CLINICAL MEDICAL POLICY	
Policy Name:	Ambulance Services (Ground) (L35162)
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Responsible Department(s):	Medical Management
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Retirement Date:	09/01/2023
Products:	Pennsylvania Medicare Assured
Application:	All participating and nonparticipating hospitals and providers
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Policy History

Date	Activity
09/01/2023	Policy Retirement date
06/19/2023	QI/UM Committee review
06/21/2023	Annual Review: Policy to be retired as CMS LCD/LCA policies were retired as of 02/09/2023.
10/01/2022	Provider Effective date
07/20/2022	QI/UM Committee review
07/20/2022	Annual Review: No changes to clinical criteria. The following ICD-10 code has been deleted and therefore has been removed from the article: M54.5 from Group 1 Codes. The following ICD-10-CM codes have been added: M54.50 and M54.51 to Group 1 Codes. Updated 'Reference Sources' section.
09/20/2021	Provider effective date
07/21/2021	QI/UM Committee review
07/21/2021	Annual Review: No changes to clinical criteria. The following ICD-10-CM codes have been removed from the Group 1 Codes: O99.89 and R51. The following ICD-10-CM code(s) have been added to the Group 1 Codes: M79.602, O99.891, O99.892, O99.893 and R51.0. Updated Reference section. Removed 'Paramedic Intercept Services' definition. Policy changed from postservice/post-payment to pre service/prepayment
09/07/2020	Provider effective date
07/15/2020	QI/UM Committee Review

07/15/2020	Annual Review: Removed all hyperlinks; Updated reference section.
09/16/2019	Provider Effective Date
07/17/2019	QI/UM Committee Review
07/17/2019	Annual Review: Changed attachment A "coding information" to "Local Coverage Article: Billing and Coding: Ambulance Services (A54574)"; replaced the word "beneficiary" with the word "patient"; added article guidance in Attachment A; formatting revisions; added reference; revised reference
09/15/2018	Provider effective date
07/18/2018	QI/UM Committee review
06/21/2018	Initial policy developed

Disclaimer

Highmark Wholecare℠ medical policy is intended to serve only as a general reference resource regarding coverage for the services described. This policy does not constitute medical advice and is not intended to govern or otherwise influence medical decisions.

Policy Statement

Highmark Wholecare℠ may provide coverage under the medical-surgical benefits of the Company's Medicare products for medically necessary ground ambulance transportation.

This policy is designed to address medical necessity guidelines that are appropriate for the majority of individuals with a particular disease, illness or condition. Each person's unique clinical circumstances warrant individual consideration, based upon review of applicable medical records.

Definitions

Ground BLS (Basic Life Support) Ambulance Service – The transportation by ground ambulance vehicle and the provision of medically necessary supplies and services, including BLS ambulance services as defined by the state. The ambulance must be staffed by an individual who is qualified in accordance with state and local laws as an EMT-Basic (emergency medical technician-basic). These laws may vary from state to state or within a state. For example, only in some jurisdictions is an EMT-Basic permitted to operate limited equipment onboard the vehicle, assist more qualified personnel in performing assessments and interventions, and establish a peripheral IV (intravenous) line.

Ground ALS1 (Advanced Life Support, Level 1) – The transportation by ground ambulance vehicle and the provision of medically necessary supplies and services including the provision of an ALS assessment or at least one ALS intervention.

An advanced life support (ALS) assessment is an assessment performed by an ALS crew as part of an emergency response that was necessary because the patient's reported condition at the time of dispatch was such that only an ALS crew was qualified to perform the assessment. An ALS assessment does not necessarily result in a determination that the patient requires an ALS level of service.

An ALS intervention is a procedure that is in accordance with state and local laws, required to be done by an EMT-Intermediate (emergency medical technician-intermediate) or EMT-Paramedic.

ALS1 – Emergency – When medically necessary, the provision of ALS1 services, as specified above, in the context of an emergency response. An emergency response is one that, at the time the ambulance provider or supplier is called, it responds immediately. An immediate response is one in which the ambulance provider/supplier begins as quickly as possible to take the steps necessary to respond to the call.

Ground ALS2 (Advanced Life Support, Level 2) – An ALS2 is the transportation by ground ambulance vehicle and the provision of medically necessary supplies and services including (1) at least three separate administrations of one or more medications by intravenous push/bolus or by continuous infusion *(excluding crystalloid fluids)* or (2) ground ambulance transport, medically necessary supplies and services, and the provision of at least one of the ALS2 procedures listed below:

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

Specialty Care Transport (SCT) – The interfacility transportation of a critically injured or ill patient by a ground ambulance vehicle, including the provision of medically necessary supplies and services, at a level of service beyond the scope of the EMT-Paramedic. SCT is necessary when a patient's condition requires ongoing care that must be furnished by one or more health professionals in an appropriate specialty area. For example, emergency or critical care nursing, emergency medicine, respiratory care, cardiovascular care, or an EMT-Paramedic with additional training. The EMT-Paramedic level of care is set by each state. Medically necessary care that is furnished at a level above the EMT-Paramedic level of care may qualify as SCT.

