Coverage Summary

Ambulance Services

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Approved by:</td>
<td>UnitedHealthcare Medicare Benefit Interpretation Committee</td>
<td>Last Review Date: 01/15/2019</td>
</tr>
<tr>
<td>Related Medicare Advantage Policy Guideline:</td>
<td>Transportation Services</td>
<td></td>
</tr>
</tbody>
</table>

This information is being distributed to you for personal reference. The information belongs to UnitedHealthcare and unauthorized copying, use, and distribution are prohibited. This information is intended to serve only as a general reference resource and is not intended to address every aspect of a clinical situation. Physicians and patients should not rely on this information in making health care decisions. Physicians and patients must exercise their independent clinical discretion and judgment in determining care. Each benefit plan contains its own specific provisions for coverage, limitations, and exclusions as stated in the Member’s Evidence of Coverage (EOC)/Summary of Benefits (SB). If there is a discrepancy between this policy and the member’s EOC/SB, the member’s EOC/SB provision will govern. The information contained in this document is believed to be current as of the date noted.

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 is 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).

INDEX TO COVERAGE SUMMARY

I. COVERAGE
   1. Coverage Criteria
      a. Ground Ambulance
      b. Air Ambulance
   2. Not Covered-Examples

II. DEFINITIONS

III. REFERENCES

IV. REVISION HISTORY

V. ATTACHMENTS

I. COVERAGE

Coverage Statement: Ambulance services are covered when Medicare coverage criteria are met.

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.
Guidelines/Notes:

1. 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.

   a. **Ground Ambulance**

      1) 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. Contractors may presume this requirement is met under certain circumstances, including when the beneficiary was bed-confined before and after the ambulance trip. A beneficiary is bed-confined if he/she is:

            o Unable to get up from bed without assistance;
            o Unable to ambulate; and
            o 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 beneficiary's condition that may be taken into account in the intermediary's/carrier's determination of whether means of transport other than an ambulance were contraindicated.

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

         a) Hospital
         b) Member’s residence
         c) Skilled nursing facilities
         d) 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;
         e) Critical Access Hospital (CAH) (See Section III for the definition of CAH)
         f) Beneficiaries home

            **Note:** Ambulance service from an institution to the beneficiary’s home is covered when the home is within the locality of such institution or where the beneficiary’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.

         g) Dialysis center for ESRD patients who require dialysis

            **Note:** 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.

3) 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:
   a) Radiation therapy
   b) Dialysis (to the nearest appropriate facility, regardless of whether the dialysis facility is located at a hospital)
   c) 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.

b. **Air Ambulance**

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

1) Air ambulance transportation services, either by means of a helicopter or fixed wing aircraft, may be determined to be covered only if:
   a) Air crew meet Medicare requirements
   b) The member’s medical condition required immediate and rapid ambulance transportation that could not have been provided by ground ambulance; and either
      (1) 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
(2) Great distances or other obstacles are involved in getting the patient to the nearest hospital with appropriate facilities.

Note: 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.

2) Medical Reasonableness

Medical appropriateness is only established when the beneficiary’s condition is such that the time needed to transport a beneficiary by ground, or the instability of transportation by ground, poses a threat to the beneficiary’s survival or seriously endangers the beneficiary’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.

3) 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 beneficiary’s life or health. As a general guideline, when it would take a ground ambulance 30-60 minutes or more to transport a beneficiary whose medical condition at the time of pick-up required immediate and rapid transport due to the nature and/or severity of the beneficiary’s illness/injury, contractors 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 beneficiary’s home.


