ASPEN Ambulance Information for All States - Authored

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LOB HOST, Individual - Non-ACA, Individual - Off Exchange, Individual - On Exchange, Large Group, National Account, Small Group - Non-ACA, Small Group - Off Exchange, Small Group - On Exchange
State ALL

1. System(s) – ASPEN
2. Functional Area(s) – Provider Experience
3. Description – The purpose of this article is to give the Provider Experience associate detailed information for researching Ambulance Claims.
4. Note – Ambulance Services do not include: MediVan, Wheelchair Van, taxi, or bus.

Reminder for JAA - Please refer to the specific Benefit, Precertification Guidelines, and updates for this case number to ensure the group specifics do not differ from the below.

Overview

Provider Reimbursement

Ambulance services are reimbursed based upon the 'all inclusive' method for claim submission and payment according to Anthem's professional fee schedule. This policy applies to Covered Services as defined in the provider contract. The allowable amount is based upon the lesser of the Anthem professional fee schedule or the provider's billed charges.

The base rate code encompasses transportation by the ambulance, all services rendered and all services consumed in association with the patient's transport.

Mileage codes are also reimbursable. Only the ambulance base rate and mileage are reimbursed. All supplies and services are included in the ambulance base rate. Refer to the Coding and Processing sections.

For all ambulance services, regardless of whether or not the provider participates, payment is always made to the provider and considered at High Tier for PPO only. For HMO, Anthem will pay the same allowable amount to both in and out of network providers. For OON providers, the member can be balance billed for the difference between the allowable amount and the billed amount.

Always verify in the Evidence of Coverage (EOC) and Eligibility and Benefits, what Ambulance coverage the member has, checking for Surface, Air Ambulance and Exclusions and Limitations.

Ambulance Service.

See information below for specific title or State information.

Claims Manual Mail Back and Rejected Claims for Additional Information. What to do next?

As a provider rep, you may receive calls from a provider regarding a mailed back or rejected claim. Keep notes, who did you speak to, can they send the information directly to you or will they send the information through their normal channels? What is their timeframe for sending the requested information? Can they put the bill on hold until this is resolved if the provider mentions an issue with the bill such as age, getting ready to refer to collections, etc.

- Ambulance / Emergency Medical Transportation (EMT) transport notes. Sometimes known as **TRIP Run Records**.
- **Medical necessity** of air/water transportation vs. ground transport.
- Complete records from transferring /send facility. (you will have to look for additional claims)
- Ask the provider (Ambulance and/or facility) for records. Ask that the Provider HOLD any bills. Note the name, and phone number for person(s) you spoke with. Advise the provider of the time frame, to avoid another call.
- If rejected for "Not a Covered Expense of Your Plan" check TX pop up and the type of transportation code. (Perhaps an ambulance came but the member was not taken to any facility, 'false alarm')
- Also check "Prudent Lay Person" language in EOC to help determine if a transport should be covered. For example, if a prudent person called an ambulance for a slip and fall victim and the patient didn't require transportation. This "false alarm" claim could still be covered.

Look for other Related Claims for that date of service.

Verify if it could be a Downstream Claim, **check for an ER / Hospital Claim that may have come in *after* the Ambulance claim (but same DOS)**. If you find an ER or Hospital Claim for the same date of service (but it was submitted to Anthem after the ambulance company submitted their claim), send the ambulance claim for adjustment – give the adjustor the claim number for the ER or Hospital claim and ask for the claim to be adjusted based on a related claim in history.

Related Content:

Air and Ground Ambulance Claims – Individual and Small Group – All States

Processing Ambulance Service Guidelines – National ASO and FI

Ambulance Services: Ground Emergent - Clinical UM Guideline - Follow departmental guidelines

Ambulance Services: Ground: Non- Emergent – Clinical UM Guideline - Follow departmental guidelines

Ambulance Services: Air and Water – Clinical UM Guidelines - Follow departmental guidleines

CAA Surprise Bill – Federal Mandate - Explains Qualified Payment Amount (QPA), Consent Form, Recognized Amount (RA), MAA Rate

CAA Surprise Bill Federal Mandate – FAQ - The purpose of this document is to answer questions that associates may encounter related to the CAA Surprise Billing Federal Mandate.

State Mandates, see the State Surprise Billing Quickstep

Revision History

Date	What was changed?
10/11/22	Updated taxonomy
04/22/22	Updated per SME review - JAA
04/13/22	Added Air Ambulance Surprise Bill information to child and related links
10/01/21	Original Post

Prudent Lay Person – Emergency Medical Condition

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Prudent Lay Person – Emergency Medical Condition

The term 'emergency medical condition' means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a **prudent layperson**, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in":

- Placing the health of the individual (or, in the case of a pregnant woman, the health of the woman or her unborn child) in serious jeopardy,
- Serious impairment to bodily functions, or
- Severe dysfunction of any bodily organ or part, [or]
- Serious disfigurement.