Procedures

1. Highmark Wholecare considers ambulance services medically necessary only if furnished to a patient whose medical condition at the time of transport is such that transportation by other means would endanger the patient's health. A patient whose condition permits transport in any type of vehicle other than an ambulance does not qualify for payment. Payment for ambulance transportation depends on the patient's condition at the actual time of the transport regardless of the patient's diagnosis. For the ambulance service to be deemed medically necessary for payment, the patient must require both the transportation and the level of service provided.

    A. Highmark Wholecare covers both emergency ambulance transportation and non-emergency ambulance transportation when ALL of the following conditions:
        1) The patient's condition requires the vehicle itself or the specialized services of the trained ambulance personnel; AND
        2) The needed services of the ambulance personnel were provided; AND
        3) Clear clinical documentation validates the personnel's medical need and their provision in the record of the service (usually the run sheet).

B. Highmark Wholecare will cover emergency ambulance services when the services are medically necessary, meet the destination limits of closest appropriate facilities, and are provided by an ambulance service that is licensed by the state. Emergency response means responding immediately at the Basic Life Support (BLS) or Advanced Life Support 1 (ALS1) level of service to a 911 call or the equivalent. An immediate response is one in which the ambulance supplier begins as quickly as possible to take the steps necessary to respond to the call.

Application: The determination to respond emergently with a BLS or ALS1 ambulance must be in accord with the local 911 or equivalent service dispatch protocol (ALS2 has additional requirements). If the call came in directly to the ambulance provider/supplier, then the provider's/supplier's dispatch protocol must meet, at a minimum, the standards of the dispatch protocol of the local 911 or equivalent service. In areas that do not have a local 911 or equivalent service, the protocol must meet, at a minimum, the standards of a dispatch protocol in another similar jurisdiction within the state or, if there is no similar jurisdiction within the state, the standards of any other dispatch protocol within the state. Where the dispatch was inconsistent with this standard of protocol, including where no protocol was used, the patient's condition (for example, symptoms) at the scene determines the appropriate level of payment.

The patient's condition is an emergency that renders the patient unable to be safely transported to the hospital in a moving vehicle (other than in an ambulance) for the amount of time required to complete the transport. Emergency ambulance services are services provided after the sudden onset of a medical condition. For the purposes of this medical policy, acute signs or symptoms of sufficient severity must manifest the emergency medical condition such that the absence of immediate medical attention could reasonably be expected to result in one or more of the following:

- Place the patient's health in serious jeopardy.
- Cause serious impairment to bodily functions.
- Cause serious dysfunction of any body organ or part.

C. Non-Emergency Ambulance Service
Ambulance services are covered in the absence of an emergency condition in either of the two general categories of circumstances that follow:

- The patient being transported has, at the time of ground transport, a condition such that all other methods of ground transportation (e.g., taxi, private automobile, wheelchair van, or other vehicle) are contraindicated. In this circumstance, contraindicated means that the patient cannot be transported by any other means from the origin to the destination without endangering the individual's health. Having or having had a serious illness, injury, or surgery does not necessarily justify payment for ambulance transportation, thus a thorough assessment and documented description of the patient's current state is essential for coverage. All statements about the patient's medical condition must be validated in the documentation using contemporaneous objective observations and findings. See medical conditions below for examples of findings required for coverage of ambulance transportation.

- The patient is before, during and after transportation, bed confined. For the purposes of this medical policy, "bed confined" means the patient must meet all of the following three criteria:
  - Unable to get up from bed without assistance.
  - Unable to ambulate.

- Unable to sit in a chair (including a wheelchair).

As stated above, statements about the patient's bed-bound status must be validated in the record with contemporaneous objective observations and findings as to the patient's functional physical or mental limitations that have rendered him bed-bound.

Non-emergency ambulance transportation is not covered for patients who are restricted to bed rest by a physician's instructions but who do not meet the above three criteria. If some means of transportation other than an ambulance (e.g., private car, wheelchair van, etc.) could be utilized without endangering the individual's health, whether such other transportation is actually available, no payment may be made for ambulance service.

Non-emergency ambulance services may be those that are scheduled in advance – scheduled services being either repetitive or non-repeating.

Non-emergency ambulance transportation is not covered if transportation is provided for the patient who is transported to receive a service that could have been safely and effectively provided in the point of origin (residence, Skilled Nursing Facility [SNF], hospital, etc.). Such transportation is not covered even if the patient could only have gone for the service by ambulance.

Ambulance transportation for services excluded from SNF consolidated billing must meet the criteria as reasonable and necessary as indicated in non-emergency ambulance services above.

Ambulance transports to or from an Independent Diagnostic Testing Facility (IDTF) are considered paid in the SNF Prospective Payment System (PPS) rate when the patient is in a covered Part A stay, and may not be paid separately as Part B services. The ambulance transport is included in the SNF PPS rate if the first or second character (origin or destination) of any HCPCS code ambulance modifier is "D" (diagnostic or therapeutic site other than "P" or "H"), and the other modifier (origin or destination) is "N" (SNF). In this instance, the SNF is responsible for the costs of the transport. The "D" origin/destination modifier includes cancer treatment centers, wound care centers, radiation therapy centers, and all other diagnostic or therapeutic sites.

