Ambulance – All Information and All States - Authored

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LOB 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) – Solution Central
2. Functional Area(s) – Member Experience; Broker Experience; Provider Experience
3. Description – The purpose of this article is to give Service Experience all the information on Ambulance Claims in one location.
4. Notes – Transportation Services do not include: MediVan, WheelChair Van, taxi, or bus. As of 1/1/2022 Air Ambulances are no longer allowed to balance bill.

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 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. See the State Mandates below.

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

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

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

See information below for specific title or State info.
Also, located in Solution Central is a link to all Mandates and Policies – this is located under the Benefit and Costs Task > under Plan Coverage.

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

You may need to reach out to the Ambulance Company or a Facility. 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?

- 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)
- Reach out to the Ambulance and/or facility for records. Ask that the Provider would HOLD any bills. Note the name, account number, and phone number for person(s) you spoke with. Advise the member of the time frame, to avoid another member inbound 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 if there was never a transport to the Hospital. See Prudent Lay Person Below. If false alarm or someone thought the person needed an ambulance.

Look for other Related Claims for that date of service.

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 claim for adjustment – give the adjustor the claim number for the ER or Hospital and ask for the claim to be adjusted based on a related claim in history.

Related Content:

Federal Surprise Bill – Balanced Billing

Processing Ambulance Service Guidelines – National ASO and FI

Ambulance Services: Ground Emergent - Clinical UM Guideline

Ambulance Services: Ground: Non- Emergent – Clinical UM Guideline

Ambulance Services: Air and Water – Clinical UM Guidelines

Revision History

Date	What was changed?
02/10/23	Updated Non-Emergency Ambulance Transport to Dialysis Center section
11/17/22	Added NH Ambulance document to NH section.
11/09/22	Updated ME section
02/07/22	Added link to Federal Surprise Bill – Balance Billing and that Air ambulances are covered under this mandate but NOT ground ambulances.
4/28/21	Added Ambulance claims sub section
2/24/20	Original Post

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

Ambulance Claims

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Ambulance Claims

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General Information

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)

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 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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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

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

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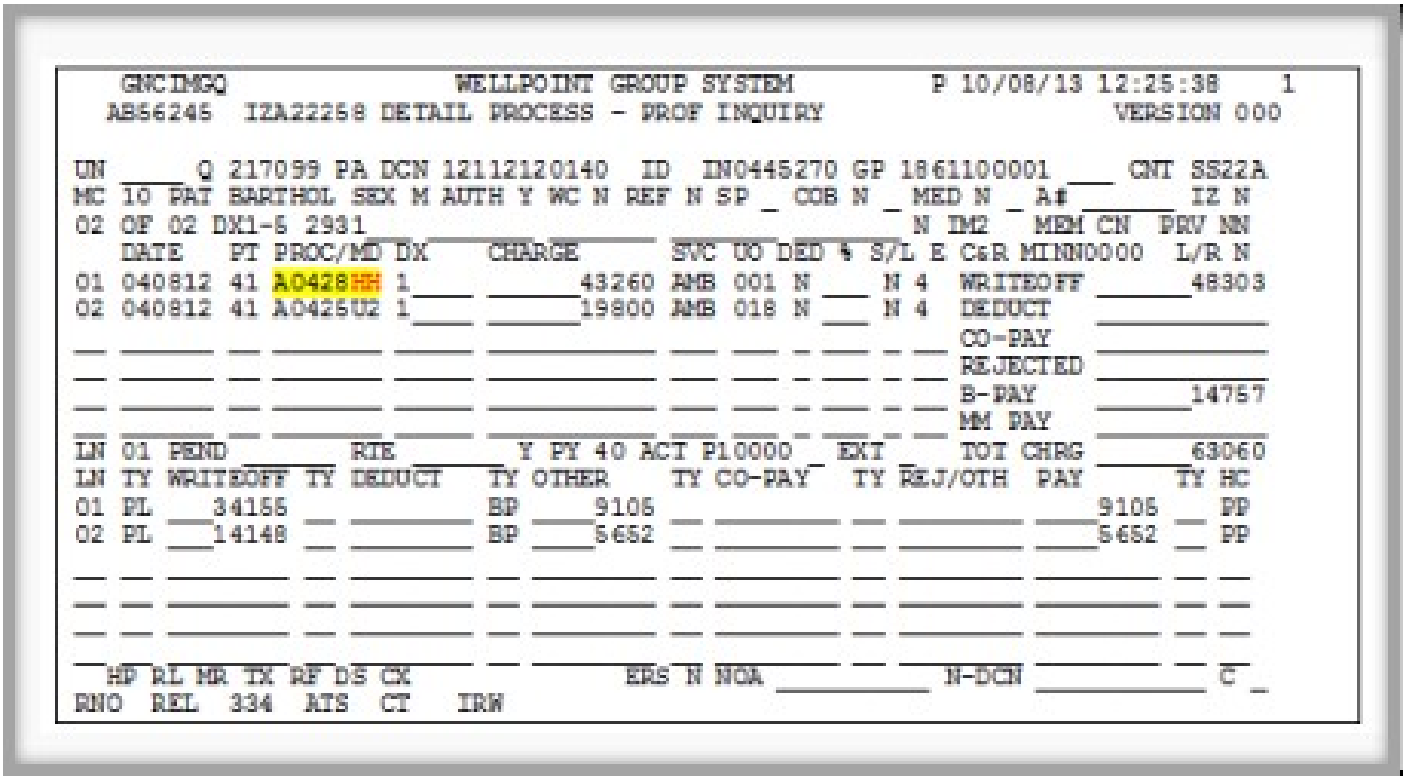
Definition of From and To Modifier

