

Ambulance Services

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Authority: [32 CFR 199.4\(d\)\(3\)\(v\)](#), [32 CFR 199.14\(j\)\(1\)\(i\)\(A\)](#), and [10 USC 1079\(h\)\(1\)](#)

1.0 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 the TRICARE Management Activity (TMA) and specifically included in the network provider agreement.

2.0 ISSUE

How are ambulance services to be reimbursed?

3.0 POLICY

3.1 For coverage policy on ambulance services, refer to the TRICARE Policy Manual (TPM), Chapter 8, Section 1.1.

3.1.1 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.

3.1.2 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.

3.1.3 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).

3.1.4 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

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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.

3.1.5 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:

- If local ordinances or regulations mandate ALS as the minimum standard of patient transportation, then ALS reimbursement will be made.
- If the ALS was the only vehicle available, then the transfer may be reimbursed at the ALS level at the discretion of the contractor.
- 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.

3.1.6 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.

3.1.7 For ambulance transportation to or from a Skilled Nursing Facility (SNF), the provisions in [Chapter 8, Section 2, paragraph 4.3.13.5](#) will apply to determine if ambulance costs are included in the SNF Prospective Payment System (PPS) rate.

3.2 Reimbursement

For ambulance services provided on or after October 1, 2013, TRICARE adopts Medicare's Ambulance Fee Schedule (AFS) as the TRICARE CHAMPUS Maximum Allowable Charge (CMAC) for ambulance services, in accordance with [32 CFR 199.14\(j\)\(1\)\(i\)\(A\)](#). TRICARE will follow Medicare Claims Processing Manual, Chapter 15, and reimbursement shall be based on Medicare's AFS, **except as provided under [paragraph 3.2.1](#) during TRICARE's transition to the fully phased-in Medicare AFS.** The AFS is provided on the Centers for Medicare and Medicaid Services (CMS) web site at <http://www.cms.gov/medicare/medicare-fee-for-service-payment/ambulancefeeschedule/index.html?redirect=/ambulancefeeschedule>.

3.2.1 TRICARE Transition to Medicare AFS for Air Ambulance Services

3.2.1.1 Air ambulance service from October 1, 2013 through September 30, 2014 shall be paid in accordance with [Chapter 5, Section 1](#).

3.2.1.2 Contractors shall establish a base year rate for purposes of calculating reimbursement rates during the transition to reimbursement based on Medicare's AFS, applicable to air ambulance services on or after October 1, 2014. The base year rate, calculated by state, shall be either 1) the

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actual state prevailing rate in effect on September 30, 2013, or 2) for air ambulance codes without a state prevailing rate in effect on September 30, 2013, a specially calculated state prevailing rate. The specially calculated state prevailing rate shall use claims data from July 1, 2013 through June 30, 2014; if there is an insufficient number of claims during this period to establish the rate, the contractor shall include claims data from July 1, 2012 through June 30, 2013 for that state.

3.2.1.3 Air ambulance services on or after October 1, 2014, shall be paid the greater of the Medicare AFS or the TRICARE provisional air ambulance CMAC. For the initial transition period of October 1, 2014 through December 31, 2015, the TRICARE provisional air ambulance CMAC shall be calculated as 85% of the base year rate established under paragraph 3.2.1.2. For each subsequent year of transition beginning January 1, 2016, the TRICARE provisional air ambulance CMAC shall be calculated by reducing the base year rate an additional 15% per year until the TRICARE provisional CMAC equals the Medicare AFS. (For example, the provisional CMAC beginning January 1, 2016, shall be 72.25% (0.85×0.85) of the base year rate; beginning January 1, 2017, 61.4% ($0.85 \times 0.85 \times 0.85$) etc.) Once the provisional CMAC equals the AFS, the transition period is over and air ambulance services will be reimbursed based on Medicare's AFS.