D. Destination

For ambulance services to be a covered benefit, the transport must be to the nearest institution with appropriate facilities for the treatment of the illness or injury involved. The term "appropriate facilities" means that the institution is generally equipped to provide hospital care necessary to manage the illness or injury involved. It is the institution, its equipment, its personnel, and its capability to provide the services necessary to support the required medical care that determine whether it has appropriate facilities. The fact that a more distant institution may be better equipped (either subjectively or quantitatively) does not mean that the closer institution does not have "appropriate facilities." In the case of a hospital, it also means that a physician or a physician specialist is available to provide the necessary care required to treat the patient's condition. However, the fact that a particular physician does or does not have staff privileges in a hospital is not a consideration in determining whether the hospital has appropriate facilities. Thus, ambulance service to a more distant hospital solely to avail a patient of the service of a specific physician or physician specialist does not make the hospital in which the physician has staff privileges the nearest hospital with appropriate facilities. However, a legal impediment that bars the patient's admission would preclude that institution from having "appropriate

facilities." For example, if the nearest appropriate specialty hospital is in another state, and that state's law precludes admission of non-residents, that facility is not an "appropriate facility."

An institution is also not considered an appropriate facility if there is no bed available. The carrier, however, will presume there are beds available at the local institutions unless the claimant furnished evidence that none of these institutions had a bed available at the time the ambulance service was provided.

In the case of ambulance services to a facility other than the closest appropriate facility, only those miles to the closest facility are eligible for coverage.

- Covered destinations for emergency ambulance services include:
  - Hospitals
  - Physician's office only if during an emergency transportation to a hospital the ambulance stops at a physician's office en route due to a dire need for professional attention and thereafter continues to the hospital. In such cases, the patient is deemed not to have been transported to the physician's office and payment may be made for the entire trip.
- Covered destinations for "non-emergency" transports include:
  - Hospitals ("appropriate facility")
  - Skilled nursing facilities
  - Dialysis facilities – Ambulance services furnished to a maintenance dialysis patient only when the patient's condition at the time of transport requires ambulance services
  - From an SNF to the nearest supplier of medically necessary services not available at the SNF where the patient is a resident, including the return trip (for instance, cardiac catheterization; specialized diagnostic imaging procedures such as computerized axial tomography or magnetic resonance imaging; surgery performed in an operating room; specialized wound care; cancer treatments) when the patient's condition at the time of transport requires ambulance services
  - The patient's residence only if the transport is to return from an "appropriate facility" and the patient's condition at the time of transport requires ambulance services

E. Physician Certification Statement (PCS)

For scheduled and non-scheduled non-emergency ambulance transports, providers of ambulance transportation must obtain a written statement (PCS) from the patient's attending physician certifying that medical necessity requirements for ambulance transportation are met. The signature of the medical professional completing the PCS must be legible (or accompanied by a typed or printed name) and include credentials. Furthermore, signatures on the PCS must be dated at the time they are completed. A PCS is not required for emergency transports or for non-scheduled non-emergency transports of patients residing at home or in facilities where they are not under the direct care of a physician. ***It is important to note that the mere presence of the signed physician certification statement does not, by itself, demonstrate that the transport was medically necessary and does not absolve the ambulance provider from meeting all other coverage and documentation criteria.***

For non-repetitive non-emergency transports, the following apply:

- The PCS must be obtained from the attending physician within 48 hours after the transport.
- If the ambulance provider is unable to obtain the PCS from the attending physician within 48 hours of transport, the provider may submit a claim if a certification has been obtained from a Physician Assistant (PA), Nurse Practitioner (NP), Clinical Nurse Specialist (CNS), Registered Nurse (RN) or discharge planner who is knowledgeable about the patient's condition and who

is employed by either the attending physician or the facility in which the patient is admitted. (Please note that the term "admitted" does not necessarily mean admission to inpatient status. It also includes acceptance for care at an Emergency Room, ESRD Facility, etc., implying transfer of care).

- Alternatively, the provider may submit the claim after 21 days if there is documentation of a good faith effort to obtain the order and certification. The ambulance supplier must document efforts to obtain certification. When the PCS cannot be obtained, the provider/supplier may send a letter via U.S. Postal Service certified mail with return receipt or proof of mailing or other similar service demonstrating delivery of the letter as evidence of the attempt to obtain the PCS.

For repetitive non-emergency transports, the following apply:

- A PCS for repetitive transports must be signed by the patient's attending physician.
- The PCS must be dated no earlier than 60 days in advance of the transport for those patients who require repetitive ambulance services and whose transportation is scheduled in advance.

F. Tables of Medical Conditions

The medical condition tables listed below illustrate the expectations with respect to the severity of the patient's condition to justify payment for ambulance transportation services when all other coverage and payment conditions are met. Though not all-inclusive, the following tables list the medical conditions for which ambulance transportation is commonly required and can be used to judge relative severity of conditions not listed.