Note: Account benefits must be verified because not all accounts follow Prudent Lay Person guidelines.

This policy concerns legislation passed that changes the way emergency care claims are administered.

- Insurers must now administer emergency medical benefits based on the understanding of a Prudent Lay Person and can no longer administer benefits as if the member has the insight of a medical professional.
- House Bill 4 legislation in the state of Ohio required Anthem to add Prudent Lay Person to the emergency care language for Fully Insured business. It was a corporate decision by Anthem to include ASO business for consistent administration of benefits.
- Medical review is no longer needed. Examiners should continue to follow the steps in the ER claims section of the Workflow for Medical Review to determine if services allowed as medically necessary.
- Per Medicare Guidelines and Medicare Compliance – If Medicare pays a claim, Anthem doesn't have to review the claim for prudent layperson medical emergency guidelines.

EOC Language example:

Emergency, or Emergency Medical Condition means a medical or behavioral health condition of recent onset and sufficient severity, including but not limited to, severe pain, that would lead a prudent layperson, possessing an average knowledge of medicine and health, to believe that his or her condition, sickness, or injury is of such a nature that not getting immediate medical care could result in putting the patient in serious danger or life threatening situation.

Examples:
A 70-year-old man has severe chest pain. His wife calls an ambulance. The ambulance takes him to a hospital emergency room. The hospital personnel determine he had indigestion.

- It was emergency because an average person reasonably believed that the enrollee's health was in serious danger.
- Covered this ambulance response.
- Conclusion would be the same for a 30-year-old man with past claims for a heart condition.

A 25-year-old pregnant woman falls down the steps at the back of her house. A neighbor sees the incident and calls an ambulance. A telephone consultation between the paramedic, an emergency room physician and the woman results in a decision not to transport her to a hospital. The medical personnel instruct her to see her obstetrician before the end of the day.

- It was emergency because an average person reasonably believed that the enrollee's health and the health of an unborn child was in serious danger.
- Covered this ambulance response with no transportation.

Terms and Definitions Related to Ambulance Claims

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Terms and Definitions Related to Ambulance Claims

Term	Definition
Ambulance	• Land, water or air vehicle that contains equipment for transporting sick and injured people. • Licensed for emergency medical transportation in accordance with state and local laws. • Trained and legally certified staff present to provide emergency medical care.
ALS	Advanced Life Support
ASO	Administrative Services Only
BLS	Basic Life Support
CMS	Centers for Medicare & Medicaid Services
CPR	Cardiopulmonary Resuscitation
EKG or ECG	Electrocardiogram

EOB	Explanation of Benefits
EOC	Evidence of Coverage
HCFA	Health Care Financing Administration
ISG	Individual and Small Group
IV	Intravenous
MBU	Management Business Units
Medical Emergency	When an average person (also called a prudent layperson) requests an ambulance because he or she reasonably believes that an enrollee's medical symptoms or physical circumstances pose a serious threat to the enrollee's health.
MEWA	Multiple Employer Welfare Arrangement
SNF	Skilled Nursing Facility

Non-Emergency Ambulance Transport to Dialysis Center - All States

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Non-Emergency Ambulance Transport to Dialysis Center - All States

Non-emergency Ambulance transportation to any Dialysis Center is NOT COVERED and certificate language (EOC) is being updated to reflect this.

Groups cannot choose to opt out and there are no exceptions.

Always check benefits and Costs and the EOC.

Claims:

If….	Then…
Claim Denied	Claim should be denied, there are no exceptions because this is NOT based on the diagnosis code but rather the non-emergency transport itself. Read the EOC.
How would the EOB read.	Not a Covered Expense of the Plan
Whose liability is it?	Member
What if there are multiple dates of service on the same claim or additional procedure codes?	The claim should be denied on incurred date of service. Anything related to the non-covered ambulance transport to or from dialysis center should be denied including but not limited to EKG's and services provided by ambulance staff.
What if the claim has a modifier code?	Modifier codes do not change that this is a non-covered service.

What can a provider do?

- Advise the provider of appeal rights for their state.
- Explain the appeals process and timeframe to the provider to avoid call backs.
- let the ambulance company know this is NOT a covered service for the plan. The ambulance company from that point will need to deal directly with the member for payment.
- Note call in wrap up.

For more information: Non-Emergency Ambulance Transport for Dialysis

The purpose of this Quick Reference Guide (QRG) is to provide an overview of Centers for Medicare & Medicaid Services (CMS) requirements that Anthem uses to determine non-emergency ambulance transport of members to and from dialysis.

Reimbursement When Medicare is Primary

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Reimbursement When Medicare is Primary

Per the Legal department, Anthem policies do not apply if Medicare is primary. If Medicare has allowed ambulance services that would have been denied by Anthem as included in the base rate and mileage allowances (in the absence of Medicare), Anthem should follow Medicare's payment logic and consider those services for payment on the Anthem secondary claim.