3.2.2 Payment Under the AFS

- Includes a base rate payment plus a separate payment for mileage;
- Covers both the transport of the beneficiary to the nearest appropriate facility and all items and services associated with such transport; and
- Does not include a separate payment for items and services furnished under the ambulance benefit.

Payments for items and services are included in the fee schedule payment. Such items and services include but are not limited to oxygen, drugs, extra attendants, and Electrocardiogram (EKG) testing (e.g., ancillary services) - but only when such items and services are both medically necessary and covered by TRICARE under the ambulance benefit.

3.2.3 Components of the AFS

The mileage rates provided in this section are the base rates that are adjusted by the yearly Ambulance Inflation Factor (AIF). The payment amount under the fee schedule is determined as follows:

3.2.3.1 For ground ambulance services, the fee schedule amount includes:

- A money amount that serves as a nationally uniform base rate, called a "Conversion Factor" (CF), for all ground ambulance services;
- A Relative Value Unit (RVU) assigned to each type of ground ambulance service;
- A Geographic Adjustment Factor (GAF) for each AFS locality area (Geographical Practice Cost Index (GPCI));
- A nationally uniform loaded mileage rate; and

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- An additional amount for certain mileage for a rural point-of-pickup.

3.2.3.2 For air ambulance services, the fee schedule amount includes:

- A nationally uniform base rate for fixed wing and a nationally uniform base rate for rotary wing;
- A GAF for each AFS locality area (GPCI);
- A nationally uniform loaded mileage rate for each type of air service; and
- A rural adjustment to the base rate and mileage for services furnished for a rural point-of-pickup.

3.2.4 Zip Code/Point of Pickup

All claims for services must include the zip code for the point of pickup. The provider shall report one valid and accurate zip code on each claim. Refer to the Medicare Claims Processing Manual, Chapter 15, for zip code requirements at <http://www.cms.gov/manuals/downloads/clm104c15.pdf>, and the zip code file at <http://www.cms.gov/medicare/medicare-fee-for-service-payment/ambulancefeeschedule/index.html?redirect=/ambulancefeeschedule>.

3.2.5 Effect of Beneficiary Death on TRICARE Payment for Ground Ambulance Transports

Because the TRICARE ambulance benefit is a transport benefit, if no transport of a beneficiary occurs, then there is no TRICARE-covered service. In general, if the beneficiary dies before being transported, then no TRICARE payment may be made. Thus, in a situation where the beneficiary dies, whether any payment under the TRICARE ambulance benefit may be made depends on the time at which the beneficiary is pronounced dead by an individual authorized by the State to make such pronouncements. Figure 1.14-1 shows the TRICARE payment determination for various ground ambulance scenarios in which the beneficiary dies. In each case, the assumption is that the ambulance transport would have otherwise been medically necessary.

FIGURE 1.14-1 GROUND AMBULANCE SCENARIOS IN WHICH THE BENEFICIARY DIES

TIME OF DEATH PRONOUNCEMENT	TRICARE PAYMENT DETERMINATION
Before dispatch.	None.
After dispatch, before beneficiary is loaded onboard ambulance (before or after arrival at the point-of-pickup).	The provider's/supplier's BLS base rate, no mileage or rural adjustment; use the QL modifier when submitting the claim.
After pickup, prior to or upon arrival at the receiving facility.	Medically necessary level of service furnished.

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dead by an individual authorized by the State to make such pronouncements. Figure 1.14-2 shows the TRICARE payment determination for various air ambulance scenarios in which the beneficiary dies. In each case, the assumption is that the ambulance transport would have otherwise been medically necessary. If the flight is aborted for other reasons, such as bad weather, the TRICARE payment determination is based on whether the beneficiary was onboard the air ambulance.

