Ambulance Transportation

Policy Number: BIP006.L
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Instructions for Use

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Related Benefit Interpretation Policies

- Dialysis Services
- Emergency and Urgent Services
- Medical Necessity
- Transplantation Services

Federal/State Mandated Regulations

Note: The most current federal/state mandated regulations for each state can be found in the links below.

Oklahoma

Oklahoma Administrative Code Section 365:40-5-21-Supplemental Health Care Services

https://regulations.justia.com/states/oklahoma/title-365/chapter-40/subchapter-5/part-5/section-365-40-5-21/
https://www.oid.ok.gov/wp-content/uploads/2019/10/091517_C40S5.pdf

Supplemental health care services of an HMO may include the following:
(8) Ambulance services, unless medically necessary.

Title 36 Oklahoma Statutes Section 6907

Title 36 Insurance Section 36-6058. Newly-Born Children, Health Insurance Benefits

https://law.justia.com/codes/oklahoma/2014/title-36/section-36-6058/

(B) The coverage for newly born children shall consist of coverage of injury or sickness including the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities. Such coverage shall also include transportation necessary for the provision of medical care for such newly born children when (1) the newly born is transported to the nearest hospital capable of providing the medically necessary treatment on a timely basis, and (2) the mode of transportation is the most economical consistent with the well-being of the newly born. Transportation coverage shall not exceed the reasonable costs of providing such service and an itemized statement of costs shall accompany each claim.

Oregon

Oregon Revised Statutes Section 743A.014 Payments for Ambulance Care and Transportation

https://www.oregonlaws.org/ors/743A.014

(1) As used in this section, “health benefit plan” has the meaning given that term in ORS 743B.005 (Definitions)
(2) Notwithstanding ORS 743.543 (Payment of benefits under blanket health insurance policies), with respect to a health benefit plan or a Medicare supplement insurance policy that provides coverage for ambulance care and transportation, the insurer shall indemnify directly the provider of the ambulance care and transportation. [Formerly 743.718; 2013 c.91 §1; 2015 c.588 §4]

Texas

Texas Administrative Code Title 28 Part 1 Chapter 11 Subchapter F § 11.508: Basic Health Care Services and Mandatory Benefit Standards: Group, Individual, and Conversion Agreements

https://texreg.sos.state.tx.us/public/readtac$ext.TacPage?sl=R&app=9&p_dir=&p_rloc=&p_tloc=&p_ploc=&pg=1&p_tac=&ti=28&pt=1&ch=11&rl=508

(a) Each evidence of coverage providing basic health care services must provide the following basic health care services when they are provided by network physicians or providers, or by non-network physicians and providers as set out in §11.506(b)(9) or §11.506(b)(14) of this title (relating to Mandatory Contractual Provisions: Group, Individual, and Conversion Agreement and Group Certificate):

(1) (J) Emergency services as required by Insurance Code §1271.155 (concerning Emergency Care), including emergency transport in an emergency medical services vehicle licensed under Health and Safety Code Chapter 773 (concerning Emergency Medical Services), which is considered emergency care if it is provided as part of the evaluation and stabilization of medical conditions of a recent onset and severity, including severe pain, that would lead a prudent layperson possessing an average knowledge of medicine and health to believe that the individual's condition, sickness, or injury is of such a nature that failure to get immediate care through emergency transport could place the individual's health in serious jeopardy, result in serious impairment to bodily functions, result in serious dysfunction of a bodily organ or part, result in serious disfigurement, or for a pregnant woman, result in serious jeopardy to the health of the fetus;

Washington

Senate Bill (SB) 5986

https://lawfilesext.leg.wa.gov/biennium/2023-24/Pdf/Bills/Session%20Laws/Senate/5986-S.SL.pdf

New Section, Section 8

A new section is added to chapter 48.49 RCW to read as follows:

(1) For health plans issued or renewed on or after January 1, 2525, a nonparticipating ground ambulance services organization may not balance bill an enrollee for covered ground ambulance services.