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 your claim has a "DP" or "RL" radio button and it appears to be a duplicate, you must check the modifier that was billed on both your claim and the duplicate claim. If the modifiers are different ("RH" & "HR") do not reject the claim as a duplicate. If the modifiers are the same on both claims, you must check the claim image to make sure the correct information was keyed on your claim. If after reviewing, you find the modifiers to be the same reject your claim as a duplicate. If they are different route the claim back to Anthem with text as to why you are routing it back.

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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. Please follow the bulletin located in the knowledge library for the steps on how to process transport claims.

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

Reasons 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

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Ambulance – Ground , Air, Water and Benefits and Costs

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Air & Water Ambulance:

Ambulance Services: Air and Water Anthem Clinical Guidelines

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Air Ambulance
Air ambulance claims from providers of emergency and non-emergency Air Ambulance should be filed to the Blue Cross and/or Blue Shield plan in whose service area the point of pick-up zip code is located. If the Claim contains incomplete or invalid zip code claim reject code would be RAMP00 and the EOB code would show 00AIF. Call the provider if this is an in-state/local claim and have the provider resubmit with the correct zip code. If the provider is out of state contact Plan to Plan or send a request through Blue Square.

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.

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
Percent of charges	Allow the specified percent of the ambulance charge. 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.

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 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 lay 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.

Non-Emergency Ambulance Transport to Dialysis Center

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Non-Emergency Ambulance Transport to Dialysis Center

For Medicare line of business, non-emergency Ambulance transportation to any Dialysis Center is NOT COVERED and certificate language (EOC) is being up dated 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. You can email a copy to the member.
How would the EOB read.	Not a Covered Expense of the Plan
Whose liability is it?	Member – give appeal rights
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 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 Member do?

- Advise the member of appeal rights for their state.
- Explain the appeals process and timeframe to the member to avoid call backs.
- Call the ambulance company and let them know this is NOT a covered service or their plan and help the member with negotiating the bill down or ask if the member can make payment arrangements? Member would have to deal with the ambulance company from that point.
- Note call in wrap up.

Additional Resource:

Line of Business: Medicare

Products: Medicare Advantage and Amerivantage

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 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.

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..

CA AIR Ambulance Services

California places requirements on the benefit coverage of enrollees in health plans and policies regulated by California Department of Managed Health Care (DMHC) and the California Department of Insurance (CDI).

This requires that an enrollee's cost sharing be the same for in -network and out-of-network (OON) air ambulance service providers, regardless of whether the provider is "in -network," and would require that such cost sharing count towards any deductible and annual out-of-pocket limits.

California also places a prohibition on air ambulance service providers, in that it prohibits balance billing a commercial or CalPERS enrollee for more that the set in-network cost-sharing amount.

General Information

No balance billing on Air-Ambulance services in CA

- Members current in-network benefit/cost shares for air-ambulance services will apply
- Follow usual procedures in processing these claims

Changes will be updated in EOC's/SOB of impacted plans

Updated SOB language provided by product: *Air Ambulance charges are paid at the same cost share for network and non-network providers. You are not responsible for the difference between the covered expense and the actual non-participating provider's charge*.

Colorado

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Colorado

Colorado Out-of- Network (OON) Ambulance Mandate

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

Ambulance Reference Guide GA Function: Claims Individual Small Group, Large Group.

Indiana

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Indiana

BAP 512.00 AmbulanceThis 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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Maine

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Maine

Ambulance Benefit Detail – ME

Ambulance transportation is defined as a means for transporting the sick or injured by a specially designed and equipped vehicle licensed by the State of Maine.

Coverage

Benefits will be provided from the scene of a life-threatening accident or emergency to the nearest appropriate hospital with bed availability. Ambulance services to a more distant hospital, solely to avail a patient of the service of a specific physician or physician specialist, do not qualify for benefits.

Benefits will be provided between the hospital of a registered inpatient to another location to obtain medically necessary specialized diagnostic or therapeutic services, e.g., Magnetic Resonance Imaging, Computerized Tomography Scans, Cobalt Therapy, with return to the point of origin.

