Ambulance Services

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Instructions for Use

Table of Contents Page

Related Medicare Advantage Policy Guideline

- Transportation Services

Coverage Guidelines

Ambulance services are covered when Medicare coverage criteria are met.

COVID-19 Public Health Emergency Waivers and Flexibilities: In response to the COVID-19 public health emergency, CMS has updated some guidance for certain ambulance services. For details, refer to the following coronavirus waivers/flexibilities: Ambulances (PDF). For a comprehensive list of coronavirus waivers and flexibilities, refer to https://www.cms.gov/about-cms/emergency-preparedness-response-operations/current-emergencies/coronavirus-waivers. (Accessed January 11, 2021)
Notes:

- Routine Transportation Benefit: Depending on the plan, some members have additional routine transportation benefit (not a Medicare covered benefit). Refer to the member's evidence of coverage or contact the customer service department to determine eligibility for this additional benefit.
- Ambulance Services Outside the United States: Medicare does not cover emergency and urgent services provided outside the United States. Some UnitedHealthcare Medicare Advantage plans may provide coverage for out-of-area emergent/urgent services rendered outside the United States. Refer to the member's evidence of coverage or contact the customer service department to determine eligibility for this additional benefit.

Coverage Criteria for Ambulance Transportation

Ambulance transportation by ground or air to the nearest appropriate facility is covered when medically necessary and other means of transportation would be contraindicated. This can include both emergent and non-emergent, yet medically necessary, situations.

Ground Ambulance

Member's medical condition requires ambulance transportation:

- Medical necessity is established when the patient's condition is such that use of any other 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, whether or not such other transportation is actually available, no payment may be made for ambulance services.
- As stated above, medical necessity is established when the patient's condition is such that the use of any other method of transportation is contraindicated. Medicare administrative contractors (MACs) may presume this requirement is met under certain circumstances, including when the patient was bed-confined before and after the ambulance trip. A patient is bed-confined if he/she is:

- Unable to get up from bed without assistance;
- Unable to ambulate; and
- Unable to sit in a chair or wheelchair

- The term "bed confined" is not synonymous with "bed rest" or "nonambulatory". 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 patient's condition that may be taken into account in the MAC's determination of whether means of transport other than an ambulance were contraindicated.

Ambulance transports (that meet all other program requirements for coverage) are covered only to the following destinations:

- Hospital
- Member's residence
- Skilled nursing facility
- From a SNF to the nearest supplier of medically necessary services not available at the SNF where the member is a resident and not in a covered Part A stay, including the return trip.
- Critical access hospital (CAH) (Refer to the Definitions section)
- Member's home
  Note: Ambulance service from an institution to the member's home is covered when the home is within the locality of such institution or where the member's home is outside of the locality of such institution but the institution, in relation to the home, is the nearest one with appropriate facilities.
- Dialysis center for ESRD patients who require dialysis

Note for ambulance service to physician's office: 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. These trips are covered only under the following circumstances:

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

Ground ambulance round trips for specialized services (e.g., the member requires services that are not available at the SNF/hospital), are covered when medical necessity for ground ambulance transport is met. Examples include, but are not limited to:

- Radiation therapy
- Dialysis (to the nearest appropriate facility, regardless of whether the dialysis facility is located at a hospital)
- Receipt of emergency care at a non-contracting hospital (the member should be transferred to a contracting hospital as soon as possible)

Note: Institution to institution transfers-occasionally, the institution to which the patient is initially taken is found to have inadequate or unavailable facilities to provide the required care, and the patient is then transported to a second institution having appropriate facilities. In such cases, transportation by ambulance to both institutions would be covered to the extent of the mileage to be the nearest institution with appropriate facilities. In these cases, transportation from such second institution to the patient's home could be covered if the home is within the locality served by that institution, or the locality served by the first institution to which the patient was taken.

Air Ambulance

Medically appropriate air ambulance transportation is a covered service regardless of the state or region in which it is rendered. However, MACs approve claims only if the patient's medical condition is such that transportation by either basic or advanced life support ground ambulance is not appropriate.

