Transportation Services

Guideline Number: MPG320.10
Approval Date: November 8, 2023

Terms and Conditions

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Related Policies
None

Policy Summary

See Purpose

Overview

Medicare covers ambulance services only if they are furnished to a member whose medical condition is such that use of any other means of transportation is contraindicated. A member whose condition permits transport in any type of vehicle other than an ambulance would not qualify for services under Medicare. The member's condition at the time of the transport is the determining factor in whether medical necessity is met.

Guidelines

Emergency Ambulance Services (Ground)

Emergency response means responding immediately at the Basic Life Support (BLS) or Advanced Life Support, Level 1 (ALS1) level of service to a 911 call or the equivalent in areas without a 911 call system. Medicare will cover emergency ambulance services when the services are medically necessary, meet the destination limits of closest appropriate facilities, and are provided by an ambulance service that is licensed by the state.

Medical Reasonableness

Medical reasonableness is established if the member's condition is an emergency and the member is unable to go to the hospital by other means. An emergency means services provided after the sudden onset of a medical condition, manifesting itself by acute signs or symptoms of sufficient severity such that the absence of immediate medical attention could reasonably be expected to result in the following: placing the member's health in serious jeopardy; serious impairment to bodily functions; or serious dysfunction of any bodily organ or part.

Examples of emergency situations are:
Note: This list is not all inclusive.

- Injury resulting from an accident, or illness with acute symptoms. Examples are hemorrhage, shock, chest pain, acute neurological symptoms or respiratory distress.
- The member requires restraints by a professionally trained ambulance attendant as a means of preventing injury either to the member or to another person. A description of why restraints are necessary is required. Such descriptions may include narrative describing specific violent or psychotic acts, frequency/severity/predictability of seizure activity, or a precise

description of the risk to safety that unrestrained and unsupervised transport would create. A sole diagnosis of senility, forgetfulness, or Alzheimer's does not qualify.
- Oxygen is required by the member during transport. The administration of oxygen itself does not satisfy the requirement that the member needed oxygen. Documentation should reflect the need such as hypoxemia, syncope, airway obstruction, and chest pain. Ambulance transport is not medically necessary if the only reason for the ambulance service is to provide oxygen during transport, and the member has a portable oxygen system available.
- Immobilization of the member is necessary because of a suspected fracture, a compound fracture, severe pain, the need for pain medication, or suspicion of neurological injury.
- A transfer is made of a member between institutions for necessary services not available at the transferring institution and the member meets any of the criteria 1-4 above. Examples are members with cardiac disease requiring cardiac catheterization or coronary bypass not available at the transferring institution.

Destination

An ambulance transport is covered to the nearest appropriate facility to obtain necessary diagnostic and/or therapeutic services (such as a CT scan or cobalt therapy) as well as the return transport. In addition to all other coverage requirements, this transport situation is covered only to the extent of the payment that would be made for bringing the service to the patient.

Medicare covers ambulance transports (that meet all other program requirements for coverage) only to the following destinations:
- Hospital.
- Critical Access Hospital (CAH).
- Skilled Nursing facility (SNF).
- 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.
- Member’s home.
- Dialysis facility for ESRD member who requires dialysis.

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.

As a general rule, only local transportation by an ambulance is covered, and therefore, only mileage to the nearest appropriate facility equipped to treat the member is covered.

Non-Emergency (Scheduled) Ambulance Service (Ground)

For non-emergency ambulance transportation, transportation by ambulance is appropriate if the member is bed-confined and it is documented that the member’s medical condition is such that other methods of transportation are contraindicated, or if his or her medical condition, regardless of bed-confinement, is such that transportation by ambulance is medically required.

Three criteria determine whether a member has Medicare coverage for non-emergency (scheduled) ambulance services:
- Only when transportation by any other means of transportation is contraindicated by the medical condition of the member;
- Only to specific destinations; and
- Only when certified as medically necessary by a physician directly responsible for the member’s care.

Note: All three of the above criteria must be met.

