SECTION 5: BILLING AND REIMBURSEMENT GUIDELINES

of the Professional Provider Office Manual

5.4 AMBULANCE TRANSPORT BENEFIT

This is a subsection of Section 5: Billing and Reimbursement Guidelines of the *Professional Provider Office Manual*. If we make any procedural changes, in our ongoing efforts to improve our service to you, we will update the information in this subsection and notify our network providers. For complete *Professional Provider Office Manual* information, please refer to the other sections of this manual. Contact information for all manual sections is available in the Manual Reference Section.

For member eligibility, benefits or claims status information, we encourage you to use iLinkBlue (www.bcbsla.com/ilinkblue), our online self-service provider tool. Additional provider resources are available on our Provider page at www.bcbsla.com/providers.

This manual is provided for informational purposes only and is an extension of your Professional Provider Agreement. You should always directly verify member benefits prior to performing services. Every effort has been made to print accurate, current information. Errors or omissions, if any, are inadvertent. The Member Contract/Certificate contains information on benefits, limitations and exclusions, and managed care benefit requirements. It also may limit the number of days, visits or dollar amounts to be reimbursed.

As stated in your agreement: This manual is intended to set forth in detail Blue Cross policies. Blue Cross retains the right to add to, delete from and otherwise modify the *Professional Provider Office Manual* as needed. This manual and other information and materials provided by Blue Cross are proprietary and confidential and may constitute trade secrets of Blue Cross.

AMBULANCE TRANSPORT BENEFIT

The ambulance transport benefit is a transport by an ambulance. The transport may be covered when the use of any other method of transportation is inadvisable due to the member's condition and the additional requirements discussed below are met.

Blue Cross covers and processes two types of ambulance claims:

- Ground
  - ALS – advanced life support
  - BLS – basic life support
- Air

In addition to the participating provider responsibilities outlined in this manual, ambulance providers should:

- File only the codes listed in their contracts, if applicable. This will prevent returned claims and/or delays in claim processing.
- File claims for members even if you do not have the patient's signature. Patient signatures are not required for filing claims.

Report Full Ambulance Miles

The Centers for Medicare & Medicaid Services (CMS) established a new rule in 2011 regarding how to report fractional mileage amounts for ambulance services. Their rule requires ambulance providers and suppliers to bill mileage that is accurate to a tenth of a mile.

At this time, Blue Cross is not able to accommodate this CMS change; therefore, we will not accept mileage billed in increments of less than a full mile. Mileage billed with decimal places will not be recognized for claims processing.

Ambulance Modifiers

Ambulance services must be reported with a combination of two modifiers listed below—the first character representing the origin and the second character representing the destination:

D	Diagnostic or therapeutic site other than P or H when these are used as origin codes
E	Residential, domiciliary or custodial facility
G	Hospital-based dialysis facility
H	Hospital
I	Site of transfer between modes of ambulance transport
J	Non-hospital based dialysis facility
N	Skilled nursing facility (SNF)
P	Physician's office

R Residence

S Scene of accident or acute event

X Intermediate stop at physician's office on the way to the hospital (destination code only)

The ambulance provider must retain all appropriate documentation on file for an ambulance transport furnished to a member. This documentation must be presented to Blue Cross upon request and may be used to assess, among other things, whether the transport meets medical necessity, eligibility, coverage, benefit category and any other criteria necessary for payment. The ambulance transport is not covered if some means of transportation other than ambulance could be used without endangering the member's health, regardless of whether the other means of transportation is actually available.

Ground Ambulance Transports

A member may be transported on land for a reasonable and medically necessary ground ambulance transport. The following coverage requirements apply to ground transports:

- A Blue Cross member is transported.
- The destination is local.
- The facility is appropriate.
- Due to the member's condition, the use of any other method of transportation is inadvisable.
- The purpose of the transport is to obtain a Blue Cross-covered service or to return from obtaining such service.

Ground ambulance transports include the following:

- Basic Life Support (BLS) – Includes the provision of medically necessary supplies and services and BLS ambulance transportation as defined by the state where you provide the transport. An emergency response is one that, at the time you are called, you respond immediately. A BLS emergency is an immediate emergency response in which you begin as quickly as possible to take the steps necessary to respond to the call.
- Advanced Life Support, Level 1 (ALS1) – Includes the provision of medically necessary supplies and services and the provision of an ALS assessment or at least one ALS intervention. An ALS assessment is performed by an ALS crew as part of an emergency response that is necessary because the member's reported condition at the time of dispatch indicates that only an ALS crew is qualified to perform the assessment. An ALS assessment does not necessarily result in a determination that the member requires an ALS level of transport. An ALS intervention is a procedure that must be performed by an emergency medical technician-intermediate (EMT-Intermediate) or an EMT-Paramedic in accordance with State and local laws. An ALS1 emergency is an immediate emergency response in which you begin as quickly as possible to take the steps necessary to respond to the call.