- Air ambulance transportation services, either by means of a helicopter or fixed wing aircraft, may be determined to be covered only if:
  - Air crew meet Medicare requirements
  - The member's medical condition required immediate and rapid ambulance transportation that could not have been provided by ground ambulance; and either:
    - The point of pickup is inaccessible by ground 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 are involved in getting the patient to the nearest hospital with appropriate facilities
  Notes:
  - Medicare allows payment for an air ambulance service when the air ambulance takes off to pick up a Medicare beneficiary, but the beneficiary is pronounced dead before being loaded onto the ambulance for transport (either before or after the ambulance arrives on the scene). This is provided the air ambulance service would otherwise have been medically necessary. In such a circumstance, the allowed amount is the appropriate air base rate, i.e., fixed wing or rotary wing. However, no amount shall be allowed for mileage or for a rural adjustment that would have been allowed had the transport of a living beneficiary or of a beneficiary not yet pronounced dead been completed.
  - For the purpose of this policy, a pronouncement of death is effective only when made by an individual authorized under state law to make such pronouncements.
  - The *Medicare Ambulance Policy* states no amount shall be allowed if the dispatcher received pronouncement of death and had a reasonable opportunity to notify the pilot to abort the flight. Further, no amount shall be allowed if the aircraft has merely taxied but not taken off or, at a controlled airport, has been cleared to take off but not actually taken off.

- Medical Reasonableness: Medical appropriateness is only established when the patient's condition is such that the time needed to transport a patient by ground, or the instability of transportation by ground, poses a threat to the patient's survival or seriously endangers the patient's health. Following is an advisory list of examples of cases for which air ambulance could be justified. The list is not inclusive of all situations that justify air transportation, nor is it intended to justify air transportation in all locales in the circumstances listed.
  - 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.
- Time needed for ground transport: Differing statewide emergency medical services (EMS) systems determine the amount and level of basic and advanced life support ground transportation available. However, there are very limited emergency cases where ground transportation is available but the time required to transport the patient by ground as opposed to air endangers the patient's life or health. As a general guideline, when it would take a ground ambulance 30 - 60 minutes or more to transport a patient whose medical condition at the time of pick-up required immediate and rapid transport due to the nature and/or severity of the patient's illness/injury, MACs should consider air transportation to be appropriate.
  Air ambulance services are not covered for transport to a facility that is not an acute care hospital, such as a nursing facility, physician's office, or a patient's home.

Refer to the:
- Medicare Benefits Policy Manual, Chapter 10 – Ambulance Services. (Accessed January 11, 2021)
- NCD for Pronouncement of Death (70.4). (Accessed January 11, 2021)

Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) exist and compliance with these policies is required where applicable. Refer to the table for Ambulance Services.

Non-Covered Ambulance Services

Ambulance services that are not covered include, but are not limited to:
- Member's condition does not meet the Medicare criteria for ambulance transportation. Refer to the Coverage Criteria above.
- Transport of ambulance staff or other personnel when the member is not onboard the ambulance (e.g., an ambulance transport to pick up a specialty care unit from one hospital to provide services to a member at another hospital). This applies to both ground and air ambulance transports. Refer to the Medicare Benefits Policy Manual, Chapter 10, § 10.2.5 – Transport of Persons Other Than the Beneficiary. (Accessed January 11, 2021)
- Paramedic charges for BLS (basic life support) or ALS (advanced life support) when the member is not transported by the ambulance supplier (e.g., charges from a city fire department or an ambulance provider that responds to a call without transport).

Note: The ambulance benefit is a transportation based benefit, so if ambulance supplier does not transport the member, no service was provided. Refer to the Medicare Benefit Policy Manual, Chapter 10, §10.2.6 – Effect of Beneficiary Death on Medicare Payment for Ground Ambulance Transports. (Accessed January 11, 2021)

- Paramedic intercept (PI) services and emergency response system (EMS) non-paramedic services that are billed separately from the transporting ambulance provider are not covered except when all the requirements are met. For specific requirements, refer to the Medicare Benefits Policy Manual, Chapter 10, §30.1.1 – Ground Ambulance Services. (Accessed January 8, 2020)
  Notes:
  - The state of New York meets the requirements for the paramedic intercept services benefit; refer to the Medicare Claims Processing Manual, Chapter 15, §20.1.4 – Components of the Ambulance Fee Schedule. (Accessed January 11, 2021)
  - There are MACs that have determined some states in their jurisdictions meet the rural area requirements; refer to the Ambulance Services table.