Medical Reasonableness

Ambulance transport in non-emergency situations must meet medical necessity guidelines.
- Medical reasonableness is established for non-emergency ambulance services when the member’s condition is such that the use of any other method of transportation (such as: taxi, private car, wheelchair van, or other type of vehicle) is contraindicated. **Note**: Bed confinement does not include a member who is restricted to bed rest on a physician's instructions due to a short-term illness. Bed confinement, by itself, is neither sufficient nor is it necessary to determine the coverage for Medicare ambulance benefits. It is simply 1 element of the member's condition that may be taken into account in the A/B MAC determination of whether means of transport, other than an ambulance, were contraindicated. Examples of

situations in which members are bed-confined and cannot be moved by wheelchair, but must be moved by stretcher include:
    - Contractures creating non-ambulatory status and the member cannot sit.
    - Severe generalized weakness.
    - Severe vertigo causing inability to remain upright.
    - Immobility of lower extremities (member in spica cast, fixed hip joints, or lower extremity paralysis) and unable to be moved by wheelchair.
- If some means of transportation other than an ambulance (such as: private car, wheelchair van, etc.) could be utilized without endangering the individual's health, whether or not such other transportation is actually available, no payment may be made for ambulance service.
- If transportation is for the purpose of receiving an excluded service (such as a routine dental examination) then the transportation is also excluded even if the member could only have gone by ambulance.
- If transportation is for the purpose of receiving a service that could have been safely and effectively provided in the point of origin then the transport is not covered even if the member could only have gone by ambulance. Examples include (a) A transport from a residence to a hospital for a service that can be performed more economically in the member's home, and (b) A transport of a skilled nursing facility member to a hospital or to another SNF for a service that can be performed more economically in the first SNF.
- Ambulance transportation for services excluded from SNF consolidated billing must meet the criteria as reasonable and necessary (i.e. other means contraindicated).

Emergency Air Ambulance Transportation

Emergency response means responding immediately at the BLS or ALS1 level of service to a 911 call or the equivalent in areas without a 911 call system. An immediate response is one in which the ambulance supplier begins as quickly as possible to take the steps necessary to respond to the call. Medically appropriate air ambulance transportation either by means of a helicopter or fixed wing aircraft is a covered service regardless of the state or region in which it is rendered only if the member's medical condition required immediate and rapid ambulance transportation that could not have been provided by land ambulance, or either:

- The point of pick-up is inaccessible by land 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 (for example, heavy traffic) are involved in getting the patient to the nearest hospital with appropriate facilities as described in this policy.

Medical Reasonableness for Emergency Air Ambulance Transportation

If the air transport was medically appropriate (that is, ground transportation was contraindicated, and the member required air transport to a hospital), but the member could have been treated at a hospital nearer than the one to which they were transported, the air transport payment is limited to the rate for the distance from the point of pickup to that nearer hospital.

Destination

Air ambulance services may be paid only for ambulance services to a hospital. Other destinations e.g., skilled nursing facility, a physician's office, or a patient's home may not be paid air ambulance.

Appropriate Facilities

The term "appropriate facilities" means that the institution is generally equipped to provide the needed hospital or skilled nursing care for the illness or injury involved.

The fact that a more distant institution is better equipped, either qualitatively or quantitatively, to care for the patient does not warrant a finding that a closer institution does not have "appropriate facilities." Such a finding is warranted, however, if the member's condition requires a higher level of trauma care or other specialized service available only at a more distant hospital. In addition, a legal impediment barring a patient's admission would permit a finding that the institution did not have "appropriate facilities." For example, the nearest appropriate specialty hospital may be in another State and that State's law precludes admission of nonresidents.

An institution is also not considered an appropriate facility if there is no bed available.

Note: If the transport is for the purpose of receiving a non-covered service, then the transport is also non-covered, even if the destination is an appropriate facility.

Ambulance Service to a Physician's Office

Ambulance service to a physician's office is 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 member's dire need for professional attention, and immediately thereafter, the ambulance continues to a covered destination.

In such cases, the member 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.