- Advanced Life Support, Level 2 (ALS2) – Includes the provision of medically necessary supplies and services and:

  - At least three separate administrations of one or more medications by intravenous push/bolus or by continuous infusion (excluding crystalloid fluids)

  - At least one of the following procedures:

    - Manual defibrillation/cardioversion
    - Endotracheal intubation
    - Central venous line
    - Cardiac pacing
    - Chest decompression
    - Surgical airway
    - Intraosseous line

- Specialty Care Transport (SCT) – Includes the provision of medically necessary supplies and services beyond the scope of an EMT-Paramedic. SCT is the inter-facility transportation of a critically ill or injured member that is necessary because the member's condition requires ongoing care furnished by one or more professionals in an appropriate specialty (such as emergency or critical care nursing, emergency medicine, respiratory or cardiovascular care, or a paramedic with additional training).
- Paramedic Intercept (PI) – When an entity that does not provide the ambulance transport provides ALS services. PI may be required when a provider can provide only a BLS level of service and the member requires an ALS level of service (such as electrocardiogram monitoring, chest decompression or intravenous therapy).

Air Ambulance Transports

A member may be transported by fixed wing (airplane) or rotary wing (helicopter) aircraft for a medically necessary air ambulance transport. The following coverage requirements apply to air transports:

- The member's medical condition requires immediate and rapid ambulance transport.
- It cannot be furnished by BLS or ALS ground ambulance transport because one of the following pose a threat to the members' survival or seriously endangers his or her health.
- The point-of-pick-up (POP) is not accessible by ground vehicle (this requirement may be met in remote or sparsely populated areas). POP is the location of the member at the time he or she is placed on board the ambulance. The ZIP code of the POP or the nearest ZIP code to the POP must be reported on the claim.
- The distance to the nearest appropriate facility or the time a ground ambulance transport will take (generally more than 30-60 minutes).
- The instability of ground transportation.

The medical conditions that may justify air ambulance transport include, but are not limited to, the following (this list is not intended to justify air ambulance transport in all localities):

- Intracranial bleeding that requires neurosurgical intervention;
- Cardiogenic shock;
- Burns that require treatment in a burn center;
- Conditions that require treatment in a Hyperbaric Oxygen Unit;
- Multiple severe injuries; or
- Life-threatening trauma.

Specialized medical services that are generally not available at all facilities include, but are not limited to, the following:

- Burn care
- Cardiac care
- Trauma care
- Critical care

An air ambulance transport to transfer a member from one hospital to another hospital must meet the following requirements:

- A ground ambulance transport endangers the member's health;
- The transferring hospital does not have the needed hospital or skilled nursing care for the member's illness or injury; and
- The second hospital is the nearest appropriate facility.

Include ZIP Codes on Air Ambulance Claims:

Ambulance providers must include the 5-digit ZIP code of the point-of-pick-up. This is required for both emergent and non-emergent air ambulance services. This claims filing requirement also applies for Medicare crossover claims when Medicare's benefits do not cover the claim.

- For claims filed electronically through a clearinghouse, include the pick-up location ZIP code in the 2310E Ambulance Pick-up Location loop of the ASC X12N Health Care Claim (837).
- For hardcopy and iLinkBlue-filed claims, include the pick-up location ZIP code in Block 23 of the CMS-1500 claim form.

Claims that do not include the point-of-pick-up ZIP code on the claim will be denied for insufficient information.

Where to file air ambulance claims:

If the pick-up location ZIP code is in Louisiana, the claim should be filed directly to Blue Cross and Blue Shield of Louisiana.

If the pick-up location ZIP code is outside of Louisiana, the claim should be filed to the local Blue Plan that covers the area of pick-up.

If the pick-up location is outside of the United States, Puerto Rico or U.S. Virgin Islands, the claim must be filed to the Blue Cross Blue Shield Global Core Program.

Non-transport Ambulance Services

In situations where an ambulance is called to transport a patient and upon arrival the patient is able to be stabilized by the ambulance personnel, eliminating the need for transport, HCPCS code A0998 may be billed.

Participating ambulance providers non-transport pricing rules are as follows:

- When A0998 is billed without transport services, one unit per date of service is allowed.
- When A0998 is billed with other ambulance transport services and mileage, the service is considered bundled as part of the transport being billed and thus not separately reimbursable.