Highmark Wholecare requires the run report to include a description of the patient's symptoms and physical findings in sufficient detail as to demonstrate conditions such as those described in the tables.

- Special Note Regarding Patients Transported To and From Hemodialysis Centers:
  Only a fraction (approximately 10 percent) of End Stage Renal Disease (ESRD) patients on chronic hemodialysis require ambulance transportation to and from hemodialysis sessions. The presence of ESRD and the requirement for hemodialysis do not alone qualify a patient for ambulance transportation. Payment requires patients transported to and from hemodialysis centers to have other conditions such as those described in the tables below and requires adequate documentation of those conditions in the ambulance supplier's run reports and in the medical records of other providers involved with the patient's care.

Ambulance Services (Ground Ambulance) Medical Conditions

Complaint or Symptom	Condition Requirement	Examples of Symptoms and Findings Necessary (and Documented) for Coverage
Abdominal Pain	Accompanied by other signs or symptoms	Associated symptoms include nausea, vomiting, fainting. Associated signs include tender or pulsatile mass, distention, rigidity, rebound tenderness on exam, guarding.
Abdominal cardiac rhythm / cardiac dysrhythmia	Symptomatic or potentially life-threatening arrhythmia	Necessary symptoms include syncope or near syncope, chest pain and dyspnea. Signs required include severe bradycardia or tachycardia (rate < 60 or > 120), signs of congestive heart failure. Examples include junctional and ventricular rhythms, non-sinus tachycardias, PVCs > 6/min, bi- and trigeminy, ventricular tachyarrhythmias, PEA, asystole.

Complaint or Symptom	Condition Requirement	Examples of Symptoms and Findings Necessary (and Documented) for Coverage
		Patients are expected to have conditions that require monitoring during and after transportation.
Abnormal skin signs		Includes diaphoresis, cyanosis, delayed capillary refill, diminished skin turgor, mottled skin. Presence of other emergency conditions
Alcohol or drug intoxication	Severe intoxication	Unable to care for self. Unable to ambulate. Altered level of consciousness. Airway may or may not be at risk.
Allergic reaction	Potentially life-threatening manifestations	Includes rapidly progressive symptoms, prior history of anaphylaxis, wheezing, oral / facial / laryngeal edema
Animal bites /sting / envenomation	Potentially life- or limb-threatening	Symptoms of specific envenomation, significant face, neck, trunk and extremity involvement. Special handling and/or monitoring required. Presence of other emergency conditions.
Sexual assault	With significant external and/or internal injuries	
Blood glucose	Abnormal <80 or >250 **with symptoms**	Signs include altered mental status (altered beyond baseline function), vomiting, significant volume contraction, and significant cardiac dysfunction.
Back pain (see general pain listing below)	Sudden onset, severe non-traumatic pain suggestive of cardiac or vascular origin or requiring special positioning only available by ambulance	7-10 on 10-point severity scale. Neurologic symptoms and/or signs, absent leg pulses, pulsatile abdominal mass, concurrent chest or abdominal pain
Respiratory arrest		Includes apnea or hypoventilation requiring ventilatory assistance and airway management
Respiratory distress, shortness of breath, need for supplemental oxygen	Objective evidence of abnormal respiratory function	Includes tachypnea, labored respiration, hypoxemia requiring oxygen administration. Includes patients who require advanced airway management such as ventilator management, apnea monitoring for possible intubation and deep airway suctioning. Includes patients who require positioning not possible in other conveyance vehicles. **Note that oxygen administration absent signs or symptoms of respiratory distress is, by itself, an inadequate reason to justify ambulance transportation in a patient capable of self-administration of oxygen**. Patient must require oxygen therapy and be so frail as to require assistance of medically trained personnel.
Cardiac arrest with resuscitation in progress		

Complaint or Symptom	Condition Requirement	Examples of Symptoms and Findings Necessary (and Documented) for Coverage
Chest pain (non-traumatic)	Cardiac origin suspected. Obvious non-emergent cause not identified	Pain characterized as severe, tight, dull or crushing, substernal, epigastric, left-sided chest pain. Especially with associated pain of the jaw, left arm, neck, back, GI symptoms (such as nausea, vomiting), arrhythmias, palpitations, difficulty breathing, pallor, diaphoresis, alteration of consciousness. Atypical pain accompanied by nausea and vomiting, severe weakness, feeling of impending doom or abnormal vital signs.
Choking episode	Respiratory or neurologic impairment	
Cold exposure	Potentially life- or limb-threatening	Findings include temperature < 95° F, signs of deep frost bite or presence of other emergency conditions.
Altered level of consciousness (non-traumatic)	Neurologic dysfunction in addition to any baseline abnormality	Acute condition with Glasgow Coma Scale <15 or transient symptoms of dizziness associated with neurologic or cardiovascular symptoms and/or signs or abnormal vital signs
Convulsions / seizures	Active seizing or immediate post-seizure at risk of repeated seizure and requires medical monitoring / observation	Conditions include new onset or untreated seizures or history of significant change in baseline control of seizure activity. Findings include ongoing seizure activity, postictal neurologic dysfunction.
Non-traumatic headache	Associated neurologic signs and/or symptoms or abnormal vital signs	
Heat exposure	Potentially life-threatening	Findings include hot and dry skin, core temperature >105° F, neurologic dysfunction, muscle cramps, profuse sweating, severe fatigue.
Hemorrhage	Potentially life-threatening	Includes uncontrolled bleeding with signs of shock and active severe bleeding (quantity identified) ongoing or recent with potential for immediate re-bleeding.
Infectious diseases requiring isolation procedures/public health risk	The nature of the infection or the behavior of the patient must be such that failure to isolate poses significant risk of spread of a contagious disease.	Infections in this category are limited to those infections for which isolation is provided both before and after transportation.
Hazardous substance exposure	The nature of the exposure should be such that potential injury is likely.	Toxic fume or liquid exposure via inhalation, absorption, oral, radiation, smoke inhalation
Medical device failure	Life- or limb-threatening malfunction, failure or complication	Malfunction of ventilator, internal pacemaker, internal defibrillator, implanted drug delivery device, O_2 supply malfunction, orthopedic device failure
Neurologic dysfunction	Acute or unexplained neurologic dysfunction in addition to any baseline abnormality	Signs include facial drooping, loss of vision without ophthalmologic explanation, aphasia, dysphasia, difficulty swallowing, numbness, tingling extremity, stupor, delirium,