Documentation Requirements

In all cases, the appropriate documentation must be kept on file and, upon request, presented to the contractor. It is important to note that the presence (or absence) of a physician's order for a transport by ambulance does not necessarily prove (or disprove) whether the transport was medically necessary. The ambulance service must meet all program coverage criteria in order for payment to be made.

- IOM Pub 100-01, Medicare General Information, Eligibility, and Entitlement Manual, chapter 4 - Physician Certifications and Recertification of Services, contains specific information on supplier requirements for ambulance certification.
- IOM Pub. 100-08, Medicare Program Integrity Manual, chapter 6 - Medicare Contractor Medical Review Guidelines for Specific Services contains information on medical review instructions of ambulance services.

Utilization Guidelines

Aspirin alone does not qualify to validate as an indicator that an ALS-2 level has been supplied. Oxygen alone, even at high flow rates, does not qualify to validate as an indication that an ALS-2 level has been supplied. Administration of IV fluids even with a fluid challenge does not qualify to validate as an indication that an ALS-2 level has been supplied.

Nitroglycerin administered as an assist to the member's own nitroglycerin does not qualify to validate as an indication ALS-2 level has been supplied. Nitroglycerin administered intravenously from the ambulance stock under a physician's telephonic order, or standing orders does qualify as an indication (as one of three medications) that an ALS-2 level has been supplied.

Billing for Ground Ambulance Services when the Beneficiary is Pronounced Deceased

According to Pub. 100-02, Chapter 10, Section 10.2.6, reimbursement of ambulance services provided to a deceased Medicare member;

Because the Medicare ambulance benefit is a transport benefit, if no transport of a Medicare member occurs, then there is no Medicare-covered service. In general, if the member dies before being transported, then no Medicare payment may be made. Thus, in a situation where the member dies, whether any payment under the Medicare ambulance benefit may be made depends on the time at which the member is pronounced dead by an individual authorized by the State to make such pronouncements.

Billing Procedures When Patient Refuses Transport

Refusal of transport (Procedure code A0998 definition-"Ambulance response and treatment, no transport") is statutorily excluded from Medicare coverage and, therefore, is not payable when billed to Medicare.

Note: Noridian jurisdiction requires different billing for this service please refer to the following for further instruction; Noridian Billing Procedures When Patient Refuses Transport.

Limitations

Medicare does not cover the following services:

- Transportation in Ambi-buses, ambulettes (Mobility Assistance Vehicle (MAV)), Medi-cabs, vans, privately owned vehicles, taxicabs.
- Transportation via Mobile Intensive Care Unit (MICU) (if billed under Part A).
- Parking fees.
- Tolls for bridges, tunnels and highways.

The IOM Publication 100-04, Chapter 15, Section 40 states: Refer to https://www.cms.gov/Center/Provider-Type/Ambulances-Services-Center.html for a medical conditions list and instructions to assist ambulance providers and suppliers to communicate the patient's condition to Medicare contractors, as reported by the dispatch center and as observed by the ambulance crew. Use of the medical conditions list does not guarantee payment of the claim or payment for a certain level of service.

In addition to reporting one of the medical conditions on the claim, one of the transportation indicators may be included on the claim to indicate why it was necessary for the patient to be transported in a particular way or circumstance. The provider or supplier will place the transportation indicator in the "narrative" field on the claim. Information on the appropriate use of transportation indicators is also available at https://www.cms.gov/Center/Provider-Type/Ambulances-Services-Center.html.

Effective January 1, 2006, items and services which include but are not limited to oxygen, drugs, extra attendants, supplies, EKG, and night differential are no longer paid separately for ambulance services. This occurred when CMS fully implemented the Ambulance Fee Schedule, and therefore, payment is based solely on the ambulance fee schedule.

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 Guidelines may apply.

