CHAPTER 1
SECTION 14

AMBULANCE SERVICES

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I. APPLICABILITY

This policy is mandatory for reimbursement of services provided by either network or non-network providers. However, alternative network reimbursement methodologies are permitted when approved by TMA and specifically included in the network provider agreement.

II. ISSUE

How are ambulance services to be reimbursed?

III. POLICY

A. General.

1. Allowable charge/cost methodology will be used to adjudicate ambulance claims. Information from ambulance companies in each service area is to be used in the development of prevailing base rate screens.

2. In contractor service areas where suppliers routinely bill a mileage charge for ambulance services in addition to a base rate, an additional payment based on prevailing mileage charges may be allowed. Charges for mileage must be based on loaded mileage only, i.e., from the pickup of a patient to his/her destination. It is presumed that all unloaded mileage costs are taken into account when a supplier establishes its basic charge for ambulance services and its rate for loaded mileage.

3. When there are both basic life support (BLS) and advanced life support (ALS) ambulances furnishing services in a state, separate prevailing profiles are to be developed for each type.

a. BLS vs. ALS - There are situations when an advanced life support ambulance is provided but, based on hindsight, it appears that a BLS would have sufficed. In such cases, the question is whether ALS should be billed (since it was provided) or whether BLS should be billed (since that was the minimum service that would have met the patient's needs).

(1) In localities which offer only ALS ambulance service, the type of vehicle used, rather than the level of service, is normally the primary factor in determining TRICARE payments. Therefore, ALS may be billed for all transports if only ALS is offered in the locality. However, if the provider has established a different pattern of billing for the level of service provided, then the contractor may recognize the difference and allow payment to be based upon the level of services rendered rather than the type of vehicle and crew. In other words, in an all ALS environment where the provider has established different billing patterns based on the level of care (e.g., emergency vs. non-emergency), the contractor may allow one amount for emergency and another for non-emergency.

(2) If the company has only ALS vehicles but BLS and ALS vehicles operate in the locality, then it is the level of service required which will determine the amount allowed by TRICARE. Thus, even though the provider transported via ALS, it may be paid ALS or BLS rates, based on the following:

(a) If local ordinances or regulations mandate ALS as the minimum standard of patient transportation, then ALS reimbursement will be made.

(b) If the ALS was the only vehicle available, then the transfer may be reimbursed at the ALS level at the discretion of the contractor.

(c) If the company receives a call and dispatches ALS, although BLS was available, then BLS will be paid if the patient's condition was such that BLS would have sufficed. There must be justification on the claim supporting the use of the ALS ambulance in those areas where both ALS and BLS ambulances are available and no state or local ordinances are in effect mandating ALS as the minimum standard transport.

b. Information will be shared among the Managed Care Support Contractors (MCSCs) regarding local and state ordinances/laws affecting payment of advanced life support ambulance transfers within their respective jurisdictional areas/regions, the sharing of this information among MCSCs should allow for the accurate processing and payment of beneficiaries traveling outside their contract areas.

4. For ambulance transportation to or from a skilled nursing facility (SNF), the provisions in Chapter 8, Section 2, paragraph IV.C.13.e. will apply to determine if ambulance costs are included in the SNF prospective payment system (PPS) rate.

B. Charges made in addition to base rates and mileage charges. The following guidelines shall be used when an ambulance supplier bills for other than the base rate and a mileage charge.

1. Reusable devices and equipment such as backboards, neckboards and inflatable leg and arm splints are considered part of the general ambulance services and shall be included in the cost of, or charge for, the trip. Any additional charge for such items is to be denied.

2. A separate reasonable charge based on actual quantities used may be recognized for non-reusable items and disposable supplies such as oxygen, gauze, dressings and disposable linens required in the care of the patient during his trip.

3. When separate charges are billed for specific covered ALS services, allowable charge profiles for each such service should be developed. When a claim is filed for any one or a combination of such covered services, the maximum allowable charge for the total ambulance service will be the sum of the allowable amounts for the supplier's base rate, any mileage charges, and the specific specialized service(s). When the contractor does not have a profile for the specialized service, it may use the profile for an equivalent service as a guideline for determining an appropriate allowance. For example, if an ambulance supplier submits a separate additional charge for covered EKG monitoring and the contractor does not have a prevailing profile for such charges submitted by an ambulance supplier, the contractor may use the profiles for CPT[1] procedures codes 93012 and 93270 as guidelines for determining the allowable amount.

