

AMBULANCE SERVICES

Guideline Number: CDG.001.09

Effective Date: January 1, 2019

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INSTRUCTIONS FOR USE

This Coverage Determination Guideline provides assistance in interpreting UnitedHealthcare benefit plans. When deciding coverage, the member specific benefit plan document must be referenced. The terms of the member specific benefit plan document [e.g., Certificate of Coverage (COC), Schedule of Benefits (SOB), and/or Summary Plan Description (SPD)] may differ greatly from the standard benefit plan upon which this Coverage Determination Guideline is based. In the event of a conflict, the member specific benefit plan document supersedes this Coverage Determination Guideline. All reviewers must first identify member eligibility, any federal or state regulatory requirements, and the member specific benefit plan coverage prior to use of this Coverage Determination Guideline. Other Policies and Coverage Determination Guidelines may apply. UnitedHealthcare reserves the right, in its sole discretion, to modify its Policies and Guidelines as necessary. This Coverage Determination Guideline is provided for informational purposes. It does not constitute medical advice.

UnitedHealthcare may also use tools developed by third parties, such as the MCG™ Care Guidelines, to assist us in administering health benefits. The MCG™ Care 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.

BENEFIT CONSIDERATIONS

Before using this guideline, please check the member specific benefit plan document and any federal or state mandates, if applicable.

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.

Essential Health Benefits for Individual and Small Group

For plan years beginning on or after January 1, 2014, the Affordable Care Act of 2010 (ACA) requires fully insured non-grandfathered individual and small group plans (inside and outside of Exchanges) to provide coverage for ten categories of Essential Health Benefits (“EHBs”). Large group plans (both self-funded and fully insured), and small group ASO plans, are not subject to the requirement to offer coverage for EHBs. However, if such plans choose to provide coverage for benefits which are deemed EHBs, the ACA requires all dollar limits on those benefits to be removed on all Grandfathered and Non-Grandfathered plans. The determination of which benefits constitute EHBs is made on a state by state basis. As such, when using this guideline, it is important to refer to the member specific benefit plan document to determine benefit coverage.

COVERAGE RATIONALE

Indications for Coverage

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 services can be performed.

Check the member specific benefit plan document for prior authorization and notification requirements.

The following Emergency ambulance services are covered:

- Ground ambulance or air ambulance transportation requiring basic life support or advanced life support
- Treatment at the scene (paramedic services) without ambulance transportation
- Wait time associated with covered ambulance transportation
- To a hospital that provides a required higher level of care that was not available at the original hospital

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.

Refer to Medicare Benefit Policy Manual in the [References](#) section below.

Additional Information

For covered Emergency ambulance, supplies that are needed for advanced life support or basic life support to stabilize a member's medical condition are covered under the ambulance benefit.

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 we determine 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.

Cost Effective Alternatives (UHIC 2007 COC and 2009 Amendment)

If an alternate method of ambulance transportation is clinically appropriate and more cost effective, we reserve the right to adjust the Allowed Amounts. As we determine to be appropriate, the coverage determination is based on the member's medical condition, and geographic location.

Medically Necessary (UHIC 2011- 2018 COC)

Non-Emergency ambulance transportation is Medically Necessary when the member's condition requires treatment at another facility and when another mode of transportation would endanger the member's medical condition. If another mode of transportation could be used safely and effectively, then ambulance transportation is not Medically Necessary.

Benefit Level for Non-Emergency Ambulance

The applicable benefit 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. Please refer to the member specific benefit plan document to determine benefits. The following are UHIC examples for inpatient ambulance transfer:
 - UHIC 2001 COC: The Hospital Inpatient Stay section of the COC
 - UHIC 2007–2018 COC: The Ambulance Services section of the COC
- 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.

Member Pre-Service Notification Requirements for Non-Emergency Ambulance

- If UHIC initiates the non-Emergency ambulance transportation, member notification is not required.
- If UHIC does not initiate the non-Emergency ambulance transportation, certain plans may require the member or the provider to call in for notification. Please see the member specific benefit plan document for details on the notification requirements.

Additional Information

- Provider notification requirements are not addressed by this document.
- Ambulance transportation that is done for convenience of the member is not covered. Please see the [Coverage Limitations and Exclusions](#) section below for more information on non-covered ambulance transportation.

Benefit Level for Out-of-Network Ambulance (Emergency)

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

Additional Information

- For UHIC Choice, Choice+, and Options PPO Plans: out-of-Network Emergency ambulance is covered at a negotiated rate, or, at billed charges if a negotiated rate is not reached.
- For UHIC Non-Differential PPO Plans: The benefits for Network and out-of-Network are the same level but these plans do not require billed charges to be paid on out-of-Network ambulance.
- For UHIC Plans Without a Network (e.g., Managed Indemnity): These plans do not have Network benefit levels. These plans do not require billed charges to be paid on ambulance services.

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, 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

Additional Information

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.

DEFINITIONS

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

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.

Long-Term Acute Care Facility (LTAC): Means 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 (2011 Generic COC): Health care services provided for the purpose of preventing, evaluating, diagnosing or treating a Sickness, Injury, substance use disorder, condition, disease or its symptoms, that are all of the following as determined by us or our designee, within our sole discretion:

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

We develop and maintain clinical policies that describe the *Generally Accepted Standards of Medical Practice* scientific evidence, prevailing medical standards and clinical guidelines supporting our determinations regarding specific services. These clinical policies (as developed by us and revised from time to time), are available to Covered Persons on www.myuhc.com or by calling Customer Care at the telephone number on your ID card, and to Physicians and other health care professionals on www.UHCprovider.com.

Medically Necessary (2018 Generic COC): Health care services that are all of the following as determined by us 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 your convenience or that of your 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 your 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.

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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 www.UHCprovider.com.

Short-Term Acute Care Facility: Means 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: Means 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 Coverage Determination Guidelines may apply.

Ambulance claims are billed with the following modifiers. The first digit indicates the place of origin, and the destination is indicated by the second digit. The modifiers most commonly used are:

- 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)
- 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 545 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

HCPCS Code	Description
Ground/Other Ambulance	
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)
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
540	Ambulance; general classification
541	Ambulance; supplies
542	Ambulance; medical transport
543	Ambulance; heart mobile
544	Ambulance; oxygen
545	Air ambulance
546	Neo-natal ambulance
547	Ambulance; pharmacy
548	Ambulance; telephone transmission EKG
549	Other ambulance

REFERENCES

Medicare Benefit Policy Manual, Chapter 10 – Ambulance Services
<http://www.cms.gov/manuals/Downloads/bp102c10.pdf>. Accessed April 4, 2018.

GUIDELINE HISTORY/REVISION INFORMATION

Date	Action/Description
01/01/2019	<ul style="list-style-type: none"> Updated definition of “Medically Necessary (2018 Generic COC)” Archived previous policy version CDG.001.08