HCPCS Code	Description
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)
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
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)
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)
A0430	Ambulance service, conventional air services, transport, one way (fixed wing)
A0431	Ambulance service, conventional air services, transport, one way (rotary wing)
A0432	Paramedic intercept (PI), rural area, transport furnished by a volunteer ambulance company which is prohibited by state law from billing third-party payers

HCPCS Code	Description
A0433	Advanced life support, level 2 (ALS 2)
A0434	Specialty care transport (SCT)
A0435	Fixed wing air mileage, per statute mile
A0436	Rotary wing air mileage, per statute mile
A0888	Non-covered ambulance mileage, per mile (e.g., for miles traveled beyond closest appropriate facility) (Non-Covered)
A0998	Ambulance response and treatment, no transport (Non-Covered)
A0999	Unlisted ambulance service

Coding Clarification: For ambulance service claims, institutional-based providers and suppliers must report an origin and destination modifier for each ambulance trip provided in HCPCS/Rates. Origin and destination modifiers used for ambulance services are created by combining two alpha characters. Each alpha character, with the exception of "X", represents an origin code or a destination code. The pair of alpha codes creates one modifier. The first position alpha code equals origin; the second position alpha code equals destination. Origin and destination codes and their descriptions are listed below.

Modifier	Description
D	Community mental health center, FQHC, RHC, urgent care facility, non-provider-based ASC or freestanding emergency center, location furnishing dialysis services and not affiliated with ESRD facility
E	Residential, domiciliary, custodial facility (other than 1819 facility) if the facility is the beneficiary's home
G	Hospital based ESRD facility
H	Alternative care site for hospital, including CAH, provider-based ASC, or freestanding emergency center
I	Site of transfer (e.g., airport or helicopter pad) between modes of ambulance transport
J	Freestanding ESRD facility
N	Alternative care site for SNF
P	Physician's office
R	Beneficiary's home
S	Scene of accident or acute event
X	Intermediate stop at physician's office on way to hospital (destination code only)

Revenue Code	Description
540	Ambulance
541	Supplies
542	Medical transport
543	Heart mobile
544	Oxygen
545	Air ambulance
546	Neonatal ambulance services
547	Pharmacy
548	Telephone transmission EKG
549	Other (ALS)

Definitions

Advanced Life Support, Level 1 (ALS1): Advanced life support, level 1 (ALS1) is the transportation by ground ambulance vehicle and the provision of medically necessary supplies and including the provision of an ALS assessment by ALS personnel or at least one ALS intervention.

Advanced Life Support, Level 1 (ALS1)-Emergency: When medically necessary, the provision of ALS1 services, in the context of an 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.

Advanced Life Support, Level 2 (ALS2): Advanced Life Support, level 2 (ALS2) is the transportation by ground ambulance vehicle and the provision of medically necessary supplies and services including (1) at least three separate administrations of one of more medications by intravenous (IV) push/bolus or by continuous infusion (excluding crystalloid fluids) or (2) ground ambulance transport, medically necessary supplies and services, and the provision of at least one of the ALS2 procedures listed: Manual defibrillation/cardioversion; Endotracheal intubation; Central venous line; Cardiac pacing; Chest decompression; Surgical airway; or Intraosseous line.

Basic Life Support: Basic life support (BLS) is transportation by ground ambulance vehicle and the provision of medically necessary supplies and services, including BLS ambulance services as defined by the State. The ambulance vehicle must be staffed by at least two people who meet the requirements of the state and local laws where the services are being furnished, and at least one of the staff members must be certified at a minimum as an emergency medical technician-basic (EMT-Basic) by the state or local authority where the services are being furnished and be legally authorized to operate all lifesaving and life-sustaining equipment on board the vehicle. These laws may vary from State to State or within a State. For example, only in some jurisdictions is an EMT-Basic permitted to operate limited equipment onboard the vehicle, assist more qualified personnel in performing assessments and interventions, and establish a peripheral intravenous (IV) line.

Basic Life Support (BLS) Emergency: When medically necessary, the provision of BLS services, in the context of an 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.

Fixed Wing Air Ambulance (FW): Fixed wing air ambulance is furnished when the member's medical condition is such that transport by ground ambulance, in whole or in part, is not appropriate. Generally, transport by fixed wing air ambulance may be necessary because the member's condition requires rapid transport to a treatment facility, and either great distances or other obstacles, e.g., heavy traffic, preclude such rapid delivery to the nearest appropriate facility. Transport by fixed wing air ambulance may also be necessary because the member is inaccessible by a ground or water ambulance vehicle.