Covered Ambulance Services

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Covered Ambulance Services

The following services and supplies are covered for ambulance transportation:

- The base charge which includes the service of ambulance attendants and the use of reusable equipment and devices.
- Emergency response charges.
- Monitoring, electrocardiograms (EKG or ECG), cardiac defibrillation, cardiopulmonary resuscitation (CPR), the administration of oxygen, and intravenous (IV) solutions in connection with ambulance services. An appropriately licensed person must render the services.
- Advanced life support services including, but not limited to:
  - IV administration
  - Application of anti-shock trousers

- Application of electrical counter shock to the heart
- Establishing and maintaining a patient's airway

- Non-reusable supplies such as gauze and dressing, injectable medications, intravenous solutions, oxygen and tubing.
- Ambulance companies bill for each person they transport. If several members of one family are transported at the same time, a bill for each family member transported will be submitted. Some ambulance companies may prorate the charges when transporting more than one person but are not required to do so.

Transportation of Special Equipment and Medical Personal

When ambulance transportation is medically necessary for obtaining needed medical care, additional transportation fee for life sustaining equipment and/or a medical doctor, registered nurse, or respiratory care practitioner who accompanies a patient in the ambulance are covered.

Processing Supplies - Codes and Modifier Codes

Processing:

Oxygen and any other supplies should be separately coded from the base rate and mileage on Ambulance claims. However, only the base rate and mileage should be allowed and paid. All other services / supplies should be denied as inclusive to the base rate. The base rate definition includes any services rendered during transportation of the ambulance. List separately any additional services / supplies billed and manually deny as inclusive.

- Use the appropriate code (Basic Life Support, Advanced Life Support, mileage, etc.) based on service date.
- Only the ambulance base rate and mileage are reimbursed. All supplies and services are included in the ambulance base rate.
- Code out mileage separately with the number of miles in the units' field.
- Code oxygen A0422 and deny as inclusive to base rate.
- If the service billed is not base rate or mileage, reject the service as inclusive. Use message code U006.
- If a ground ambulance is called but no transport occurs, allow the "base" rate (A0998) as medically necessary according to clinical guidelines. Deny supplies as inclusive. Reimburse for mileage charges separately.
- When a claim is billed with return trips key two lines for base services and two lines for the mileage.

Ambulance Service/Code and Descriptions:

Coding:

Service/Code	Description
Place of Service 41	Ground Ambulance
Place of Service 42	Air or Water Ambulance
Type of Service AIR	Air Ambulance
Type of Service AMB	Ground Ambulance
Procedure Code	A0010 through A0999

Base Rate Codes and descriptions:

A0426	Ambulance Service, Advanced Life Support, Non-Emergency
A0427	Ambulance Service, Advanced Life Support, Emergency
A0428	Ambulance Service, Basic Life Support, Non-Emergency
A0429	Ambulance Service, Basic Life Support, Emergency Transport
A0430	Ambulance Service, Conventional Air Services, Transport
A0431	Ambulance Service, Convert Air Services, Transport, One Way
A0432	Paramedic Intercept Rural Area, Transport Furnished By
A0433	Advanced Life Support, Level 2
A0434	Specialty Care Transport
A0988	Ambulance Response and Treatment, No Transport

Mileage codes: Mileage is keyed on a separate line with number of miles keyed in the Units field (unless services are billed with a code that includes the mileage).

A0425	Ground Mileage, Per Statute Mile
A0435	Fixed Wing Air Mileage, Per Statute Mile
A0436	Rotary Wing Air Mileage, Per Statute Mile

Oxygen: Billed separately coded from base rate and mileage, if itemized:

A0422	Oxygen

Miscellaneous: Supplies should be separately coded from the base rate and mileage, if itemized:

Y9043	Advanced life support from hospital to hospital (convert to A0380)
Y9045	Advanced life support mileage (convert to A0390)
Y9050	Night service call (lump with base call)
Y9004	Emergency lights and siren (lump with base call)

System reject: as indicated when coded separately.

A0021	A0110	A0160	A0200
A0080	A0120	A0170	A0210
A0090	A0130	A0180	A0420
A0100	A0140	A0190	A0888

Note: All other codes will require the processor to determine if they are payable.

Ambulance Modifiers:

Select the correct modifier from the Ambulance modifier table.