Complaint or Symptom	Condition Requirement	Examples of Symptoms and Findings Necessary (and Documented) for Coverage
		confusion, hallucinations, paralysis, paresis (focal weakness), abnormal movements, vertigo, and unsteady gait/balance.
Pain not otherwise specified in this table	Pain is the reason for the transport. Acute onset or bed confining.	Pain is severity of 7-10 on 10-point severity scale despite pharmacologic intervention. Patient needs specialized handling to be moved. Other emergency conditions are present or reasonably suspected. Signs of other life- or limb-threatening conditions are present. Associated cardiopulmonary, neurologic, or peripheral vascular signs and symptoms are present.
Poisons ingested, injected, inhaled or absorbed, alcohol or drug intoxication	Potentially life-threatening	Requires cardiopulmonary and/or neurologic monitoring and support and/or urgent pharmacologic intervention. Includes circumstances in which quantity and identity of agent known to be life-threatening; instances in which quantity and identity of agent are not known but there are signs and symptoms of neurologic dysfunction, abnormal vital signs, or abnormal cardiopulmonary function. Also, includes circumstances in which quantity and identity of agent are not known but life-threatening poisoning reasonably suspected.
Complication of pregnancy / childbirth and postoperative procedure complications	Requires special handling for transport	Includes major wound dehiscence, evisceration, organ prolapse, hemorrhage or orthopedic appliance failure
Psychiatric / behavioral	Is expressing active signs and/or symptoms of uncontrolled psychiatric condition or acute substance withdrawal. Is a threat to self or others requiring restraint (chemical or physical) or monitoring and/or intervention of trained medical personnel during transport for patient and crew safety. Transport is required by state law / court order.	Includes disorientation, suicidal ideations, attempts and gestures, homicidal behavior, hallucinations, violent or disruptive behavior, sign / symptoms or DTs, drug withdrawal signs / symptoms, severe anxiety, acute episode or exacerbation of paranoia. Refer to definition of restraints in the CFR, Section 482.13(e). For behavioral or cognitive risk such that patient requires attendant to assure patient does not try to exit the ambulance prematurely, see CFR, Section 482.13(f)(2) for definition.
Fever	Significantly high fever unresponsive to pharmacologic intervention or fever with associated symptoms.	Temperature after pharmacologic intervention >102° F (adult). Temperature after pharmacologic intervention >104° F (child). Associated neurologic or cardiovascular symptoms / signs, other abnormal vital signs
Gastrointestinal distress	Accompanied by other signs or symptoms	Severe nausea and vomiting or severe, incapacitating diarrhea with evidence of volume depletion, abnormal vital signs or neurologic dysfunction

Complaint or Symptom	Condition Requirement	Examples of Symptoms and Findings Necessary (and Documented) for Coverage
General mobility issues and bed confinement	Patient's physical condition is such that patient risks injury during vehicle movement despite restraints or positioning and/or record demonstrates specialized handling required and provided	This may be due to any or multiple of the conditions listed above. All conditions that contribute to general mobility issues **must** be adequately described. Includes conditions such as: • Decubitus ulcers on sacrum or buttocks that are grade 3 or greater for transfers requiring more than 60 minutes of sitting. • Lower extremity contractures that are of sufficient degree as to prohibit sitting in a wheelchair (severe fixed contractures at or proximal to the knee). • Unstable joints. Includes flail weight-bearing joints following joint surgery. Includes other patients who, in the expressed opinion of the operating surgeon, must absolutely bear no weight on a postoperative joint or patients who are incapable of protecting the joint without the assistance of the trained medical ambulance personnel. Patients who have undergone successful weight bearing joint repair / replacement and those who have successfully undergone long-bone fracture repair (and who are not otherwise immobilized in casts that prohibit sitting) will generally not be included. • Severely debilitating chronic neurological conditions such as degenerative conditions or strokes with severe sequelae. Neurological deficits must be described. • Morbid obesity (as a sole qualifying condition) causing the patient to meet the regulatory definition of bed confined. Highmark Wholecare does not expect this to occur with persons whose BMI is <80.

