Clinical Policy: Ambulance Services

Reference Number: WNC.CP.187
Last Review Date: 03/23

Coding Implications
Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Note: When state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

Description[1]

Ambulance services provide medically necessary treatment for NC Medicaid beneficiaries. Transport is provided only if the beneficiary's medical condition is such that the use of any other means of transportation is contraindicated.

Policy/Criteria

A. It is the policy of WellCare of North Carolina® that ambulance transport is a covered benefit as follows: **Air Medical Ambulance**
   1. The point of origin is the beneficiary's loading point and runway taxiing, until the beneficiary is offloaded from the air medical ambulance.
   2. Covered in any **one** of the following situations:
      a. the beneficiary's medical condition requires immediate and rapid ambulance transport that cannot be provided by ground ambulance;
      b. the point of pickup is inaccessible by ground vehicle; **or**
      c. the beneficiary's condition is such that the time needed to transport the beneficiary by land, or the instability of transport by land, to the nearest appropriate facility poses a threat to the beneficiary's survival or endangers the beneficiary's health.
   3. Some conditions requiring emergency air medical ambulance transportation are:
      a. intracranial bleeding requiring neurosurgical intervention;
      b. shock;
      c. major burns requiring treatment in a burn center;
      d. conditions requiring immediate treatment in a hyperbaric oxygen unit;
      e. multiple severe injuries;
      f. life-threatening trauma;
      g. ST Segment Elevation Myocardial Infarction (STEMI); **and**
      h. cardiovascular Accident (CVA).

B. **Ambulance Transport of Deceased Beneficiaries**
   1. Covered in either **one** of the following situations:
      a. The beneficiary is pronounced dead by a legally authorized individual after the dispatch of the ambulance, but before the beneficiary is loaded on board the ambulance. The provider is reimbursed for the BLS base rate. No mileage is reimbursed. The date of service is the date of the dispatch of the ambulance. Use QL modifier, "Patient pronounced dead after ambulance called," on the claim; **or**
      b. The beneficiary is pronounced dead by a legally authorized individual after pick-up but prior to arrival at the receiving facility. The same reimbursement rules apply as if the beneficiary were alive.

C. **Out-of-State (Non-Contiguous) Transport of Beneficiaries**

1. Hospitals, acute medical care, and ambulance services are out-of-state services when they are provided more than 40 miles outside of the N.C. border.
2. Hospitals, acute medical care, and ambulance services provided within 40 miles of the N.C. border in the contiguous states of Georgia, South Carolina, Tennessee, and Virginia will be covered to the same extent and under the same conditions as services provided in North Carolina. These facilities and providers shall obtain Medicaid provider numbers.

D. **Out-of-County Transport of Beneficiaries**
1. Ground ambulance loaded mileage is reimbursable only for out of county transport.

E. **Transport to Behavioral Health Crisis Centers**
1. The plan shall cover transport of beneficiaries in behavioral health crisis to behavioral health clinics or alternative appropriate care locations when the following criteria are met:
   a. Emergency Medical Services (EMS) providers have received appropriate education in caring for beneficiaries in behavioral health crisis;
   b. EMS system has at least one partnership with a receiving facility that is able to provide care appropriate for those beneficiaries; **and**
   c. EMS systems shall be required to include in its EMS system plan a report on beneficiary experiences and outcomes in accordance with rules adopted by Department of Health and Human Services (DHHS), Division of Health Service Regulation (DHSR), Division of Health Benefits (DHB), and Office of Emergency Services (OEMS).

F. **Origin and Destination –** WellCare of NC shall cover only **emergency** ambulance transports that meet all other program requirements for coverage and only to the following destinations:
1. Transportation to and from a hospital for inpatient care or outpatient emergency care;
2. Transportation from a hospital to the nearest facility which is prepared to accept the beneficiary AND is able to provide needed service(s) which is (are) not available at the hospital where the beneficiary is presently confined;
3. Critical access hospital;
4. Transfer site (airport/helipad);
5. Emergency transportation to a physician's office shall meet the following conditions:
   a. the beneficiary is en route to a hospital;
   b. there is medical need for a professional to stabilize the beneficiary's condition; **and**
   c. the ambulance continues the trip to the hospital immediately after stabilization.
6. Emergency transport from hospital to hospital is appropriate when the transferring facility does not have adequate facilities to provide needed care. Coverage is available only if the beneficiary is transferred to the nearest appropriate facility such as, transportation between burn centers, trauma units, primary cardiac intervention centers, and stroke centers.
7. Emergency transport to a behavioral health clinic or other appropriate location during a behavioral health crisis.