Benefits will be provided for ambulance services for the transfer of an inpatient from one acute care hospital to another, provided the necessary care is not available at the facility the patient is currently being treated at.

Benefits will only be provided for ambulance services from an acute care hospital to a patient's home when any other method of transportation is contraindicated. Benefits will not be provided from any facility other than an acute care hospital.

Benefits will be provided for ambulance services to or from a Skilled Nursing Facility or Free-Standing Dialysis Center. These services will not require Medical Review intervention.

Billing

Ambulance services must be billed with a combination of two of the following modifiers:

D - Diagnostic or therapeutic site/free standing facility other that "P" or "H"

E - Residential or domiciliary/custodial facility

G - Hospital-based dialysis facility

H - Hospital inpatient/outpatient

I - Site of transfer between modes of transfer

J - Non-hospital-based dialysis facility

N - Skilled nursing facility

P - Physician's office

R - Private residence

S - scene of accident or acute event

X - Intermediate stop at physician's office on the way to the hospital

Note: Benefits will only be provided if an "H" is one of the two modifiers billed.

Deceased Members

Benefits will be provided for ambulance services to a deceased member when:

- The member was pronounced dead by a legally authorized individual (Physician, medical examiner) after the ambulance call was made, but before pick-up. Benefits are allowable for the response to the call but not for the transfer of the patient to a funeral home, morgue, or hospital.
- The member was pronounced dead while in route to or upon arrival at the destination. In lieu of paying two ambulance trips, benefits will only be provided for extra ordinary long waiting time for unusual circumstances.

Note: Benefits are not provided for transportation for the purpose of repatriation (e.g., to bring a deceased back to their country of birth, citizenship, or origin).

Critically Ill Neonates

Benefits will be provided for the transportation of a critically ill neonate to the nearest appropriate hospital with bed availability. Once the neonate has stabilized, benefits will also be provided for the transportation back to the hospital of origin or to the neonate's regional hospital. Any transportation of the mother must be medically necessary and to the nearest appropriate hospital.

Water and Air Ambulance Services

Benefits are available for water and air ambulance services rendered by licensed water and air ambulance services when the above coverage guidelines are met. When a licensed air ambulance service is not available, an unlicensed airline must obtain and complete a "Maine EMS (Emergency

Medical Services) Report of Flight Under License Waiver Form". This report is signed by a physician and filed to EMS for approval. Coverage will be provided for services accompanied by the waiver provided they meet our coverage guidelines.

Note: See CG.ANC.04 - Ambulance Services: Air and Water – Adopted 04- 21-2010.

Air Ambulances are covered under the Federal Surprise Bill – Balance Billing Mandate as of 1/1/2022. See KM article: Federal Surprise Bill – Balance Billing

Effective with date of service 04/19/2015:

Air Ambulance claims are subject to ancillary claims filing guidelines. The pickup ZIP code determines the Blue Cross Blue Shield plan to which the claim should be submitted. In order for a claim to be processed locally, the ZIP code must be located in CT, ME, NH, or a Contiguous County (Air Ambulance Transport Filing Rules Contiguous County List. If the ZIP code is missing or not in our service area, the claim will be rejected with a message to resubmit to the appropriate plan based on pickup ZIP code.

Nursing Attendant Services

Benefits will be provided for nursing services provided in an ambulance on an individual consideration basis. The nursing services must be rendered by a registered nurse, be prescribed by a physician, and be medically necessary.

Ground Ambulance
Maine residents are protected from balance billing with an out of network provider under Maines surprise bill mandate.

A carrier shall reimburse an out-of-network provider for ambulance services that are covered emergency services at the out-of-network provider's rate unless the carrier and out-of-network provider agree otherwise.

See KM doc - Surprise Billing Mandates - State Level

Referral

Covered services for all ambulance claims pay at the highest benefit level based on the charged amount with no referral required on Managed Care (HMO or POS) products.

PPO Plans

Covered services with a non-par/out of network ambulance using provider code 71 pay at the in-network level based on the charged amount and are not subject to the 20% non-par reduction on PPO plans.

Exclusions

Vans, coaches, wheelchair cars, etc. are not recognized by the State of Maine as ambulances. The ambulance must have customary patient care equipment and supplies. Reusable devices, non-reusable items, and disposable supplies are considered part of the general ambulance service and should not be included in the base charge for the trip.

Benefits are not available for ambulance usage when a means of transportation, other than ambulance, could be used without endangering the patient's health.

Benefits will not be provided for ambulance services when the patient refuses treatment or transport.

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 Large Group Function: Member Service

NH Ambulance Claim Payment Mandate

Nevada

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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.

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 they provide 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.

B. Emergency Inpatient Admissions (regardless 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 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 Links for 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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