Definitions

Critical Access Hospital (CAH): A facility that meets the following criteria may be designated by CMS as a CAH:

- Be located in a State that established a State rural health plan for the State Flex Program (as of September 2011, only Connecticut, Delaware, Maryland, New Jersey, and Rhode Island did not have a State Flex Program);
- Be located in a rural area or be treated as rural under a special provision that allows qualified hospital providers in urban areas to be treated as rural;
- Demonstrate compliance with the CoPs found at 42 CFR Part 485 subpart F at the time of application for CAH certification;
- Furnish 24-hour emergency care services 7 days a week, using either on-site or on-call staff, with specific on-site response timeframes for on-call staff;
- Maintain no more than 25 inpatient beds that may also be used for swing bed services. It may also operate a distinct part rehabilitation and/or psychiatric unit, each with up to 10 beds;
- Have an annual average length of stay of 96 hours or less per patient for acute care (excluding swing bed services and beds that are within distinct part units). This requirement cannot be assessed on initial certification but applies subsequent to CAH certification. (Note that payment rules require a physician to certify that an individual may reasonably be expected to be discharged or transferred to a hospital within 96 hours after admission to the CAH); and
- Be located more than a 35-mile drive from any hospital or other CAH; or
- Located more than a 15-mile drive from any hospital or other CAH in an area with mountainous terrain or only secondary roads; or
- Certified as a CAH prior to January 1, 2006, based on State designation as a "necessary provider" of health care services to residents in the area.

Note:
Effective October 1, 2014, under new Office of Management and Budget (OMB) delineations, some CAHs previously located in rural areas may now be located in urban areas. A 2-year transition period is provided, effective October 1, 2014, through September 30, 2016, for affected CAHs to seek rural classification under 42 CFR 412.103 to retain their CAH status after the 2-year transition period ends. This policy to provide for a 2-year transition period also applies to future changes in OMB delineations. Medicare Learning Network – Critical Access Hospital. (Accessed January 11, 2021)

Emergency Response: 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. Medicare Benefits Policy Manual, Chapter 10, §30.1.1 – Ground Ambulance Services. (Accessed January 11, 2021)

Member's Residence: The place where the member makes his/her home and dwells permanently, or for an extended period of time. Medicare Benefits Policy Manual, Chapter 10, §20 – Coverage Guidelines for Ambulance Service Claims. (Accessed January 11, 2021)

Paramedic Intercept (PI): Paramedic Intercept services are advance life support (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. Medicare Benefits Policy Manual, Chapter 10, §30.1.1 – Ground Ambulance Services. (Accessed January 11, 2021)

Supporting Information

Important Note: When searching the Medicare Coverage Database, if no LCD/LCA is found, then use the applicable referenced default policy below for coverage guidelines.

Ambulance Services Accessed January 11, 2021				
LCD/LCA ID	LCD/LCA Title	Contractor Type	Contractor Name	Applicable States/Territories
L37697 (A57674)	Emergency and Non-Emergency Ground Ambulance Services	Part A and B MAC	First Coast Service Options, Inc.	FL, PR, VI
A52588	Ground Ambulance Services when the Beneficiary Is Pronounced Deceased	Part A and B MAC	First Coast Service Options, Inc.	FL, PR, VI
L34549 (A56468)	Ambulance Services	Part A and B MAC	Palmetto GBA	NC, SC, VA, WV, AL, GA, TN
L35162 (A54574)	Ambulance Services (Ground Ambulance)	Part A and B MAC	Novitas Solutions, Inc.	AR, CO, DC, DE, LA, MD, MS, NJ, NM, OK, PA, TX
A52917	Rural Air Ambulance Service Protocols	Part A and B MAC	Noridian Healthcare Solutions, LLC	AK, ID, OR, WA, AZ, MT, ND, SD, UT, WY
Back to Guidelines				

Policy History/Revision Information

Date	Summary of Changes
05/01/2021	Template Update • Reformatted policy; transferred content to new template
01/19/2021	• Routine review; no change to coverage guidelines

Instructions for Use

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The benefit information in this Coverage Summary is based on existing national coverage policy; however, Local Coverage Determinations (LCDs) may exist and compliance with these policies are required where applicable.

There are instances where this document may direct readers to a UnitedHealthcare Commercial Medical Policy, Medical Benefit Drug Policy, and/or Coverage Determination Guideline (CDG). 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).