

CHAPTER 7
SECTION 2.1

AMBULANCE SERVICE

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Authority: [32 CFR 199.4\(d\)\(3\)\(v\)](#)

I. PROCEDURE CODES

HCPCS Level II Codes A0030-A0050, A0225-A0424, A0999

II. DESCRIPTION

Transportation by means of a specifically designed vehicle for transporting the sick and injured that contains a stretcher, linens, first aid supplies, oxygen equipment, and such other safety and life saving equipment as is required by state and local law and is staffed by personnel trained to provide first aid treatment.

III. POLICY

Benefits are limited to medically necessary ambulance services under the following guidelines:

A. Ambulance services must be medically necessary and reasonable. "Medical necessity" is established when the patient's condition is such that the use of any other method of transportation is contraindicated. The following conditions are presumed to meet this requirement:

1. Was transported in an emergency situation; e.g., as a result of accident, injury, or acute illness, or
2. Needed to be restrained, or
3. Was unconscious or in shock, or
4. Required oxygen or other emergency treatment on the way to his or her destination, or
5. Was experiencing severe hemorrhage, or
6. Had to remain immobile because of fracture that had not been set or the possibility of a fracture, or

7. Sustained an acute stroke or myocardial infarction, or
8. Was bed confined before and after the ambulance trip, or
9. Could be moved only by stretcher.

In the absence of any of the above, additional documentation should be obtained to establish medical necessity.

B. Ambulance service is not covered when used in lieu of taxi services; i.e., to take the patient to the hospital for treatment or therapy when the use of an ambulance is not medically necessary enroute; or when the patient's condition would have permitted use of regular private transportation whether or not the private transportation was actually available.

C. Voluntary ambulances or such vehicles as medicabs and ambicabs do not qualify for benefits.

NOTE: The reference to voluntary ambulance is intended to mean the situation in which the organization that operates the vehicle does not issue a legally binding bill for services rendered but rather requests a contribution. If a legally binding bill is issued, it is not considered a "voluntary" ambulance even if manned (in whole or in part) by voluntary personnel.

D. TRICARE recognizes and will reimburse for two types of ambulance--basic ambulance and advanced life support (ALS) ambulance.

1. A basic ambulance is one that provides transportation plus the equipment and staff needed for such basic services as control of bleeding, splinting fractures, treatment for shock, cardio-pulmonary resuscitation (CPR), delivery of babies, etc.

2. An ALS ambulance has complex specialized life sustaining equipment and equipment for radio-telephone contact with a physician or hospital. They are appropriately equipped and staffed by personnel trained and authorized to administer IVs (intravenous therapy), provide anti-shock trousers, establish and maintain a patient's airway, defibrillate the heart, relieve pneumothorax conditions and perform other advanced life support procedures or services such as cardiac (EKG) monitoring. Typical of this type of ambulance are mobile coronary care units and neonatal transport units.

E. The patient must have been transported to the nearest institution with appropriate facilities for treatment of the injury or illness with the exception of transfers to a Uniformed Service Medical Treatment Facility (USMTF) or Veterans Administration (VA) hospital. Once medical necessity for the ambulance transfer is established, unless the ambulance charge appears excessive or some other reason exists to question the location of the admitting hospital, it can be assumed the nearest hospital was used.

F. Ambulance coverage includes transfers from a beneficiary's place of residence, accident scene or other location, to a USMTF or VA hospital, and for transfers to a USMTF or VA hospital after treatment at, or admission to a civilian hospital. Payment will only be made when the ambulance is ordered by other than USMTF or VA personnel.

G. Allowable charge methodology will be used to adjudicate ambulance claims. Separate prevailing charge profiles are to be developed for basic ambulances and for ALS ambulances.

1. Reusable devices and equipment are considered part of the general ambulance services and are to be included in the charge for the trip.
2. A separate charge based on actual quantities used may be recognized for nonreusable items and disposable supplies.
3. For ALS ambulances certain specialized services may also be separately reimbursed.