Modifier	Description
DH	Diagnostic or therapeutic treatment site to hospital
EH*	Residential, domiciliary, custodial facility to hospital
HH	Hospital to Hospital
NH*	Skilled nursing facility to hospital
RH*	Residence to hospital
SH*	Scene of accident
HD	Hospital to diagnostic or therapeutic treatment site to hospital
HE*	Hospital to residential, domiciliary, custodial facility
HN*	Hospital to skilled nursing facility
HP*	Hospital to physician's office
HR*	Hospital to residence
DE*	Diagnostic or therapeutic treatment site to home
DN*	Diagnostic or therapeutic treatment site to SNF
DR*	Diagnostic or therapeutic treatment to residence
ED*	Residential, domiciliary, custodial facility to diagnostic or therapeutic treatment site
ND*	SNF to diagnostic or therapeutic treatment site
PH	Physician's office to hospital

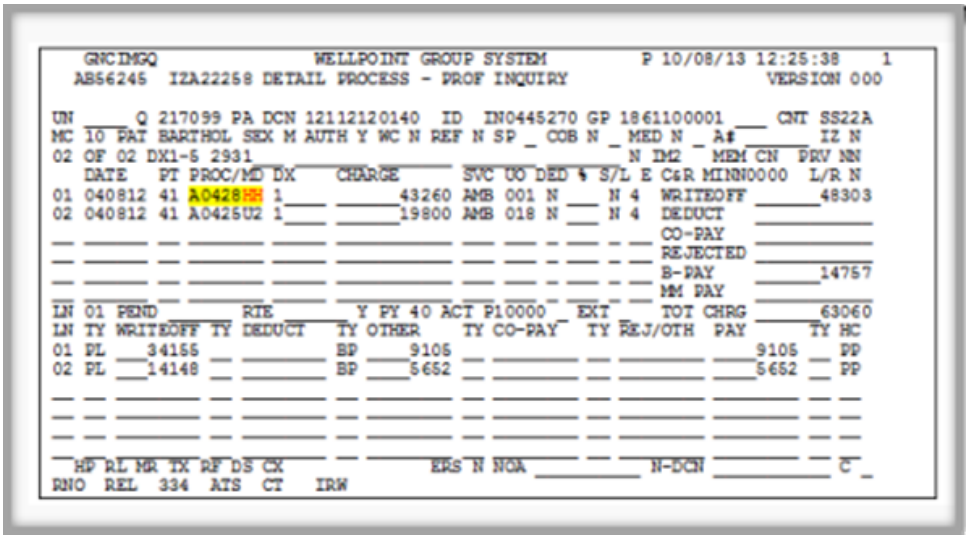
Note: The asterisk (*) means the Basic Life Support services will suspend for manual review for the modifiers listed above with an asterisk. Advanced life support services do not suspend for review.

Definition of From and To Modifier

From and To modifiers provide you with information regarding where the patient's transportation began (From) and where the patient's transportation ended (To). Knowing this information will help you to determine if the services are covered under the plan.

Modifier Location and Meaning

The first character of the modifier reflects the "From". The second character of the modifier reflects the "To". The figure below shows the location of a modifier in Mainframe



In the figure above, the "HH" represents the modifier. "HH" means the patient was transported from hospital to hospital.

Note: Upon implementation of ICD-10, the above referenced screen may contain ICD-10 codes in the DX1-5 fields.

The table below provides modifier values.

Modifier Code	Description
D	Diagnostic site other than Physician's office or hospital
E	ECF (Extended Care Facility)/Nursing Home
H	Hospital
N	Skilled Nursing Facility
P	Physician's office

R	Residence
S	Scene of accident
HT	Hospital to Hospital for diagnostic services and return

If the claim appears to be a duplicate, you must check the modifier that was billed on both the claim in question and the duplicate claim. If the modifiers are different (“RH” & “HR”), the claim is not a duplicate and will need to be sent for adjustment.If the modifiers are the same on both claims, you must check the claim image to make sure the correct information was keyed on both claims. If after reviewing, you find the modifiers to be the same the claim is a duplicate.

Circumstances for Ambulance Coverage – Emergency and Non-Emergency

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Circumstances for Ambulance Coverage – Emergency and Non-Emergency

Basic Circumstance for Ambulance Coverage

All Anthem plans cover ambulance services in the following three circumstances:

- Ambulance response was requested because of an emergency, and the member was transported to a hospital.
- Ambulance response was requested because of an emergency, but no transportation was provided.
- Ambulance transportation from a hospital or skilled nursing facility (SNF) to another facility for diagnostic or therapeutic services that is not available in the admitting hospital or skilled nursing facility.

Variable Ambulance Coverage

In addition to the circumstances for coverage you just learned about, Medicaid plans will provide coverage for ambulance services according to the contract provisions as described below:

Local emergency transportation provided that:

a. It is to the nearest hospital that can provide the required care and treatment; and

b. It is furnished by a professional ambulance service; and

c. A doctor certifies that it was necessary.

When ambulance transportation is covered by the terms of a contract, even though ground, water, or air transportation may not be specifically mentioned, any of these types of transportation will be covered. Ambulance transportation is covered even if the covered person who is transported is declared dead on arrival.

Benefit Levels

The benefit available for ambulance services is determined by the contract. Medicaid plans are programmed to adjudicate. Benefits will be pulled from the contract profile and applied to the claim upon adjudication from PAC or auto-calc functionality in Image. Navigation to the benefit screens should not be required.