II. It is the policy of WellCare of North Carolina® that ambulance transport is **not** a covered benefit as follows:

A. Nearest Appropriate Facility

1. The beneficiary is to be transferred to the nearest appropriate facility. Loaded mileage to a facility that does not meet this criterion is not reimbursed.
2. The fact that a physician does or does not have staff privileges in a hospital is not a consideration in determining whether the hospital has appropriate facilities.
3. A facility is not deemed appropriate or inappropriate based on a beneficiary's preference.

B. Transport of Deceased Beneficiaries
1. Ambulance transport of a deceased beneficiary is not covered if the beneficiary is pronounced dead by a legally authorized individual before the ambulance is called.

C. Air Medical Ambulance
1. Air medical ambulance transport to a facility that is not an acute-care hospital is not a covered service.

D. Other Non-covered Ambulance Services
1. An ambulance is called and no treatment is needed.
2. The ambulance responds to a false alarm call.
3. The beneficiary refuses all medical services.
4. Ambulance transport is for a medical service that is not a covered service.
5. Commercial airline tickets are not reimbursable.
6. Airstrip fees are not covered.
7. Charges for taxes (local, state, federal, etc.) are not covered.
8. Separate additional charges for nursing personnel who are employees of a facility or ambulance service are not covered.
9. Waiting fees are not covered.
10. Costs for oxygen and other items and supplies provided are included in the base rate and not separately reimbursable.
11. Services other than those listed above are not covered.

E. Maternity Transport
1. Ambulance transport of beneficiaries with routine pregnancies is not covered. Beneficiaries without complications that would endanger the life of the mother, the child, or both do not meet medical necessity criteria.

F. Nursing Facility Non-Ambulance Transportation
1. Non-ambulance transportation of Medicaid-eligible beneficiaries to receive medical care that cannot be provided in the nursing facility is covered in the per diem that is reimbursed to the facility. The facility may contract with a service (including county-coordinated transportation systems) to provide transportation or may provide transportation services using its own vehicles.

Note: The nursing facility cannot charge the beneficiary or the beneficiary's family for the cost of this transportation.

Background[1]

I. Definitions

A. Ground and Air Medical Ambulances
1. A ground ambulance is the same as defined in 10A NCAC 13P .0102(29). In this policy, ambulance transport by either land or water vehicles may be referred to as "ground transportation." Vehicle and equipment requirements are located at 10A NCAC 13P .0207, .0208, and .0210.

2. An air medical ambulance is the same as defined in 10A NCAC 13P .0102(5). Vehicle and equipment requirements are located at 10A NCAC 13P .0209.

B. Emergency Services
   1. Emergency Medical Condition
      a. An emergency medical condition is defined in 42 C.F.R. 489.24(b).
   2. Emergency and Immediate Responses
      a. An emergency response means responding immediately at the Basic Life Support (BLS) or Advanced Life Support Level 1 (ALS1) service to a 911 call or the equivalent in areas without a 911 call system.
      b. An immediate response is one in which the ambulance service begins as quickly as possible to take the steps necessary to respond to a 911 call.
   3. Emergency Ground Transport
      a. Emergency ground transport is medically necessary ground transportation to the nearest appropriate facility where prompt medical services are provided in an emergency situation such as accident, acute illness, or injury. Emergency ground transport includes both BLS and ALS services.
   4. Basic Life Support
      a. BLS is transportation by a ground ambulance vehicle and the provision of medically necessary supplies and services, including BLS ambulance services as defined by the State Office of Emergency Medical Services (OEMS). The ambulance shall be staffed by an individual who is credentialed in accordance with 10A NCAC 13P .0502 and G.S. 131E-159 as an Emergency Medical Technician (EMT).
   5. Advanced Life Support
      a. ALS services include BLS plus invasive procedures and techniques provided by Emergency Medical Technicians–Intermediate (EMT–I) or Emergency Medical Technicians–Paramedic (EMT–P) who are credentialed in accordance with 10A NCAC 13P .0502. An EMT–I is credentialed to perform essential advanced techniques and to administer a limited number of medications in addition to the skills of the EMT. An EMT–P is credentialed to administer additional medications and interventions in addition to the skills of the EMT and EMT-I.
      b. An ALS assessment must be a medically necessary procedure performed by an ALS crew as part of an emergency response and necessary because the beneficiary's reported condition at the time of dispatch is such that only an ALS crew is qualified to perform the assessment. An ALS assessment does not necessarily result in a determination that the beneficiary requires an ALS level of service.
      c. An ALS intervention is a procedure that is, in accordance with state and local laws, rendered by ALS personnel. If local protocols require an ALS response for all calls, WellCare of NC only covers the level of service actually provided. ALS level of service must include ALS assessment, ALS intervention, or both, and then only when the service is medically necessary.
      d. ALS Level 1 (ALS1) is the transportation by ground ambulance vehicle and the provision of an ALS assessment or at least one ALS intervention.