(2) If an enrollee receives covered ground ambulance services:

(a) The enrollee satisfies their obligation to pay for the ground ambulance services if they pay the in-network cost-sharing amount specified in the enrollee's or applicable group's health plan contract. The enrollee's obligation must be calculated using the allowed amount determined under subsection (3) of this section. The carrier shall provide an explanation of benefits to the enrollee and the nonparticipating ground ambulance services organization that reflects the cost-sharing amount determined under this subsection;

(b) The carrier, nonparticipating ground ambulance services organization, and any agent, trustee, or assignee of the carrier or nonparticipating ground ambulance services organization shall ensure that the enrollee incurs no greater cost than the amount determined under (a) of this subsection;

(c) The nonparticipating ground ambulance services organization and any agent, trustee, or assignee of the nonparticipating ground ambulance services organization may not balance bill or otherwise attempt to collect from the enrollee any amount greater than the amount determined under (a) of this subsection. This does not impact the ground ambulance services organization's ability to collect a past due balance for that cost-sharing amount with interest;

(d) The carrier shall treat any cost-sharing amounts determined under (a) of this subsection paid by the enrollee for a nonparticipating ground ambulance services organization's services in the same manner as cost-sharing for health care services provided by an in-network ground ambulance services organization and must apply any cost-sharing amounts paid by the enrollee for such services 16toward the enrollee's maximum out-of-pocket payment obligation; and

(e) A ground ambulance services organization shall refund any amount in excess of the in-network cost-sharing amount to an enrollee within 30 business days of receipt if the enrollee has paid the nonparticipating ground ambulance services organization an amount that exceeds the in-network cost-sharing amount determined under (a) of this subsection. Interest must be paid to the enrollee for any unrefunded payments at a rate of 12 percent beginning on the first calendar day after the 30 business days.

(3) Until December 31, 2027, the allowed amount paid to a nonparticipating ground ambulance services organization for covered ground ambulance services under a health plan issued by a carrier must be one of the following amounts:

(a) (i) The rate established by the local governmental entity where the covered health care services originated for the provision of ground ambulance services by ground ambulance services organizations owned or operated by the local governmental entity and submitted to the office of the insurance commissioner under section 9 of this act; or

(ii) Where the ground ambulance services were provided by a private ground ambulance services organization under contract with the local governmental entity where the covered health care services originated, the amount set by the contract submitted to the office of the insurance commissioner under section 9 of this act; or

(b) If a rate has not been established under (a) of this subsection, the lesser of:

(i) 325 percent of the current published rate for ambulance services as established by the federal centers for Medicare and Medicaid services under Title XVIII of the social security act for the same service provided in the same geographic area; or

(ii) The ground ambulance services organization's billed charges.

(4) Payment made in compliance with this section is payment in full for the covered services provided, except for any applicable in-network copayment, coinsurance, deductible, and other cost-sharing amounts required to be paid by the enrollee.

(5) The carrier shall make payments for ground ambulance services provided by nonparticipating ground ambulance services organizations directly to the organization, rather than the enrollee.

(6) A ground ambulance services organization may not request or require a patient at any time, for any procedure, service, or supply, to sign or otherwise execute by oral, written, or electronic means, any document that would attempt to avoid, waive, or alter any provision of this section.

(7) Carriers shall make available through electronic and other methods of communication generally used by a ground ambulance services organization to verify enrollee eligibility and benefits information regarding whether an enrollee's health plan is subject to the requirements of this section.

(8) For purposes of this chapter, ground ambulance services organizations are not considered providers. RCW 48.49.020, 48.49.030, 2648.49.040, and 48.49.160 do not apply to ground ambulance services or ground ambulance services organizations.

New Section, Section 12

A new section is added to chapter 48.43 RCW to read as follows:

- For health plans issued or renewed on or after January 1, 2025, a health carrier shall provide coverage for ground ambulance transports to behavioral health emergency services providers for enrollees who are experiencing an emergency medical condition as defined in RCW 48.43.005. A health carrier may not require layperson acting reasonably would have believed that an emergency medical condition existed.
- Coverage of ground ambulance transports to behavioral health emergency services providers may be subject to applicable in-network copayments, coinsurance, and deductibles, as provided in chapter 48.48 RCW.