Paramedic Intercept (PI): Paramedic Intercept services are 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.

This tiered approach to life saving is cost effective in many areas because most volunteer ambulances do not charge for their services and one paramedic service can cover many communities. Prior to March 1, 1999, Medicare payment could be made for these services, but could not be made directly to the intercept service provider; rather, Medicare payment could be made only when the claim was submitted by the entity that actually furnished the ambulance transport. In those areas where State laws prohibited volunteer ambulances from billing Medicare and other health insurance, the intercept service could not receive payment for treating a Medicare member and was forced to bill the member for the entire service.

Paramedic intercept services furnished on or after March 1, 1999, are payable separate from the ambulance transport when all of the requirements in the following three conditions are met:

- The intercept service(s) is:
  - Furnished in a rural area (as defined below);
  - Furnished under a contract with one or more volunteer ambulance services; and
  - Medically necessary based on the condition of the member receiving the ambulance service.
- The volunteer ambulance service involved must:
  - Meet Medicare's certification requirements for furnishing ambulance services;
  - Furnish services only at the BLS level at the time of the intercept; and
  - Be prohibited by State law from billing anyone for any service.
- The entity furnishing the ALS paramedic intercept service must:
  - Meet Medicare's certification requirements for furnishing ALS services, and,
  - Bill all recipients who receive ALS paramedic intercept services from the entity, regardless of whether or not those recipients are Medicare members.

For purposes of the paramedic intercept benefit, a rural area is an area that is designated as rural by a State law or regulation or that is located in a rural census tract of a metropolitan statistical area (as determined under the most recent version of the Goldsmith Modification). (The Goldsmith Modification is a methodology to identify small towns and rural areas within large metropolitan counties that are isolated from central areas by distance or other features). The current list of these areas is periodically published in the Federal Register.

Refer to the Medicare Claims Processing Manual, Chapter 15, "Ambulance," §20.1.4 for payment of paramedic intercept services.

Rotary Wing Air Ambulance (RW): Rotary wing air ambulance is furnished when the member's medical condition is such that transport by ground ambulance, in whole or in part, is not appropriate. Generally, transport by rotary wing air ambulance may be necessary because the member's condition requires rapid transport to a treatment facility, and either great distances or other obstacles, e.g., heavy traffic, preclude such rapid delivery to the nearest appropriate facility. Transport by rotary wing air ambulance may also be necessary because the member is inaccessible by a ground or water ambulance vehicle.

Rural Air Ambulance Services: "Rural air ambulance service" means fixed wing and rotary wing air ambulance service in which the point of pick-up of the individual occurs in a rural area (as defined in Section 1886(d) (2) (D)) or in a rural census tract of a metropolitan statistical area (as determined under the most recent modification of the Goldsmith Modification, originally published in the Federal Register on February 27, 1992)) (57 Fed. Reg. 6725).

Specialty Care Transport (SCT): Specialty care transport (SCT) is the interfaculty transportation of a critically injured or ill member by a ground ambulance vehicle, including the provision of medically necessary supplies and services, at a level of service beyond the scope of the EMT-Paramedic. SCT is necessary when a member's condition requires ongoing care that must be furnished by one or more health professionals in an appropriate specialty area, for example, emergency or critical care nursing, emergency medicine, respiratory care, cardiovascular care, or an EMT-Paramedic with additional training.