Medical review or authorization is required for air ambulance and any type of transport that is not from a residence or scene.

Note: Some claims billed from ambulance providers in order to provide transports for office visits to the hospital, office, from hospital to the office etc. require prior authorization..

UM May need to provide precertification for a ground or air ambulance

Non-Emergent ground or air ambulance may require medical review in certain situations. Check the benefits and precertification requirements in the contract to see if a medical necessity review is recommended.

Reasons for Pre-service review of Ground Ambulance Transport:

- Physician’s office to Skilled nursing facility (SNF)
- Skilled nursing facility (SNF) to Physician’s office
- Hospital to Residence
- Hospital to Residential custodial
- Residence to Physician’s office
- Custodial residence to Physician’s office
- Physician’s office to Residence
- Residence to Free standing ESRD
- Free standing ESRD to Residence
- Hospital to Hospital

Reason for Pre-service review of Air Ambulance Transport:

Hospital to Hospital

If the above criteria are met, and case creation is required, the case would be handled as an outpatient pre-service request using the profiles below:

- **AMBUL Air/Water** for Air Ambulance
- **AMBUL Land** for Ground Ambulance

ASO (ASC) Accounts - Employer Group Exception

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ASO (ASC) Accounts - Employer Group Exception

ASO (ASC) Accounts - Employer Group Exception

Apply our policy to ASO employer groups only if it does not cause a conflict:

- State law may or may not be the basis of our policy,
- Client agreement requires review to see if policy affects the agreement before applying it to an ASO group,
- A Review must result in one of the following:
  - Conclusion that the policy does not conflict with the benefits we agreed to administer,
  - Explanation of our policy to the ASO client and they authorize us to apply the policy.

ASO Accounts: Be aware of the following if we based the policy on a state law:

- State laws usually do not apply to ASO groups,
- State laws do apply for certain conditions when the group is:
  - A church
  - A government entity
  - MEWA (Multiple Employers Welfare Arrangement)
- Anthem complies when:
  - ASO group tells us not to apply a policy based on a state law,
  - We think state law does apply to the ASO group.
- We protect Anthem Blue Cross companies from the financial implications of erroneous ASO group decisions (refer to General Principles for Administering Benefits).

Ambulance – Ground , Air, Water

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Ambulance – Ground , Air, Water

Definition

An ambulance is an air or ground emergency vehicle, used to transport the sick or injured. In order to qualify as an ambulance, a vehicle must be equipped with life sustaining equipment. Ambulances may be designed to carry "basic" or "advanced" life support systems. Non-Emergency response ambulance transportation may involve a patient who is "bed confined" defined as: unable to get out of bed without assistance; unable to ambulate; and unable to sit in a chair or wheelchair. This type of ambulance service may be scheduled or unscheduled.

Basic Coverage.

When the terms of an EOC or certificate cover ambulance transportation, we cover the following transportation even if not mentioned specifically:

1. Ground
2. Air
3. Water

All Anthem Blue Cross company health plans cover ambulance services under any of these three circumstances:

- Ambulance requested for an emergency and an ambulance took the enrollee to a hospital
- Ambulance requested for an emergency and transportation not provided
- Ambulance took enrollee from a hospital or SNF (Skilled Nursing Facility) to another facility for therapeutic or diagnostic services **not available** at the admitting hospital or SNF.

Air Ambulance and the Federal Surprise Bill Mandate – 01/01/2022
Effective January 1, 2022, the Federal Surprise Bill Mandate covers Air Ambulances. All Lines of Business and All States A surprise bill is when a member receives a balance bill from an Out of Network provider and the member thought the service(s) would be paid In-Network. **This bill does not cover ground or water ambulance** check for State Level Mandates. **Air ambulance** services, by Federal Law are now not allowed to balance bill. See KM article: Federal Surprise Bill – Balanced Billing

Ground Transportation

Anthem Ambulance Services: Ground; Non-Emergent - Clinical Guidelines

Always verify in the Evidence of Coverage (EOC) and Benefits, what Ambulance coverage member has, check for Surface, Air Ambulance and Exclusions and Limitations.

Ambulance services are either:

Basic Life Support (BLS)

1. Transportation
2. Reusable Equipment -
3. Staff

Advanced Life Support (ALS)

1. Transportation
2. Complex/Specialized Life Saving Equipment
3. Specialized staff – equipment for radio-telephone contact with a physician or hospital

This could be Air, Water or Ground transportation. Check Benefits and EOC.

Ambulance services do not include: Medi-Van, Wheelchair-Van, taxi, bus, or car.

Claims

If you have a denied Ambulance claim, check to see if the Ambulance claim came in **before** the claims for the hospital or facility the patient was taken to with the same date of service.

If you find related claims, then send the Ambulance Claim back for an adjustment and in your notes put: Related Claims in History and tag or note them.