4. Although separate charges may be allowed for specific ALS services, no separate charge can be allowed for the personnel manning the ALS, even though they are obviously more highly qualified than the personnel in a basic ambulance. Their costs are to be included in the base and mileage charges with the exception of paramedic ALS intercept services (PI) under the following conditions:

a. Be furnished in an area that is designated as a rural area by any law or regulation of the State or that is located in a rural census tract of a metropolitan area.

b. Be furnished under contract with one or more volunteer ambulance services that meet the following conditions:

(1) Are certified to furnish ambulance services;

(2) Furnish services only at the BLS level; and

(3) Are prohibited by State law from billing for any service.

c. Be furnished by a paramedic ALS intercept supplier that meets the following conditions:

(1) Is certified to furnish ALS services.

(2) Bills all the recipients who receive ALS intercept services for the entity, regardless of whether or not those recipients are Medicare beneficiaries.

C. The cost-sharing of ambulance services and supplies will be in accordance with the status of the patient at the time the covered services and supplies are rendered (32 CFR 199.4(a)(4)).

1. Ambulance transfers from a beneficiary's place of residence, accident scene, or other location to a civilian hospital, MTF, VA hospital, or SNF will be cost-shared on an outpatient basis. Transfers from a hospital or SNF to a patient's residence will also be considered an outpatient service for reimbursement under the program. A separate cost-

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share does not apply to ambulance transfers to or from a SNF, if the costs for ambulance transfer are included in the SNF PPS rate (see Chapter 8, Section 2, paragraph IV.C.13.e.).

2. Ambulance transfers between hospitals (acute care, general, and special hospitals; psychiatric hospitals; and long-term hospitals) and SNFs will be cost-shared on an inpatient basis. The following guidelines are consistent with the inpatient deductible and cost-sharing provisions provided in Chapter 2, Section 1, paragraph I.B. and E.:

a. Deductible Amount Inpatient: None.

b. Cost-Share Amount Inpatient (Non-Network Providers).

(1) Active Duty Dependent: No cost-share is taken for ambulance services (transfers) rendered in conjunction with an inpatient stay.

(2) Other Beneficiary: The cost-share applicable to inpatient care for other than active duty dependent beneficiaries is twenty-five percent (25%) of the TRICARE/ CHAMPUS-determined allowable amount.

3. Under the above provisions, for ambulance transfers between hospitals, a nonparticipating provider may bill the beneficiary the lower of the provider's billed charge or 115 percent of the TRICARE/CHAMPUS allowable charge.

4. Transfers to a MTF, VA hospital, or SNF after treatment at, or admission to, an emergency room or civilian hospital will be cost-shared on an inpatient basis, if ordered by either civilian or military personnel.

5. Medically necessary ambulance transfers from an emergency room (ER) to a hospital more capable of providing the required level of care will also be cost-shared on an inpatient basis.

NOTE: This is consistent with current policy of cost-sharing ER services as inpatient when an immediate inpatient admission for acute care follows the outpatient ER treatment.

IV. POLICY CONSIDERATIONS

A. Ambulance Membership Programs.

1. Ambulance membership programs typically charge an annual fee for a subscription to an ambulance service. The ambulance provider agrees to accept assignment on all benefits from third party payers for medically necessary services. By paying the annual fee, the covered family members pay no additional fees (including third party cost-shares and deductibles) to the ambulance service.

2. When a beneficiary pays premiums to a pre-paid ambulance plan, the premiums are considered to fulfill the beneficiary's cost-share and deductible requirements. Under this arrangement, the ambulance membership program becomes analogous to a limited supplemental plan.

B. When an ambulance company bills a flat fee for ambulance transport within its service area, reimbursement will be at the lesser of the billed amount (flat fee) or the statewide prevailing for HCPCS A0426 through A0429 subject to applicable beneficiary cost-sharing.

C. The TRICARE/CHAMPUS national allowable charge system used to reimburse professional services does not apply to ambulance claims. The above reimbursement guidelines are to be used by the contractors.

D. Itemization requirements are dictated by the particular HCPCS codes used in filing an ambulance claim.

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