Also see the NCD for Pronouncement of Death (70.4). (Accessed January 4, 2019)

Local Coverage Determinations (LCDs)/Local Coverage Articles (LCAs) exist and compliance with these policies is required where applicable. See the LCD Availability Grid (Attachment A). (Accessed June 3, 2019)

2. Ambulance services that are not covered include, but are not limited to:
   a. Member’s condition does not meet the Medicare criteria for ambulance transportation. See Guideline 1 above for coverage criteria.
   b. 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. See the Medicare Benefits Policy Manual, Chapter 10, § 10.2.5 - Transport of Persons Other Than the Beneficiary. (Accessed January 4, 2019)
   c. 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. See the Medicare Benefit Policy Manual, Chapter 10, §10.2.6 - Effect of Beneficiary Death on Medicare Payment for Ground Ambulance Transports. (Accessed January 4, 2019)

   d. 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, see the Medicare Benefits Policy Manual, Chapter 10, §30.1.1 - Ground Ambulance Services. (Accessed January 4, 2019)

   Notes:
   • The state of New York meets the requirements for the paramedic intercept services benefit; see the Medicare Claims Processing Manual, Chapter 15, §20.1.4 - Components of the Ambulance Fee Schedule. (Accessed January 4, 2019)
   • There are Medicare contractors that have determined some states in their jurisdictions meet the rural area requirements; see the LCD Availability Grid (Attachment A). (Accessed June 3, 2019)

II. 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 4, 2019)

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 4, 2019)


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 4, 2019)

III. REFERENCES

See above
IV. REVISION HISTORY

04/01/2019  Updated policy introduction; added language to clarify:

- There are instances where [the Coverage Summary] 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)

01/15/2019  Annual review with the following updates:

Coverage Statement – updated notes pertaining to the verification of benefits to make both notes consistent. Both notes will now have the following statement:

Refer to the member’s Evidence of Coverage or contact the Customer Service Department to determine eligibility for this additional benefit.

Guideline 1.a.2 (Ground Ambulance) – updated coverage statement making it consistent with the language in the reference Medicare Manual Policy Manual, to:

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

- Hospital
- Member’s residence
- Skilled nursing facilities
- 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;
- Critical Access Hospital (CAH) (See Section III for the definition of CAH)
- Beneficiaries home

Guideline 2.a – added “See Guideline 1 above for coverage criteria.”

Guideline 2.b – added the following: 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. See the Medicare Benefits Policy Manual, Chapter 10, § 10.2.5-Transport of Persons Other Than the Beneficiary.

Guideline 2.b – deleted the following (no Medicare reference found): Ambulance is initiated by member for convenience or non-medical services.

Guideline 2.c – deleted the following (no Medicare reference found): Costs for personal transportation, such as gasoline costs for a private vehicle or taxi fare.

Guideline 2.d

- Deleted the following: “for rural areas where paramedic intercept services as allowed by law when a voluntary ambulance service cannot bill for transportation”

- Updated to read: 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, see the Medicare Benefits Policy Manual, Chapter 10, §30.1.1 - Ground Ambulance Services.

- Added to the 1st note, “The state of” to read, “The state of New York meets the requirements for the paramedic intercept services benefit.”
- Deleted on the 2nd note, “paramedic intercept services benefit requirements”, to read: “There are Medicare contractors that have determined some states in their jurisdictions meet the rural area requirements.”

Deleted the following (outdated announcement from 2011); already included in the reference MBPM):

Definition of Ambulance Services: CMS issued Change Request (CR) 7058, effective January 1, 2011, which updates the Medicare Benefit Policy Manual (Chapter 10, §30.1.1) to incorporate the application of Basic Life Support (BLS) – Emergency; Advanced Life Support Level 1 (ALS1) and Emergency and Advanced Life Support Level 2 (ALS2) information. Refer to the MLN Matters #MM7058 - Definition of Ambulance Services. Also see the Medicare Benefits Policy Manual, Chapter 10, §30.1.1 - Ground Ambulance Services.