Air & Water Ambulance

Ambulance Services: Air and Water Anthem Clinical Guidelines

Coverage for helicopter or fixed winged aircraft transportation requires the following:

- A licensed ambulance company operated the craft
- A land ambulance could not provide immediate and rapid transportation for at least one of these reasons:
  - Point of pick-up was inaccessible by land vehicle
  - Great distance or other obstacles (for example, heavy traffic) prevented land transportation to the nearest hospital with appropriate facilities and personnel
- Transportation was to nearest hospital with appropriate facilities and personnel, and facilities and personnel were immediately available
- Effective with dates of service after 4/18/2015 air ambulance services require the claim be filed to the plan where the point of pick up is located.

We cover continuous trips when the circumstances require both ground and air ambulances to transport a patient to a hospital or SNF.

Example Transportation by:

- Ground ambulance from a hospital to an airport, then
- Air ambulance from one airport to another airport and finally
- Ground ambulance to a hospital or SNF

If the EOC or certificate specifies different levels of coverage for ground and air ambulances, we calculate each benefit separately.

We cover ambulance transportation when the enrollee is declared dead on arrival.

Legacy Plans Benefits and Claims

When checking Benefits and Costs especially for Legacy Plans – check to make sure there is not a limit on the cost. (Example: Up to $7000.00)

Rural Ambulance Services

In rural areas:

- Volunteer ambulance companies have contracts with independent paramedics
- Ambulance companies pay the paramedics
- When someone calls an ambulance:
  - Volunteer ambulance companies contact their contracting paramedics
  - Paramedics drive their own vehicle (called a fly car) to the scene of the emergency
  - Ambulance crews drive the ambulance to the scene

Some states prohibit volunteer ambulance companies from billing for their own services. Volunteer ambulance companies:

- Can bill for paramedic services in the paramedic intercept situation
- Bill for paramedic services only

When state law allows the volunteer ambulance company to bill for its services, the base rate charge includes paramedic services.

Participating Hospitals Billing for Ambulance Services

Hospitals sometimes bill for ambulance services. The hospital's negotiated rate determines the allowable amount. The negotiated rate is based on one of the following:

Rate Type	Handling
Per diem	Allow only the per diem amount
Per diem, with a separate rate for ambulance services	Allow the per diem plus the additional rate for the ambulance services
	Allow the specified percent of the ambulance charge.

Percent of charges	Exception: If the enrollee's plan has a limited ambulance benefit: • Reduce our allowance for the ambulance services so the amount we pay does not exceed the ambulance benefit limit. • The enrollee's obligation to the hospital is the difference between our payment and the contracted percent of the charge.

Hospitals sometimes bill ambulance charges as outpatient services. They are subject to the outpatient contractual negotiated rate. However, if the hospital that is billing for the ambulance services admitted the enrollee, we:

- Combine the outpatient and inpatient bills
- Provide coverage under the inpatient claim

The ambulance charges are subject to the appropriate negotiated rate, as stated previously.

Billing for Supplies

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Billing for Supplies

Billing of Supplies

Reimbursement for ambulance services is limited to payment of the base rate plus mileage charges. Any additional charges for supplies, drugs, etc., are considered incidental to the global base rate and should be separately reimbursed. Reject these services with EOB code 00ABH.

Ambulance Claims

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Ambulance Claims

Overview

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The base rate code encompasses transportation by the ambulance, all services rendered and all services consumed in association with the patient's transportation.

Mileage codes are also reimbursable. Only the ambulance base rate and mileage are reimbursed. All supplies and services are included in the ambulance base rate. Refer to the Coding and Processing sections.

For all ambulance services, regardless of whether or not the provider participates, payment is always made to the provider and considered at High tier for PPO only. For HMO Anthem will pay the same allowable amount to out of network providers and the member can be balance billed the difference between the allowable amount and the billed amount.

General Information

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ASO Accounts: Be aware of the following if we based the policy on a state law:

- State laws usually do not apply to ASO groups
- State laws do apply for certain conditions when the group is:
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  - ? A government entity
  - ? MEWA (Multiple Employers Welfare Arrangement)
- Anthem complies when:
  - ? ASO group tells us not to apply a policy based on a state law
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- We protect Anthem Blue Cross companies from the financial implications of erroneous ASO group decisions (refer to General Principles for Administering Benefits)

Processing:

Oxygen and any other supplies should be separately coded from the base rate and mileage on Ambulance claims. However, only the base rate and mileage should be allowed and paid. All other services/supplies should be denied as inclusive to the base rate. The base rate definition includes any services rendered during transportation of the ambulance. List separately any additional services/supplies billed and manually deny as inclusive.