Each ambulance visit should be billed on separate claims. In the event that more than one visit or date of service is billed on the same claim and one visit is a non-transport while another is a transport, the non-transport will be denied. When non-transport occurs on a different date of service than transport, provider should bill on separate claims.

Non-contracted/Non-participating Ambulance Services

Payment will be made directly to the member for non-emergency related services. Please collect **ALL** payments—including any applicable copayment, coinsurance or deductible amount—directly from the member.

Payment will be made directly to the ambulance company for true emergency-related services. Please collect any applicable copayment, coinsurance and/or deductible amounts from the member.

General Transportation Rules and Definitions

A member is transported

When multiple ambulance providers and suppliers respond, payment is made only if you actually transport or treat the member. If you respond to a call for ambulance services and the member declines transportation, but you provided treatment; A0998 is the only billable service. Member benefits will be applied.

The destination is local

As a general rule, the ground ambulance transport destination must be local, which means that only mileage to the nearest appropriate facility equipped to treat the member's condition is covered. If two or more facilities meet this requirement and can appropriately treat the member, the full mileage to any of these facilities is covered.

The facility is appropriate

An appropriate facility is an institution that is generally equipped to provide the needed hospital or skilled nursing care for the member's illness or injury. An appropriate hospital must have a physician or a physician specialist available to provide the necessary care required to treat the member's condition.

Because all duly licensed hospitals and SNFs are presumed to be appropriate sources of health care, there must be clear evidence indicating that an ambulance transport to a more distant institution is the nearest appropriate facility. Some circumstances that may justify ambulance transport to a more distant institution include:

- The member's condition requires a higher level of trauma care or other specialized service that is only available at the more distant hospital. A specialized service is a covered service that is not available at the facility where the member is a patient.
- No beds are available at the nearest institution.
- A ground or air ambulance transport to a more distant hospital solely to avail the member of the services of a specific physician or physician specialist is not covered. If a member is initially transported to an institution that is not equipped to provide the needed hospital or skilled nursing care for the member's illness or injury and is then transported to a second institution that is adequately equipped, both ground ambulance transports will be covered provided the second transport is to the nearest appropriate facility. The medical documentation must support travel to the more distant facility.

When a ground ambulance transports a member to and from the nearest appropriate facility to obtain necessary diagnostic and/or therapeutic services (such as a Computerized Axial Tomography scan or cobalt therapy), the transport is covered only to the extent of the payment that would have been made to bring the service to the member.

A ground ambulance transport from an institution to the member's home is covered when the home is:

- Within the locality of the institution. Locality is the service area surrounding the institution to which individuals normally travel or expected to travel to receive hospital or skilled nursing services; or
- Outside the locality of the institution but in relation to the members home, it is the nearest appropriate facility.

Emergency room to inpatient or observation ambulance transport

If an ambulance is used to transport the patient from an emergency room (whether free standing or located within an acute hospital) to an affiliated facility, the ambulance service furnished by the hospital, or by others, under arrangements with the hospital, are not separately reimbursed. In this instance, the ambulance provider should not bill Blue Cross separately.

- Affiliated Example - Patient is seen at ABC Hospital and is transported to DEF Hospital for care (OBS or IP service). ABC Hospital is affiliated with DEF Hospital so the ambulance service is not separately reimbursed.
- Unaffiliated Example - Patient is seen at ABC Hospital and is transported to XYZ Hospital for care (OBS or IP service). ABC Hospital and XYZ Hospital are not affiliated so ambulance service is reimbursable.

Inpatient transfer temporarily for specialized care while maintaining inpatient status with initial facility

When a member is inpatient requiring medically necessary diagnostic services that are not available at the inpatient facility and requires ground ambulance transport to receive these services, the inpatient hospital lacking the needed services is responsible for the costs of the ambulance services. In this instance, the ambulance provider should not bill Blue Cross separately.

- Example - Patient is inpatient at ABC Hospital and is transported to DEF Hospital for diagnostic services not available at ABC Hospital. The ambulance service is not separately reimbursed.

Inpatient to inpatient ambulance transport and patient does not maintain inpatient status with initial facility

If a member is transferred from one facility to another facility, and the member does not maintain inpatient status with the original provider, the ambulance provider should not bill Blue Cross separately if the receiving facility is affiliated with the original provider.