Conditions – Trauma

On-Scene Condition (General)	On-Scene Condition (Specific)	Comments and Examples (Not All-Inclusive)
Major trauma	As defined by ACS Field Triage Decision Scheme	Trauma with one of the following: Glasgow < 14; systolic BP < 90; RR < 10 or > 29; all penetrating injuries to head, neck, torso, extremities proximal to elbow or knee; flail chest; combination of trauma and burns; pelvic fracture; two or more long-bone fractures; open or depressed skull fracture; paralysis; severe mechanism of injury including: ejection, death of another passenger in same patient compartment, falls

On-Scene Condition (General)	On-Scene Condition (Specific)	Comments and Examples (Not All-Inclusive)
		> 20 feet, 20-inch deformity in vehicle or 12-inch deformity of patient compartment, auto pedestrian / bike, pedestrian thrown / run over, motorcycle accident at speeds > 20 miles per hour and rider separated from vehicle
Other trauma	Need to monitor or maintain airway or immobilize head / neck	Decreased level of consciousness, bleeding into airway, significant trauma to head, face or neck
Hemorrhage	Potentially life-threatening hemorrhage	Includes uncontrolled bleeding with signs of shock and active severe bleeding (quantity identified), ongoing or recent, with potential for immediate re-bleeding
Suspected fractures / dislocations	Suspected fracture or dislocation requires splinting / immobilization and renders patient unable to be transported by another vehicle	Signs of closed head injury, open head injury, pneumothorax, hemothorax, abdominal bruising, positive abdominal signs on exam, internal bleeding criteria, evisceration
Penetrating extremity injuries	Life-or limb-threatening injury	Uncontrolled hemorrhage, compromised neurovascular supply, uncontrollable pain requiring pharmacologic intervention
Traumatic amputations	Life-threatening injury or reattachment opportunity exists	
Suspected internal, head, chest or abdominal injuries		Signs of closed head injury, open head injury, pneumothorax, hemothorax, abdominal bruising, positive abdominal signs on exam, internal bleeding criteria, evisceration
Burns	Major: per American Burn Association (ABA)	Partial thickness burns > 10 percent Total Body Surface Area (TBSA); involvement of face, hands, feet, genitalia, perineum or major joints; third-degree burns; electrical, chemical, inhalation burns with pre-existing medical disorders; burns and trauma
Lightning		
Electrocution		
Near-drowning		
Eye injuries	Acute vision loss or blurring, severe pain or chemical exposure, penetrating, severe lid lacerations	

G. Special Considerations Regarding Patient Death

Payment for ambulance services in circumstances in which the patient dies is based on the time of the patient's death related to the time of the call for service and transport.

In cases where the patient is pronounced dead after the ambulance is called but before the ambulance arrives at the scene, payment may be made for a BLS service. Neither mileage nor a rural adjustment would be paid. In cases where the patient is pronounced dead after being loaded into the ambulance (regardless of whether the pronouncement is made during or subsequent to the transport), payment is made following the usual rules of payment as if the patient had not died. This scenario includes a determination of Dead on Arrival (DOA) at the facility to which the

patient was transported. *Please see IOM, Pub. 100-02, Medicare Benefit Policy Manual, Chapter 10, Section 10.2.6 for additional information.*

H. Ground-to-Air Ambulance Transports
For situations in which a patient is transported by ground ambulance to or from an air ambulance, the ground and air ambulance providers/suppliers providing the transports must bill independently. Under these circumstances, payment will be made to each provider/supplier individually for its respective services and mileage. Each provider/supplier must submit a claim for its respective services/mileage.

I. Limitations
Highmark Wholecare does not cover the following services:
- Transportation in Ambi-buses, ambulettes (Mobility Assistance Vehicle (MAV)), Medi-cabs, vans, privately owned vehicles, taxicabs.
- Transportation via Mobile Intensive Care Unit (MICU)
- Parking fees.
- Tolls for bridges, tunnels, and highways.
- Highmark Wholecare does not provide payment for "Ambulance response and treatment, no transport (A0998)."

Non-emergency ambulance transport is not covered for patients who are restricted to bed rest by a physician's instruction but who do not meet the criteria outlined in the policy.

Note: This medical policy imposes frequency limitations as well as diagnosis limitations that support diagnosis to procedure code automated denials. However, services performed for any given diagnosis must meet all of the indications and limitations stated in this policy, the general requirements for medical necessity as stated in CMS payment policy manuals, any and all existing CMS national coverage determinations, and all payment rules.

The redetermination process may be utilized for consideration of services performed outside of the reasonable and necessary requirements in this medical policy.

2. Reasons for Noncoverage
The ambulance benefit is a transportation benefit, and without a transport there is no payable service. When multiple ground and/or air ambulance providers/suppliers respond, payment may be made only to the ambulance provider/supplier that actually furnishes the transport. Ambulance providers/suppliers that arrive on the scene but do not furnish a transport are not due payment.