- Use the appropriate code (Basic Life Support, Advanced Life Support, mileage, etc.) based on service date.
- Only the ambulance base rate and mileage are reimbursed. All supplies and services are included in the ambulance base rate.
- Code out mileage separately with the number of miles in the units' field.
- Code oxygen A0422 and deny as inclusive to base rate.
- If the service billed is not base rate or mileage reject the service as inclusive. Use message code U006.
- If a ground ambulance is called but no transport occurs, allow the "base" rate (A0998) as medically necessary according to clinical guidelines. Deny supplies as inclusive. Reimburse for mileage charges separately.
- When a claim is billed with return trips key two lines for base services and two lines for the mileage.

Medicare Primary COB – Manage Other Insurance

Per the Legal department, Anthem policies do not apply. If Medicare has allowed ambulance services that would have been denied by Anthem as included in the base rate and mileage allowances (in the absence of Medicare), Anthem should follow Medicare's payment logic and consider those services for payment on the Anthem secondary claim.

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- If the service billed is not base rate or mileage reject the service as inclusive. Use message code U006.
- If a ground ambulance is called but no transport occurs, allow the "base" rate (A0998) as medically necessary according to clinical guidelines. Deny supplies as inclusive. Reimburse for mileage charges separately.
- When a claim is billed with return trips key two lines for base services and two lines for the mileage.

Ambulance Service/Code and Descriptions

Coding:

Service/Code	Description
Place of Service 41	Ground Ambulance
Place of Service 42	Air or Water Ambulance
Type of Service AIR	Air Ambulance
Type of Service AMB	Ground Ambulance
Procedure Code	A0010 through A0999

Base Rate Codes and descriptions:

A0426	Ambulance Service, Advanced Life Support, Non-Emergency
A0427	Ambulance Service, Advanced Life Support, Emergency
A0428	Ambulance Service, Basic Life Support, Non-Emergency
A0429	Ambulance Service, Basic Life Support, Emergency Transport
A0430	Ambulance Service, Conventional Air Services, Transport
A0431	Ambulance Service, Convert Air Services, Transport, One Way
A0432	Paramedic Intercept Rural Area, Transport Furnished By
A0433	Advanced Life Support, Level 2
A0434	Specialty Care Transport
A0988	Ambulance Response and Treatment, No Transport

Mileage codes: Mileage is keyed on a separate line with number of miles keyed in the Units field (unless services are billed with a code that includes the mileage).

A0425	Ground Mileage, Per Statute Mile
A0435	Fixed Wing Air Mileage, Per Statute Mile
A0436	Rotary Wing Air Mileage, Per Statute Mile

Oxygen: Billed separately coded from base rate and mileage, if itemized:

A0422	Oxygen

Miscellaneous: Supplies should be separately coded from the base rate and mileage, if itemized:

Y9043	Advanced life support from hospital to hospital (convert to A0380)
Y9045	Advanced life support mileage (convert to A0390)
Y9050	Night service call (lump with base call)
Y9004	Emergency lights and siren (lump with base call)

System reject as indicated when coded separately.

A0021	A0110	A0160	A0200
A0080	A0120	A0170	A0210
A0090	A0130	A0180	A0420
A0100	A0140	A0190	A0888

Note: All other codes will require the processor to determine if they are payable.

Ambulance Modifiers

- When keying ambulance claims, modifiers should be keyed, if available.
- Ambulance modifiers are not required for Ohio Control.
- If origin/destination modifiers are on the claim, they should be keyed. However, if the origin and destination is needed for benefit determination or duplicate claim processing, send a letter requesting the origin/destination information. Do not request the modifiers, as providers are not required to submit them for ambulance claims.

Select the correct modifier from the Ambulance modifier table.

Modifier	Description
DH	Diagnostic or therapeutic treatment site to hospital
EH*	Residential, domiciliary, custodial facility to hospital
HH	Hospital to Hospital
NH*	Skilled nursing facility to hospital
RH*	Residence to hospital
SH*	Scene of accident
HD	Hospital to diagnostic or therapeutic treatment site to hospital
HE*	Hospital to residential, domiciliary, custodial facility
HN*	Hospital to skilled nursing facility
HP*	Hospital to physician's office
HR*	Hospital to residence
DE*	Diagnostic or therapeutic treatment site to home
DN*	Diagnostic or therapeutic treatment site to SNF
DR*	Diagnostic or therapeutic treatment to residence
ED*	Residential, domiciliary, custodial facility to diagnostic or therapeutic treatment site
ND*	SNF to diagnostic or therapeutic treatment site
PH	Physician's office to hospital

Note: The asterisk (*) means the Basic Life Support services will suspend for manual review for the modifiers listed above with an asterisk. Advanced life support services do not suspend for review.

Related Content:

Medical and Clinical Guidelines - Type in Ambulance

California

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California

Ambulance CA Function: Claims Processing Individual, Small Group, Large Group, and National.

California Mandate SB651

The California state mandate SB651 states that out of network air ambulance claims must be processed as in network for emergency and non-emergency transports. The provider cannot balance bill the member.

California Affordable Care Act fully insured member claims must be covered as in network. Individual and Small Group.

Air and Ground Ambulance Claims – Individual and Small Group – All States.