FIGURE 1.14-2 AIR AMBULANCE SCENARIOS IN WHICH THE BENEFICIARY DIES

TIME OF DEATH PRONOUNCEMENT	TRICARE PAYMENT DETERMINATION
Prior to takeoff to point-of-pickup with notice to dispatcher and time to abort the flight.	None. Note: This scenario includes situations in which the air ambulance has taxied to the runway, and/or has been cleared for takeoff, but has not actually taken off.
After takeoff to point-of-pickup, but before beneficiary is loaded.	Appropriate air base rate with no mileage or rural adjustment; use the QL modifier when submitting the claim.
After the beneficiary is loaded onboard, but prior to or upon arrival at the receiving facility.	As if the beneficiary had not died.

3.2.7 Air Ambulance Transport Cancelled Due to Weather or Other Circumstances Beyond the Pilots Control

Figure 1.14-3 shows the TRICARE payment determination for various air ambulance scenarios in which the flight is aborted due to bad weather, or other circumstances beyond the pilot's control.

FIGURE 1.14-3 AIR AMBULANCE SCENARIOS IN WHICH THE FLIGHT IS ABORTED

ABORTED FLIGHT SCENARIO	TRICARE PAYMENT DETERMINATION
Any time before the beneficiary is loaded onboard (i.e., prior to or after take-off to point-of-pickup).	None.
Transport after the beneficiary is loaded onboard.	Appropriate air base rate, mileage, and rural adjustment.

3.2.8 Multiple Patient Ambulance Transport

3.2.8.1 If two patients are transported to the same destination simultaneously, for each TRICARE beneficiary, TRICARE will allow 75% of the payment allowance for the base rate applicable to the level of care furnished to that beneficiary plus 50% of the total mileage payment allowance for the entire trip. The **GM** modifier will be used for reporting multiple patients on one ambulance trip.

3.2.8.2 If three or more patients are transported to the same destination simultaneously, then the payment allowance for the TRICARE beneficiary (or each of them) is equal to 60% of the base rate applicable to the level of care furnished to the beneficiary. However, a single payment allowance for mileage will be prorated by the number of patients onboard. This policy applies to both ground and air transports.

3.2.9 Special Payment Limitations

If the determination is made that transport by air ambulance was necessary, but ground ambulance service would have sufficed, payment for the air ambulance service is based on the amount payable for ground transport, if less costly. If the air transport was medically appropriate

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(that is, ground transportation was contraindicated, and the beneficiary required air transport to a hospital), but the beneficiary could have been treated at a nearer hospital than the one to which they were transported, the air transport payment is limited to the rate for the distance from the point of pickup to that nearer hospital.

3.3 No separate charge is allowed for personnel manning the ALS. ALS personnel costs are included in the base and mileage charges with the exception of paramedic ALS intercept services (PI) under the following conditions:

3.3.1 Care 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.

3.3.2 Care furnished under contract with one or more volunteer ambulance services that meet the following conditions:

- Certified to furnish ambulance services;
- Furnish services only at the BLS level; and
- Are prohibited by State law from billing for any service.

3.3.3 Care furnished by a paramedic ALS intercept supplier that meet the following conditions:

- Certified to furnish ALS services.
- Bills all the recipients who receive ALS intercept services for the entity, regardless of whether or not those recipients are TRICARE beneficiaries.

3.4 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\(a\)\(4\)](#)).

3.4.1 Ambulance transfers from a beneficiary's place of residence, accident scene, or other location to a civilian hospital, Military Treatment Facility (MTF), Veterans Affairs (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-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 4.3.13.5](#)).

3.4.2 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.

3.4.3 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% of the TRICARE allowable charge.

3.4.4 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.

3.4.5 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. 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.

3.4.6 Cost-share amounts for ambulance services are included in [Chapter 2, Section 1](#).

4.0 POLICY CONSIDERATIONS

4.1 Ambulance Membership Programs

4.1.1 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.

4.1.2 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.

4.2 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 Healthcare Common Procedure Coding System (HCPCS) codes A0426 through A0429 subject to applicable beneficiary cost-sharing.

4.3 The TRICARE 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.

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

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