No payment may be made for the transport of ambulance staff or other personnel when the patient is not onboard the ambulance (e.g., an ambulance transport to pick up a specialty care unit from one hospital to provide services to a patient at another hospital).

Items and services which include but are not limited to oxygen, drugs, extra attendants, supplies, EKG, and night differential are no longer paid separately for ambulance services.

3. Post-payment Audit Statement
The medical record must include documentation that reflects the medical necessity criteria and is subject to audit by Highmark Wholecare at any time pursuant to the terms of your provider agreement.

4. Place of Service
   The proper place of service for ambulance transport is outpatient.

5. Related Policies
   - MP-075-MC-PA Ambulance Air

Coverage Determination and Links

Highmark Wholecare℠ follows the coverage determinations made by CMS as outlined in either the National Coverage Determination (NCD), and/or the state-specific Local Coverage Determination (LCD)/Local Coverage Article (LCA).

CMS Link
- CMS Website

NCD/LCD Links
- There are no current NCDs related to this topic.
- LCD: Ambulance Services (Ground Ambulance) (L35162)

Article Link
- LCA: Billing and Coding: Ambulance Services (Ground Ambulance) (A54574)

Article Guidance
The ambulance benefit is for transportation of a patient. Payment for ambulance services is only made to the provider/supplier that provides the transport regardless of how many providers/suppliers respond to a request for an ambulance.

In order for claims to be processed and paid in a timely manner, it is important that claims submitted for ambulance services contain all of the required information. The information in this Article is intended to assist ambulance provider/suppliers in the proper submission of claims to ensure timely and accurate processing.

Please note that the ICD-10-CM codes provided in this Article do not represent an all-inclusive list of acceptable diagnoses. Due to the large number of diagnosis codes available, the codes are being provided only as a list of suggested diagnoses codes in an effort to assist providers/suppliers.

Providers/suppliers may choose a diagnosis code from the provided list in the coding section of this Article to report as the primary diagnosis code or they may choose a diagnosis code from the ICD-10-CM manual that accurately depicts the patient's condition at the time of transport.

In addition to the primary diagnosis code, a secondary diagnosis code will be required on all claims reporting ambulance services. Please refer to the LCD (L35162), Ambulance Services (Ground Ambulance) for the list of secondary diagnoses that are considered Reasonable and Necessary.

While reporting of applicable diagnoses codes is an important part of submitting claims for ambulance services, there are other key items that need to be reported correctly in order for proper processing. The

following are a few reminders of key elements that are required on all ambulance claims. (Please refer to the *CMS Internet Only Manual, 100-04, Chapter 15* for complete billing requirements).

- Date of Service: The date of service reported on the claim should be the date that the ambulance departs the point of pickup with the patient on board.
- ZIP Code of the point of pick up: The Zip code for the location where the patient is at the time that they are placed on board the ambulance must be reported on all claims. Electronic billers must report the ZIP code for the point of origin and destination. All Zip codes should be reported with 5 numbers.
- Service Units: For each ambulance trip represented by HCPCS codes A0426, A0427, A0428, A0429, A0433 and A0434 the units of service should be one. The units of service for HCPCS code A0425 should represent the number of loaded miles.

Coding Requirements

Procedure Codes

HCPCS Code	Description
A0425	Ground mileage, per statute mile
A0426	Ambulance service, advanced life support, non-emergency transport level 1 (ALS1)
A0427	ALS1- Emergency
A0428	Ambulance service, basic life support, non-emergency transport (BLS)
A0429	BLS - Emergency
A0433	ALS 2
A0434	Specialty care transport
A0888	Noncovered ambulance mileage
A0999	Unlisted ambulance service (e.g., sea ambulance)

ICD-10 Codes that Support Medical Necessity

The following is a list of suggested ICD-10 codes that may be used as a primary diagnosis for transport to acute care, or for the transport on to another facility for specialty or other care.

Note: A secondary diagnosis code is required.

Primary Diagnosis Codes for Acute Care Transport:

ICD-10 Code	Description
A41.9	Sepsis, unspecified organism
B89	Unspecified parasitic disease
B96.89	Other specified bacterial agents as the cause of diseases classified elsewhere
B99.9	Unspecified infectious disease
D49.89	Neoplasm of unspecified behavior of other specified sites
E10.65	Type 1 diabetes mellitus with hyperglycemia
E10.69	Type 1 diabetes mellitus with other specified complication
E11.65	Type 2 diabetes mellitus with hyperglycemia
E11.69	Type 2 diabetes mellitus with other specified complication
E15	Nondiabetic hypoglycemic coma

