Applicable To:
- ☑ Medicare – excluding AZ, NJ, NY, HI
- ☑ Medicaid – excluding FL, KY, MO, NY, HI

Claims and Payment Policy: Prepayment Ambulance Services (IH007)

Policy Number: CPP-153

Original Effective Date: 6/25/2019
Revised Date(s): N/A

BACKGROUND

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 the amount of 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.

POSITION STATEMENT

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))

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

- Bed confinement status (ICD-10 code A74.01)
- 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.

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.

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 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

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When submitting a claim for payment, it is essential that providers supply claim 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.

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. If State policies **do not specify coverage provisions**, then the State will follow National coverage guidelines as outlined in this 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.

CODING & BILLING

ICD-10 Codes

Code	Description
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

HCPCs Codes

Code	Description
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))

Coding information is provided for informational purposes only. The inclusion or omission of a CPT, HCPCS, or ICD-10 code does not imply member coverage or provider reimbursement. Consult the member's benefits that are in place at time of service to determine coverage (or non-coverage) as well as applicable federal / state laws.

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

IMPORTANT INFORMATION ABOUT THIS DOCUMENT

Claims and Payment Policies (CPPs) are policies regarding claims or claim line processing and/or reimbursement related to the administration of health plan benefits. They are not recommendations for treatment, nor should they be used as treatment guidelines. Providers are responsible for diagnosing, treating, and making clinical recommendations to the member. CPPs are subject to, but not limited to, the following:

- State and federal laws and regulations;
- Policies and procedures promulgated by the Centers for Medicare and Medicaid Services, including National Coverage Determinations and Local Coverage Determinations;
- The health plan's contract with Medicare and/or a state's Medicaid agency, as applicable;
- Other CPPs and clinical policies as applicable including, but not limited to, *Pre-Payment and Post-Payment Review*.
- The provisions of the contract between the provider and the health plan; and
- The terms of a member's particular benefit plan, including those terms outlined in the member's Evidence of Coverage, Certificate of Coverage, and other policy documents.

In the event of a conflict between a CPP and a member's policy documents, the terms of a member's benefit plan will always supersede the CPP.
The use of this policy is neither a guarantee of payment, nor a prediction of how a specific claim will be adjudicated. Any coding information is for informational purposes only. No inference should be made regarding coverage or provider reimbursement as a result of the inclusion, or omission, in a CPP of a CPT, HCPCS, or ICD-10 code. Always consult the member's benefits that are in place at time of service to determine coverage or non-coverage. Claims processing is subject to a number of factors, including the member's eligibility and benefit coverage on the date of service, coordination of benefits, referral/authorization requirements, utilization management protocols, and the health plan's policies. Services must be medically necessary in order to be covered.
References to other sources and links provided are for general informational purposes only, and were accurate at the time of publication. CPPs are reviewed annually but may change at any time and without notice, including the lines of business for which they apply. CPPs are available at www.wellcare.com. Select the "Provider" tab, then "Tools" and then "Payment Guidelines".

RULES, PRICING & PAYMENT COMMITTEE HISTORY AND REVISIONS

Date	Action
05/12/2020	• Approved by RGC