Amending RCW 48.43.005, 5 48.49.003, 48.49.060, 48.49.070, 48.49.090, 48.49.100, and 48.49.130; 6 adding new sections to chapter 48.49 RCW; adding new sections to 7 chapter 18.73 RCW; adding a new section to chapter 48.43 RCW; 8 creating a new section; and repealing RCW 48.49.190.

State Market Plan Enhancements

None

Covered Benefits

Important Note: Covered benefits are listed in *Federal/State Mandated Regulations*, *State Market Plan Enhancements*, and *Covered Benefits* sections. Always refer to the *Federal/State Mandated Regulations* and *State Market Plan Enhancements* sections for additional covered services/benefits not listed in this section.

Note: Refer to the member's Evidence of Coverage (EOC)/Schedule of Benefit (SOB) for additional information.

- Ambulance transportation by ground or air to the nearest appropriate facility when medically necessary (refer to the Benefit Interpretation Policies titled Emergency and Urgent Services and Medical Necessity).
  Note: The use of an ambulance (land or air) is covered without preauthorization when the member, as a prudent layperson, reasonably believes there is an emergency medical or psychiatric condition that requires ambulance transport to access emergency health care services.
  - Ground ambulance transportation using a basic life support or an advanced life support ambulance for the following transfers when medical necessity for ground ambulance transport is met:
    - Inter-hospital or skilled nursing facility transfers (skilled care only);
    - Hospital and renal dialysis facility;
    - Skilled nursing facility and dialysis facility (skilled care only);

        - Skilled nursing facility and radiation therapy (skilled care only);
        - Skilled nursing facility (SNF) and hospital and member's home.
    - Air ambulance transportation is a covered benefit only when:
        - The member's destination is an acute care hospital;
        - The member's condition is such that the ground ambulance would endanger the member's life or health;
        - Inaccessibility to ground ambulance transport or extended length of time required to transport the member via ground transport could endanger the member;
        - Weather or traffic conditions make ground transport impractical, impossible or overly time consuming.
    - Out-of-area ambulance service (ground or air) in conjunction with out-of-area care as listed above.
- Ambulance transportation for the member that is requested by public entities (e.g., police, school, and social services) is covered if one of the following criteria is met:
    - Reasonably complete and accurate documentation by the ambulance supplier demonstrates that the transportation furnished was medically necessary;
    - UnitedHealthcare independently determines that the transportation.
- Use of an ambulance for non-emergency health care services is covered only when specifically authorized by the member's network medical group or UnitedHealthcare.

Not Covered

- Any ambulance service to provide member transport for routine care when transport by other means would not endanger the member's health except as indicated in the *Covered Benefits* section.
- Any ambulance service when the member is unable to locate another form of transport and the member's health would not be compromised.
- Any ambulance service that serves only as a convenience for either the member or his/her family.
- Wheelchair transportation services (e.g., a private vehicle or taxi fare).
- Ambulance service (ground or air) to the coroner's office or mortuary.
- Personal transportation costs such as gasoline costs for a private vehicle or taxi fare.
- Inter-hospital or skilled nursing facility transportation due to a member request or convenience.
- Any ambulance service from one contracting facility to another contracting facility **unless the transfer is necessary to deliver medical services when a higher level of care is required.**
- For members out-of-country, transportation back to the United States when there is a foreign facility that is capable of managing the member's condition.
- Transportation is not a covered benefit except for ambulance transportation as defined in the *Covered Benefits* section.

Policy History/Revision Information

Date	State(s) Affected	Summary of Changes
08/01/2024	All	**Supporting Information** • Archived previous policy version BIP006.K
	Washington	**Federal/State Mandated Regulations** • Added language pertaining to the *Substitute Senate Bill 5986*

Instructions for Use

Covered benefits are listed in three (3) sections: *Federal/State Mandated Regulations*, *State Market Plan Enhancements*, and *Covered Benefits*. All services must be medically necessary. Each benefit plan contains its own specific provisions for coverage, limitations, and exclusions as stated in the member's Evidence of Coverage (EOC)/Schedule of Benefits (SOB). If there is a discrepancy between this policy and the member's EOC/SOB, the member's EOC/SOB provision will govern.