- Affiliated Example – Patient is IP at ABC Hospital and is transferred to DEF Hospital for specialized IP care. ABC Hospital is affiliated with DEF Hospital so the ambulance service is not separately reimbursed.
- Unaffiliated Example – Patient is IP at ABC Hospital and is transferred to XYZ Hospital for specialized IP care. ABC Hospital and XYZ Hospital are not affiliated so ambulance service is reimbursable.

Ambulance transport reimbursement eligibility

The chart below illustrates ambulance transport eligibility for separate reimbursement.

Ambulance Transport Scenario	To an Affiliated Facility	To an Unaffiliated Facility
Emergency room to inpatient or observation.	Ambulance provider should not bill Blue Cross separately.	Ambulance provider may bill Blue Cross separately.
Inpatient transfer temporarily for specialized care while maintaining inpatient status with initial facility.	Ambulance provider should not bill Blue Cross separately.	Ambulance provider should not bill Blue Cross separately.
Inpatient to inpatient and patient does not maintain inpatient status with initial facility.	Ambulance provider should not bill Blue Cross separately.	Ambulance provider may bill Blue Cross separately.

Non-emergency transport

Blue Cross and HMO Louisiana member benefits may be available for ambulance services for local transportation of members for non-emergency conditions to obtain medically necessary diagnostic or therapeutic outpatient services (e.g., MRI, CT scan, dialysis, wound care, etc.), when the member is bed-confined or his/her condition is such that the use of any other method of transportation is contraindicated.

The member must meet all of the following criteria for bed-confinement:

1. unable to get up from bed without assistance; and
2. unable to ambulate; and
3. unable to sit in a chair or wheelchair

Transport by a wheelchair van is not a covered ambulance service.

Ambulance Vehicles

Ground and air ambulance vehicles must comply with state and/or local laws governing the licensing and certification of emergency medical transportation vehicles and must be designed and equipped to respond to medical emergencies. At a minimum, ambulance vehicles must be equipped with the following:

- Stretcher
- Linens
- Emergency medical supplies
- Oxygen equipment
- Other lifesaving emergency medical equipment and reusable devices (such as inflatable leg and arm splints, backboards and neckboards).
- Emergency warning lights, sirens and telecommunications equipment as required by state or local laws.
- A two-way voice radio or wireless telephone. In nonemergency situations, ambulance vehicles must be capable of transporting members with acute medical conditions.

Ambulance personnel

A BLS ambulance vehicle must be staffed by at least two individuals, one of whom must be qualified in accordance with state and/or local laws as an EMT-Basic and is legally authorized to operate all lifesaving and life-sustaining equipment on board the vehicle.

An ALS ambulance vehicle must be staffed by at least two individuals, one of whom must be qualified in accordance with state and/or local laws as an EMT-Intermediate or an EMT-Paramedic.

Statement about ambulance vehicles and personnel

To indicate that you meet the above requirements, include the following information about your ambulance vehicles and personnel in a statement you provide with your credentialing application:

- The first aid, safety and other patient care items with which the vehicles are equipped;
- The extent of first-aid training acquired by the personnel assigned to the vehicles;

- An agreement to notify Blue Cross of any change in operation that could affect the coverage of ambulance transports; and
- Documentary evidence (such as a letter or copy of a license, permit or certificate issued by state and/or local authorities) indicating that the vehicles are equipped as required.

HMO Louisiana, Blue Connect, BlueHPN, Community Blue, Precision Blue, Signature Blue, Bridge Blue and OGB's Magnolia Local Requirements

Emergency services (air or ground) - Prior authorization is not required but the provider is advised to submit the trip notes with the claim. Claims are reviewed for medical necessity.

Non-emergency services (air) - An authorization must be obtained prior to services being rendered. No payment will be made for non-emergency air services rendered without prior authorization and services are not billed to the member. If a member contacts you to request non-emergency air services, you must obtain an authorization from HMO Louisiana prior to rendering services.

Non-emergency services (ground) - An authorization is not required for non-emergency ground services. Please note our criteria for approval of non-emergency ambulance transport described below. If the non-emergency transport criteria listed below is not met, an authorization is recommended to determine medical necessity for the services prior to being provided. Failure to obtain an authorization of non-emergency ambulance services will result in our review for medical necessity prior to any payment determination.

Non-Emergency Transport (ground) - Member benefits may be available for ambulance services for local transportation of members for non-emergency conditions to obtain medically necessary diagnostic or therapeutic outpatient services (e.g., MRI, CT scan, dialysis, wound care, etc.) when the member is bed-confined and:

1. Unable to get up from bed without assistance; and
2. Unable to ambulate; and
3. Unable to sit in a chair or wheelchair