References

CMS Local Coverage Determinations (LCDs) and Articles

LCD	Article	Contractor	Medicare Part A	Medicare Part B
L34549 Ambulance Services	A56468 Billing and Coding: Ambulance Services	Palmetto	AL, GA, TN, NC, SC, VA, WV	

LCD	Article	Contractor	Medicare Part A	Medicare Part B
L35162 Ambulance Services (Ground Ambulance) **Retired 02/09/2023**	A54574 Billing and Coding: Ambulance Services (Ground Ambulance) **Retired 02/09/2023**	Novitas	AR, CO, DC, DE, LA, MD, MS, NJ, NM, OK, PA, TX	AR, CO, DC, DE, LA, MD, MS, NJ, NM, OK, PA, TX
	A55096 Reminder Regarding Ambulance Transports – Dual Diagnoses (Provider Bulletin) **Retired 12/01/2022**			
L37697 Emergency and Non-Emergency Ground Ambulance Services **Retired 02/09/2023**	A57674 Billing and Coding: Emergency and Non-Emergency Ground Ambulance Services **Retired 02/09/2023**	First Coast	FL, PR, VI	FL, PR, VI
N/A	A52917 Rural Air Ambulance Service Protocols	Noridian	AK, AZ, ID, MT, ND, OR, SD, UT, WA, WY	
N/A	A52588 Billing for Ground Ambulance Services when the Beneficiary Is Pronounced Deceased **Retired 10/25/2022**	First Coast	FL, PR, VI	

CMS Benefit Policy Manual

Chapter 10; Ambulance Services

CMS Claims Processing Manual

Chapter 1; § 10.1.4.5 Appeals of Denied Charges for Physicians and Ambulance Services in Connection with Foreign Hospitalizations
Chapter 6, § 20.3.1 Ambulance Services
Chapter 15 Ambulance

MLN Matters

CMS MLN, Special Edition
Article MM12707, Update of Internet Only Manual (IOM), Pub. 100-04, Chapter 15 - Ambulance

Other(s)

Ambulance Fee Schedule and Medicare Transports
Medicare Program Integrity Manual (Pub 100-08), Chapter 6, Section 6.4 Medical Review of Rural Air Ambulance Services
Medicare Program Integrity Manual (Pub 100-08), Chapter 13 Local Coverage Determinations
Title XVIII, Social Security Act:
Section 1833 (e) prohibits Medicare payment for any claim which lacks the necessary information to process the claim
Section 1861 (v)(1)(K)(ii) defines emergency service
Section 1861(s)(7) outlines Ambulance Service where the use of other methods of transportation is contraindicated by the individual's condition, but only to the extent provided in regulations
Sections 1861 (s) and (t) outline coverage for drugs and biologicals and services and supplies
Section 1862(a)(1)(A) allows coverage and payment for only those services that are considered to be medically reasonable and necessary

Guideline History/Revision Information

Revisions to this summary document do not in any way modify the requirement that services be provided and documented in accordance with the Medicare guidelines in effect on the date of service in question.

Date	Summary of Changes

11/08/2023	**Policy Summary**
	Guidelines
	• Removed content/language addressing physician certification and written orders
	Emergency Ambulance Services (Ground)
	• Removed language indicating an immediate response is one in which the ambulance provider or supplier begins as quickly as possible to take the steps necessary to respond to the call
	Medical Reasonableness for Non-Emergency (Scheduled) Ambulance Service (Ground)
	• Removed language indicating:
	  ○ If the condition contraindicating other means of transportation is "bed confined", the beneficiary must meet the following criteria of "bed confined"; the beneficiary is:
	  ▪ Unable to get up from bed without assistance
	  ▪ Unable to ambulate; and
	  ▪ Unable to sit in a chair or wheelchair
	• Revised description of “bed confined”
	Medical Reasonableness for Emergency Air Ambulance Transportation
	• Revised language to indicate if the air transport was medically appropriate (that is, ground transportation was contraindicated, and the member required air transport to a hospital), but the member could have been treated at a hospital nearer than the one to which they were transported, the air transport payment is limited to the rate for the distance from the point of pickup to that nearer hospital
	Destination for Emergency Air Ambulance Transportation
	• Revised language to indicate air ambulance services may be paid only for ambulance services to a hospital. Other destinations e.g., skilled nursing facility, a physician’s office, or a patient’s home may not be paid air ambulance
	Appropriate Facilities for Emergency Air Ambulance Transportation
	• Removed language indicating it is the institution, its equipment, its personnel, and its capability to provide the services necessary to support the required medical care that determine whether it has appropriate facilities
	Utilization Guidelines
	• Removed language indicating:
	  ○ A single payment allowance for mileage will be prorated by the number of beneficiaries onboard for multiple patient transport
	  ○ Down coding from air to ground is a *Social Security Act §1862 (a)(1)(A)* denial
	  ○ When multiple units respond to a call for services, the entity that provides the transport for the beneficiary should be the only provider billing the service
	Billing for Ground Ambulance Services when the Beneficiary is Pronounced Deceased
	• Revised language pertaining to reimbursement of ambulance services provided to a deceased Medicare member to indicate:
	  ○ According to *Pub. 100-02, Chapter 10, Section 10.2.6,* because the Medicare ambulance benefit is a transport benefit, if no transport of a Medicare member occurs, then there is no Medicare-covered service
	  ○ In general, if the member dies before being transported, then no Medicare payment may be made, thus, in a situation where the member dies, whether any payment under the Medicare ambulance benefit may be made depends on the time at which the member is pronounced dead by an individual authorized by the State to make such pronouncements