Deleted the following:
For clarification on ambulance transport claims payment, refer to the following:
- MLN Matters #SE0724 – Medicare Payments for Ambulance Transports (claims payment information)
- CMS Questions and Answers (very general coverage information which are intended for members; Guideline 1 above provide more detailed coverage information)

09/18/2018 Updated Local Coverage Determination (LCD) Availability Grid; removed instruction to “use the applicable LCD based on member’s residence/place and type of service” (this note only applies when selecting the appropriate DME LCD Policy)

05/11/2018 Re-review; deleted the following statement; Guideline 6 of the Coverage Summary for Emergent/Urgent Services, Post-Stabilization Care and Out-of-Area Services no longer exists.
For ambulance services for members with coverage for out-of-area emergent/urgent services outside the United States, refer to Guideline #6 Out-of-Area Services, Post-stabilization and Transportation Care Guidelines in the Coverage Summary for Emergent/Urgent Services, Post-Stabilization Care and Out-of-Area Services.

01/16/2018 Annual review with the following update:
Guideline 1 - Updated the applicable LCDs to include the most recent website links and effective dates related to the Cahaba-Palmetto jurisdiction transition; no change in guideline.

01/17/2018 Annual review with the following update:
01/19/2016  Annual review with the following update:
- Updated reference link(s) of the applicable LCDs to reflect the new condensed LCD link(s).

01/20/2015  Annual review with following updates:
Definitions:
- Critical Access Hospital (CAH) – Updated with applicable CMS verbiage and added appropriate CMS reference.
- Emergency Response - added applicable CMS reference.
- Member’s Residence - added applicable CMS reference.
- Paramedic Intercept (PI) – added applicable CMS reference.

02/18/2014  Added the language to indicate information pertaining to ambulance services for out-of-area emergent/urgent services outside the United States

02/19/2013  Annual review; no updates

06/22/2012  LCD Availability Grid for Ambulance Services added. Also added a note pertaining to the additional routine transportation benefit

02/27/2012  Annual review; no changes.

08/29/2011  - Updated Guidelines #2.e to include clarification that NY is not the only state that meets the requirements for paramedic intercept services benefit
- Added the definition of Emergency Response and updated the definition of Paramedic Intercept

02/21/2011  Annual review;
- Guidelines # 1.a was updated to include information pertaining to Critical Access Hospital (CAH)
- Definition of CAH was added to Section II
- Updated to include a note regarding the CMS update of the Medicare Benefit Policy Manual pertaining to the updated definitions of ambulance services
- Guidelines # 2.d was updated to include examples of BLS or ALS
- Guidelines #2.e was updated to further clarify coverage for paramedic intercept services and emergency response system non-paramedic services

V. ATTACHMENT(S)

<table>
<thead>
<tr>
<th>LCD ID</th>
<th>LCD Title</th>
<th>Contractor Type</th>
<th>Contractor</th>
<th>States</th>
</tr>
</thead>
<tbody>
<tr>
<td>L37697</td>
<td>Emergency and Non-Emergency Ground Ambulance Services</td>
<td>A and B MAC</td>
<td>First Coast Service Options, Inc.</td>
<td>FL, PR, VI</td>
</tr>
<tr>
<td>L34549</td>
<td>Ambulance Services</td>
<td>A and B MAC</td>
<td>Palmetto GBA</td>
<td>NC, SC, VA, WV, AL, GA, TN</td>
</tr>
<tr>
<td>L35162</td>
<td>Ambulance Services (Ground Ambulance)</td>
<td>A and B MAC</td>
<td>Novitas Solutions, Inc.</td>
<td>AR, CO, DC, DE, LA, MD, MS, NJ, NM, OK, PA, TX</td>
</tr>
</tbody>
</table>
## Attachment A – LCD Availability Grid

**Ambulance Services**

CMS website accessed June 3, 2019

<table>
<thead>
<tr>
<th>LCD ID</th>
<th>LCD Title</th>
<th>Contractor Type</th>
<th>Contractor Type</th>
<th>Contractor</th>
<th>States</th>
</tr>
</thead>
<tbody>
<tr>
<td>A52917</td>
<td>Rural Air Ambulance Service Protocols</td>
<td>A and B MAC</td>
<td>Noridian Healthcare Solutions, LLC</td>
<td>Noridian Healthcare Solutions, LLC</td>
<td>AK, ID, OR, WA, AZ, MT, ND, SD, UT, WY</td>
</tr>
</tbody>
</table>

End of Attachment A