of “Covered Health Care Service(s)” <p>Supporting Information</p> <ul style="list-style-type: none"> Archived previous policy version CDG.001.11

Instructions for Use

This Coverage Determination Guideline provides assistance in interpreting UnitedHealthcare standard benefit plans. When deciding coverage, the member specific benefit plan document must be referenced as the terms of the member specific benefit plan may differ from the standard plan. In the event of a conflict, the member specific benefit plan document governs. Before using this guideline, please check the member specific benefit plan document and any applicable federal or state mandates. UnitedHealthcare reserves the right to modify its Policies and Guidelines as necessary. This Coverage Determination Guideline is provided for informational purposes. It does not constitute medical advice.

This Coverage Determination Guideline may also be applied to Medicare Advantage plans in certain instances. In the absence of a Medicare National Coverage Determination (NCD), Local Coverage Determination (LCD), or other Medicare coverage guidance, CMS allows a Medicare Advantage Organization (MAO) to create its own coverage determinations, using objective evidence-based rationale relying on authoritative evidence ([Medicare IOM Pub. No. 100-16, Ch. 4, §90.5](#)).

UnitedHealthcare may also use tools developed by third parties, such as the MCG™ Care Guidelines, to assist us in administering health benefits. UnitedHealthcare Coverage Determination Guidelines are intended to be used in connection with the independent professional medical judgment of a qualified health care provider and do not constitute the practice of medicine or medical advice.

For self-funded plans with SPD language other than fully-insured Generic COC language, please refer to the member specific benefit plan document for coverage.