Date	Summary of Changes
	Supporting Information • Updated *References* section to reflect the most current information • Archived previous policy version MPG320.09

Purpose

The Medicare Advantage Policy Guideline documents are generally used to support UnitedHealthcare Medicare Advantage claims processing activities and facilitate providers' submission of accurate claims for the specified services. The document can be used as a guide to help determine applicable:

- Medicare coding or billing requirements, and/or
- Medical necessity coverage guidelines; including documentation requirements.

UnitedHealthcare follows Medicare guidelines such as NCDs, LCDs, LCAs, and other Medicare manuals for the purposes of determining coverage. It is expected providers retain or have access to appropriate documentation when requested to support coverage. Please utilize the links in the References section above to view the Medicare source materials used to develop this resource document. This document is not a replacement for the Medicare source materials that outline Medicare coverage requirements. Where there is a conflict between this document and Medicare source materials, the Medicare source materials will apply.

Terms and Conditions

The Medicare Advantage Policy Guidelines are applicable to UnitedHealthcare Medicare Advantage Plans offered by UnitedHealthcare and its affiliates.

These Policy Guidelines are provided for informational purposes, and do not constitute medical advice. Treating physicians and healthcare providers are solely responsible for determining what care to provide to their patients. Members should always consult their physician before making any decisions about medical care.

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 member specific benefit plan document identifies which services are covered, which are excluded, and which are subject to limitations. In the event of a conflict, the member specific benefit plan document supersedes the Medicare Advantage Policy Guidelines.

Medicare Advantage Policy Guidelines are developed as needed, are regularly reviewed and updated, and are subject to change. They represent a portion of the resources used to support UnitedHealthcare coverage decision making. UnitedHealthcare may modify these Policy Guidelines at any time by publishing a new version of the policy on this website. Medicare source materials used to develop these guidelines include, but are not limited to, CMS National Coverage Determinations (NCDs), Local Coverage Determinations (LCDs), Medicare Benefit Policy Manual, Medicare Claims Processing Manual, Medicare Program Integrity Manual, Medicare Managed Care Manual, etc. The information presented in the Medicare Advantage Policy Guidelines is believed to be accurate and current as of the date of publication and is provided on an "AS IS" basis. Where there is a conflict between this document and Medicare source materials, the Medicare source materials will apply.

You are responsible for submission of accurate claims. Medicare Advantage Policy Guidelines are intended to ensure that coverage decisions are made accurately based on the code or codes that correctly describe the health care services provided. UnitedHealthcare Medicare Advantage Policy Guidelines use Current Procedural Terminology (CPT®), Centers for Medicare and Medicaid Services (CMS), or other coding guidelines. References to CPT® or other sources are for definitional purposes only and do not imply any right to reimbursement or guarantee claims payment.

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*For more information on a specific member's benefit coverage, please call the customer service number on the back of the member ID card or refer to the Administrative Guide.