e. ALS Level 2 (ALS2) is the transportation by ground ambulance vehicle and the provision of medically necessary supplies and services, including at least **one** of the following:
   1) at least three separate administrations of one or more medications by intravenous push or bolus or by continuous infusion, excluding crystalloid, hypotonic, isotonic, and hypertonic solutions (Dextrose, Normal Saline, or Ringer's Lactate); **or**
   2) at least **one** of the ALS2 procedures listed below:
      i. manual defibrillation or cardioversion;
      ii. cardiac pacing;
      iii. endotracheal intubation insertion;
      iv. central venous line;
      v. intraosseous line;
      vi. chest decompression;
      vii. surgical airway;
      viii. 12 lead electrocardiogram (ECG) for Segment Elevation Myocardial Infarction [STEMI];
      ix. Continuous Positive Airway Pressure (CPAP);
      x. ventilator operation; **or**
      xi. femoral line.

C. Air Medical Ambulance
   1. Air medical ambulance applies to both rotary-wing and fixed-wing aircraft. Rotary-wing air medical ambulance is transport by a helicopter that has been inspected and issued a permit by the State OEMS as a rotary-wing ambulance, and the provision of medically necessary supplies and services. Fixed-wing air medical ambulance is transport by a fixed-wing aircraft that has been inspected and issued a permit by the State OEMS as a fixed-wing air medical ambulance, and the provision of medically necessary supplies and services. Vehicle and equipment requirements are located at 10A NCAC 13P .0209.

D. Loaded Mileage
   1. Loaded mileage is the number of miles for which the beneficiary is transported in the ambulance vehicle.
   2. For air medical ambulance (fixed wing and rotary wing), the point of origin includes the beneficiary's loading point and runway taxiing until the beneficiary is offloaded from the air medical ambulance. Air mileage is based on loaded miles flown, as expressed in statute miles, and is reimbursable.
   3. For ground ambulance, loaded mileage is from the point of origin to the nearest appropriate facility. Mileage to a facility that does not meet this criterion is not covered. Ground ambulance loaded mileage is reimbursable only for out of county transport. In-county loaded ground mileage is not reimbursable.
   4. Out of county transport is a transport by ambulance in which the final destination of the beneficiary is outside the limits of the county in which the transport originated.

E. Locality
   1. Locality means the service area surrounding the institution to which beneficiaries normally travel or are expected to travel to receive hospital or skilled nursing services.

2. If two or more facilities that meet the destination requirements can treat the beneficiary appropriately, and the locality of each facility encompasses the place where the ambulance transportation of the beneficiary began, then the out of county mileage (if applicable) to any one of the facilities to which the beneficiary is taken is covered.

F. Nearest Appropriate Facility
   1. The nearest appropriate facility for emergency transport is the nearest institution or medical facility that is capable, under federal and state laws, of furnishing the required type of care for the beneficiary's illness or injury.

G. One-Way Trip
   1. A one-way trip is emergency or non-emergency transportation from point of pickup to destination. Delivery of the beneficiary at the destination discharges the ambulance provider's responsibility. The ambulance service is then available to transport other beneficiaries.

H. Date of Service
   1. The date of service of an ambulance service is the date that the loaded ambulance vehicle departs the point of pick-up. In the case of a ground transport, if the beneficiary is pronounced dead after the vehicle is dispatched but before the (now deceased) beneficiary is loaded into the vehicle, the date of service is the date of the vehicle's dispatch.

I. Point of Pick-up
   1. The point of pick-up is the location of the beneficiary at the time placed on board the ambulance.

Coding Implications

This clinical policy references Current Procedural Terminology (CPT®). CPT® is a registered trademark of the American Medical Association. All CPT codes and descriptions are copyrighted 2022, American Medical Association. All rights reserved. CPT codes and CPT descriptions are from the current manuals and those included herein are not intended to be all-inclusive and are included for informational purposes only. Codes referenced in this clinical policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

CPT®* Codes	Description
No applicable codes.	