NOTE: See the [Chapter 13, Section 3.5](#) for additional specific information on reimbursement for ambulance services.

H. Ambulance service by other than land vehicles (e.g., boat, airplane) may be considered only when the point of pick-up is inaccessible by a land vehicle, or great distance or other obstacles are involved in transporting the patient to the nearest hospital with appropriate facilities and the patient's medical condition warrants speedy admission or is such that transfer by other means is contraindicated.

I. Under circumstances in which air ambulance services are approved, the patient's medical condition is frequently so unstable as to require a professional attendant to accompany the patient during the trip. The attendant is usually an RN or LPN but may occasionally be a licensed physician. The nurse or physician may be employed by or under contract to the air ambulance company or may be an independent practitioner. When services to a critically ill patient are rendered by a nurse or physician during the course of an approved air ambulance transfer, benefits may be extended subject to the following conditions:

1. The air ambulance transfer during which the professional services are rendered must itself be covered under the TRICARE guidelines. If the air ambulance is not covered, the services of a medical attendant would not be covered.
2. The provider of service must be an authorized provider (physician, RN, LVN, LPN).
3. The claim must contain sufficient documentation to establish the medical necessity for the medical attendant's services.
4. The air ambulance company may include the professional attendant's services on its bill if the medical attendant is an employee of the ambulance company. In such circumstance, the cost of the medical attendant must be considered as included in the reasonable charge for the air ambulance.
5. The medical attendant who is an individual professional provider in his or her own right and who normally bills on a fee-for-service basis may do so for medical services rendered during an air ambulance transfer. However, Regulation requirements must be met. (For example: physician referral and supervision for services of an RN.)

6. When an air ambulance company bills as an agent for a medical attendant, documentation must be provided before separate payment can be made.

J. Benefits for advanced life support air ambulance (to include attendant) may be preauthorized on an individual case basis by the Medical Director at the time the transplant is preauthorized. Applicable cost-share and deductible requirements as outlined in [Chapter 13, Section 3.5](#) will apply.

NOTE: Managed care support contractors shall retain responsibility for preauthorization and medical review of all claims received for advance life support air ambulance.

K. When land ambulance would have sufficed, the reasonable charge would be limited to the amount which would have been payable for a land ambulance if this amount is less than the air ambulance charge.

IV. POLICY CONSIDERATIONS

A. Ambulance service is not payable when transport or transfer of a patient is primarily for the purpose of having the patient nearer to home, family, friends, or personal physician, with the exception of transfers to a USMTF or VA hospital.

B. Ambulance service is payable for the return of a beneficiary to his/her residence when the condition is such that the use of any other method of transportation is contraindicated; i.e., when the patient can only be moved by means of a stretcher.

C. The following guidelines should be utilized in providing benefits for ambulance services to deceased members:

1. Benefits should not be provided when the member was pronounced dead by a legally authorized individual before the ambulance was called.

2. Benefits should be provided to point of pickup where the member was pronounced dead after the ambulance call, but before pickup.

3. Benefits for the entire ambulance service should be provided to a member who was pronounced dead while enroute to or upon arrival at the destination.

D. Regular monitoring of cost trends and abuses will be conducted by the Office of Program Integrity to assess program impact.

E. The approved procedure codes for payment of ambulance services may be found in the [ADP Manual, Chapter 2, Addendum F, Figure 2-F-1](#).

F. See [OPM Part Two, Chapter 22](#) for information/payment of ambulance services in foreign countries.

V. EXCEPTION

A claim for ambulance service to a USMTF will not be denied on the grounds that there is a nearer civilian institution (hospital) having appropriate facilities to treat the patient.

VI. EFFECTIVE DATE **October 23, 1984.**

Prior to December 23, 1996, ambulance services were limited to "to, from, and between hospitals".

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