Colorado/Nevada

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Colorado/Nevada

CO/NV ACA Special Processing Rule

All plans / products in CO/NV will process all out-of-network air and ground ambulance claims at the in-network benefit level and allow the claim at billed charges (subject to Medical Necessity guidelines). Claims may still be sent for NCN edit, once all other edits are resolved.

Participating ambulance claims are allowed at the provider's contractual rates.

Ambulance Claims Processing Guidelines CO/NV – WGS Claims.

Reject Codes Most Common – Job Aide Colorado.

Connecticut

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Connecticut

Effective October 1, 2002, State of Connecticut legislation required health insurers to eliminate the $500 per land trip maximum for ambulance services benefit in certain individual and Group health insurance policies.

This land trip maximum is replaced with the Maximum Allowable Rate(s) established by the Connecticut Department of Public Health.

Georgia

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Georgia

No specific State information.

Indiana

Create Child Content

Indiana

BAP 512.00 Ambulance This article defines when an ambulance is Medically Necessary.

Information for Central States: Indiana, Kentucky, Missouri, Ohio, and Wisconsin.

Medically necessary transportation by means of a vehicle designed, equipped and used only to transport the sick and injured, operated according to state and local laws which control the issuance of valid licenses or permits, or be licensed when required by law.

Note: Other vehicles that do not meet the above definition, including but not limited to ambulettes, are not Covered Services. Ambulance Services are available:

- From the scene of an accident or medical emergency to a hospital
- Between hospitals
- Between a hospital and skilled nursing facility
- From a hospital or skilled nursing facility to your home

Kentucky

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Kentucky

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Missouri

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Missouri

Missouri

Missouri, ambulance providers must be paid directly regardless of their contracting status with the plan. Missouri pays network and non-network emergency transportation at the network level

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New Hampshire

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New Hampshire

See KM Article HB31A Ambulance Claim Payment Mandate – NH

The mandate applies to all New Hampshire (NH) nonparticipating ambulance provider claims, for all NH members. Claims for out-of-state nonparticipating ambulance providers follow payment direction guidelines established by the local plan submitting the claim to Anthem via ITS. Use the HB31A - Ambulance Claim Payment Mandate - NH - WGS online reference for assistance.

Ambulance Benefit Detail – NH – WGS

New York

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New York

Ambulances NY Individual, Small Group, Large Local

New York State Land Ambulance Mandate Applies:

- Prohibits New York State Land Ambulance Providers from balance billing when the insurer pays based on the maximum amount allowed.
- We use 90th percentile of HIAA for these claim situations since EPO does not have an out-of-network (OON) reimbursement amount on which to base non-par reimbursement [e.g. PPO has OON HIAA, so the amount of reimbursement for non-par under that standard product will be based on the particular group member's established OON HIAA reimbursement].
- There is NO appeal process for paying beyond U&C for non-par New York State Land ambulance providers, for either ER services or emergency inpatient services, due to the Mandate.

Appeal Claim Situations:

A. Emergency Room Claims (no emergency inpatient stay):

- Our current policy is that the ER copay includes ambulance claims associated only with ER visits.
- If there is no ER claim on file when the ambulance claim is received, in-network deductible and coinsurance are applied.
- Upon appeal, for ER claims ONLY filed after the ambulance services, reprocess the claim to remove in-network deductible and coinsurance; pay at 100% of allowed amount (i.e. if provider is not balance billing beyond allowed amount).
- Except for NYS land ambulance providers, if the provider is balance billing beyond "allowed amount", follow any current processes to negotiate for less-than-charges, and pay up to 100% of charges if negotiated amount does not apply. Some providers may be willing to negotiate.

B. Emergency Inpatient Admissions (regardless of if admitted via the ER).

- We DO apply in-network deductible and/or coinsurance to ambulance services for inpatient emergency admissions, the same benefit application for all other emergency inpatient services.
- For any land or air ambulance services associated with inpatient emergency stays, we do NOT pay the difference between charges and allowed amount. (This is regardless of if the patient was admitted via the ER, since in those situations, the ER copay is waived).

Related Resources:

NYS Mandates

Processing Air Ambulances NY Includes EPO Cost Shares Air and Land.

Ohio

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Ohio

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Virginia

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Virginia

Ambulance Claims Processing Guidelines – Virginia Large Group.

Special Guidelines for Children's Hospital of the King's Daughters (CHKD)

When CHKD uses their ambulance to pick up a member (babies) and that member is admitted to CHKD as an inpatient, the ambulance services are a covered service and should appear on the inpatient bill. This decision was made in the 1980's and has been followed by the hospital and Anthem accordingly. This decision was based on the fact that the CHKD ambulance was staffed and contained equipment similar to that in the hospital's ICU unit.

CHKD also has a ground ambulance provider number that is separate from their facility number. They will use this provider number to bill transports to other facilities.

Wisconsin

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Wisconsin

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