HCPCS ®* Codes	Description
A0425	Ground mileage, per statute mile
A0426*	Ambulance Service, Advanced Life Support, Non-Emergency Transport, Level 1(Als 1)

HCPCS ®* Codes	Description
A0427	Ambulance service, advanced life support, emergency transport, level 1 (ALS 1 - emergency)
A0428	Ambulance Service, Basic Life Support, Non-Emergency Transport (Bls)
A0429	Ambulance service, basic life support, emergency transport (BLS, emergency)
A0430	Ambulance service, conventional air services, transport, one way (fixed wing)
A0431	Ambulance service, conventional air services, transport, one way (rotary wing)
A0433	Advanced life support, level 2 (ALS 2)
A0435	Fixed wing air mileage, per statute mile
A0436	Rotary wing air mileage, per statute mile
T2003	Non-Emergency Transportation; Encounter/Trip (Round Trip)

Condition Code	Description
AK	Air Ambulance Required
AL	Specialized Treatment/Bed Unavailable (transported to alternate facility)
AM	Non-Emergency Medically Necessary Stretcher Transport Required

Modifier Code	Description
D	Diagnostic or therapeutic site other than "P" or "H"
E	The residential, domiciliary, custodial facility, nursing home other than SNF (other than 1819 facility)
G	Hospital-based dialysis facility (hospital or hospital-related) which includes: • Hospital administered/Hospital located • Non-Hospital administered/Hospital located
H	Hospital
I	The site of transfer (e.g., airport, ferry, or helicopter pad) between modes of ambulance transport
J	Non-hospital-based dialysis facility • Non-Hospital administered/Non-Hospital located • Hospital administered/Non-Hospital located
N	Skilled Nursing Facility (SNF) (1819 Facility)
P	Physician's Office (includes HMO non-hospital facility, clinic, etc.)
R	Residence
S	The scene of Accident or Acute Event
X	Destination Code Only (Intermediate stop at physician's office en route to the hospital (includes HMO non-hospital facility, clinic, etc.)

Reviews, Revisions, and Approvals	Date	Approval Date
Original approval date	03/21	06/21
Reviewed HCPCS codes.	08/21	11/21
Removed Background Section II.	06/22	08/22
Annual Review. NCHC verbiage removed from NC Guidance Verbiage.	03/23	

References

1. State of North Carolina Medicaid. Medicaid and Health Choice Clinical Coverage Policy No:15 Ambulance Services. Program Specific Clinical Coverage Policies | NC Medicaid (ncdhhs.gov) Published March 1, 2023. Accessed March 7, 2023.

North Carolina Guidance

Eligibility Requirements

a. An eligible beneficiary shall be enrolled in the NC Medicaid Program (Medicaid is NC Medicaid program, unless context clearly indicates otherwise);
b. Provider(s) shall verify each Medicaid beneficiary's eligibility each time a service is rendered.
c. The Medicaid beneficiary may have service restrictions due to their eligibility category that would make them ineligible for this service.

EPSDT Special Provision: Exception to Policy Limitations for a Medicaid Beneficiary under 21 Years of Age

a. 42 U.S.C. § 1396d(r) [1905(r) of the Social Security Act]

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) is a federal Medicaid requirement that requires the state Medicaid agency to cover services, products, or procedures for Medicaid beneficiary under 21 years of age if the service is medically necessary health care to correct or ameliorate a defect, physical or mental illness, or a condition [health problem] identified through a screening examination (includes any evaluation by a physician or other licensed practitioner).

This means EPSDT covers most of the medical or remedial care a child needs to improve or maintain his or her health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

Medically necessary services will be provided in the most economic mode, as long as the treatment made available is similarly efficacious to the service requested by the beneficiary's physician, therapist, or other licensed practitioner; the determination process does not delay the delivery of the needed service; and the determination does not limit the beneficiary's right to a free choice of providers.

EPSDT does not require the state Medicaid agency to provide any service, product or procedure:

1. that is unsafe, ineffective, or experimental or investigational.
2. that is not medical in nature or not generally recognized as an accepted method of medical practice or treatment.

Service limitations on scope, amount, duration, frequency, location of service, and other specific criteria described in clinical coverage policies may be exceeded or may not apply as long as the provider's documentation shows that the requested service is medically necessary "to correct or ameliorate a defect, physical or mental illness, or a condition" [health problem]; that is, provider documentation shows how the service, product, or procedure meets all EPSDT criteria, including to correct or improve or maintain the beneficiary's health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

EPSDT and Prior Approval Requirements

1. If the service, product, or procedure requires prior approval, the fact that the beneficiary is under 21 years of age does NOT eliminate the requirement for prior approval.
2. **IMPORTANT ADDITIONAL INFORMATION** about EPSDT and prior approval is found in the *NCTracks Provider Claims and Billing Assistance Guide*, and on the EPSDT provider page. The Web addresses are specified below:
   NCTracks Provider Claims and Billing Assistance Guide:
   https://www.nctracks.nc.gov/content/public/providers/provider-manuals.html
   EPSDT provider page: https://medicaid.ncdhhs.gov/

Provider(s) Eligible to Bill for the Procedure, Product, or Service
To be eligible to bill for the procedure, product, or service related to this policy, the provider(s) shall:

a. meet Medicaid qualifications for participation;
b. have a current and signed Department of Health and Human Services (DHHS) Provider Administrative Participation Agreement; and
c. bill only for procedures, products, and services that are within the scope of their clinical practice, as defined by the appropriate licensing entity.

Compliance
Provider(s) shall comply with the following in effect at the time the service is rendered:

a. All applicable agreements, federal, state and local laws and regulations including the Health Insurance Portability and Accountability Act (HIPAA) and record retention requirements; and
b. All NC Medicaid's clinical (medical) coverage policies, guidelines, policies, provider manuals, implementation updates, and bulletins published by the Centers for Medicare and Medicaid Services (CMS), DHHS, DHHS division(s) or fiscal contractor(s).

Claims-Related Information
Provider(s) shall comply with the NC Tracks Provider Claims and Billing Assistance Guide, Medicaid bulletins, fee schedules, NC Medicaid's clinical coverage policies and any other relevant documents for specific coverage and reimbursement for Medicaid:

a. Claim Type - as applicable to the service provided:
   Professional (CMS-1500/837P transaction)
   Institutional (UB-04/837I transaction)

Unless directed otherwise, Institutional Claims must be billed according to the National Uniform Billing Guidelines. All claims must comply with National Coding Guidelines.

b. International Classification of Diseases and Related Health Problems, Tenth Revisions, Clinical Modification (ICD-10-CM) and Procedural Coding System (PCS) - Provider(s) shall report the ICD-10-CM and Procedural Coding System (PCS) to the highest level of specificity that supports medical necessity. Provider(s) shall use the current ICD-10 edition and any subsequent editions in effect at the time of service. Provider(s) shall refer to the applicable edition for code description, as it is no longer documented in the policy.
c. Code(s) - Provider(s) shall report the most specific billing code that accurately and completely describes the procedure, product or service provided. Provider(s) shall use the Current Procedural Terminology (CPT), Health Care Procedure Coding System (HCPCS), and UB-04 Data Specifications Manual (for a complete listing of valid revenue codes) and any subsequent editions in effect at the time of service. Provider(s) shall refer to the applicable edition for the code description, as it is no longer documented in the policy. If no such specific CPT or HCPCS code exists, then the provider(s) shall report the procedure, product or service using the appropriate unlisted procedure or service code.
   Unlisted Procedure or Service
   CPT: The provider(s) shall refer to and comply with the Instructions for Use of the CPT Codebook, Unlisted Procedure or Service, and Special Report as documented in the current CPT in effect at the time of service.
   HCPCS: The provider(s) shall refer to and comply with the Instructions For Use of HCPCS National Level II codes, Unlisted Procedure or Service and Special Report as documented in the current HCPCS edition in effect at the time of service
d. Modifiers - Providers shall follow applicable modifier guidelines.
e. Billing Units - Provider(s) shall report the appropriate code(s) used which determines the billing unit(s).
f. Co-payments -
   For Medicaid refer to Medicaid State Plan:
   https://medicaid.ncdhhs.gov/get-involved/nc-health-choice-state-plan

g. Reimbursement - Provider(s) shall bill their usual and customary charges. For a schedule of rates, refer to: https://medicaid.ncdhhs.gov/.

Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. “Health Plan” means a health

plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan's affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members/enrollees. This clinical policy is not intended to recommend treatment for members/enrollees. Members/enrollees should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

This clinical policy is the property of the Health Plan. Unauthorized copying, use, and distribution of this clinical policy or any information contained herein are strictly prohibited. Providers, members/enrollees and their representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers, members/enrollees and their representatives agree to be bound by such terms and conditions by providing services to members/enrollees and/or submitting claims for payment for such services.