E16.1	Other hypoglycemia
E16.2	Hypoglycemia, unspecified
E86.0	Dehydration
E86.1	Hypovolemia
E86.9	Volume depletion, unspecified
F05	Delirium due to known physiological condition
F06.8	Other specified mental disorders due to known physiological condition
F10.10	Alcohol abuse, uncomplicated
F10.120	Alcohol abuse with intoxication, uncomplicated
F10.121	Alcohol abuse with intoxication delirium
F10.129	Alcohol abuse with intoxication, unspecified
F10.188	Alcohol abuse with other alcohol-induced disorder
F10.231	Alcohol dependence with withdrawal delirium
F10.239	Alcohol dependence with withdrawal, unspecified
F11.10	Opioid abuse, uncomplicated
F12.10	Cannabis abuse, uncomplicated
F12.90	Cannabis use, unspecified, uncomplicated
F13.10	Sedative, hypnotic or anxiolytic abuse, uncomplicated
F14.10	Cocaine abuse, uncomplicated
F15.10	Other stimulant abuse, uncomplicated
F15.920	Other stimulant use, unspecified with intoxication, uncomplicated
F15.929	Other stimulant use, unspecified with intoxication, unspecified
F16.10	Hallucinogen abuse, uncomplicated
F18.10	Inhalant abuse, uncomplicated
F19.10	Other psychoactive substance abuse, uncomplicated
F19.939	Other psychoactive substance use, unspecified with withdrawal, unspecified
F19.99	Other psychoactive substance use, unspecified with unspecified psychoactive substance-induced disorder
F23	Brief psychotic disorder
F29	Unspecified psychosis not due to a substance or known physiological condition
F41.1	Generalized anxiety disorder
F41.8	Other specified anxiety disorders
F41.9	Anxiety disorder, unspecified
F63.89	Other impulse disorders
F99	Mental disorder, not otherwise specified
G40.909	Epilepsy, unspecified, not intractable, without status epilepticus
G40.919	Epilepsy, unspecified, intractable, without status epilepticus
G43.909	Migraine, unspecified, not intractable, without status migrainosus
G43.919	Migraine, unspecified, intractable, without status migrainosus
G45.9	Transient cerebral ischemic attack, unspecified
G81.90	Hemiplegia, unspecified affecting unspecified side
G82.20	Paraplegia, unspecified
G82.50	Quadriplegia, unspecified
G89.11	Acute pain due to trauma
G89.18	Other acute postprocedural pain
G89.29	Other chronic pain
I20.0	Unstable angina
I21.3	ST elevation (STEMI) myocardial infarction of unspecified site

I26.99	Other pulmonary embolism without acute cor pulmonale
I46.9	Cardiac arrest, cause unspecified
I48.91	Unspecified atrial fibrillation
I49.9	Cardiac arrhythmia, unspecified
I50.9	Heart failure, unspecified
I66.9	Occlusion and stenosis of unspecified cerebral artery
I67.848	Other cerebrovascular vasospasm and vasoconstriction
I67.89	Other cerebrovascular disease
I69.920	Aphasia following unspecified cerebrovascular disease
I69.949	Monoplegia of lower limb following unspecified cerebrovascular disease affecting unspecified side
I69.959	Hemiplegia and hemiparesis following unspecified cerebrovascular disease affecting unspecified side
I80.209	Phlebitis and thrombophlebitis of unspecified deep vessels of unspecified lower extremity
I95.9	Hypotension, unspecified
J18.8	Other pneumonia, unspecified organism
J18.9	Pneumonia, unspecified organism
J44.9	Chronic obstructive pulmonary disease, unspecified
J45.901	Unspecified asthma with (acute) exacerbation
J80	Acute respiratory distress syndrome
J81.0	Acute pulmonary edema
J95.00	Unspecified tracheostomy complication
J95.821	Acute postprocedural respiratory failure
J95.851	Ventilator associated pneumonia
J95.859	Other complication of respirator [ventilator]
J96.00	Acute respiratory failure, unspecified whether with hypoxia or hypercapnia
J96.90	Respiratory failure, unspecified, unspecified whether with hypoxia or hypercapnia
J98.4	Other disorders of lung
K29.00	Acute gastritis without bleeding
K29.01	Acute gastritis with bleeding
K29.70	Gastritis, unspecified, without bleeding
K29.90	Gastroduodenitis, unspecified, without bleeding
K56.699	Other intestinal obstruction unspecified as to partial versus complete obstruction
K92.2	Gastrointestinal hemorrhage, unspecified
L03.115	Cellulitis of right lower limb
L03.116	Cellulitis of left lower limb
L89.103	Pressure ulcer of unspecified part of back, stage 3
L89.104	Pressure ulcer of unspecified part of back, stage 4
L89.109	Pressure ulcer of unspecified part of back, unspecified stage
L89.153	Pressure ulcer of sacral region, stage 3
L89.154	Pressure ulcer of sacral region, stage 4
L89.203	Pressure ulcer of unspecified hip, stage 3
L89.204	Pressure ulcer of unspecified hip, stage 4
L89.209	Pressure ulcer of unspecified hip, unspecified stage
L89.303	Pressure ulcer of unspecified buttock, stage 3
L89.304	Pressure ulcer of unspecified buttock, stage 4
L89.309	Pressure ulcer of unspecified buttock, unspecified stage
L89.43	Pressure ulcer of contiguous site of back, buttock and hip, stage 3

L89.44	Pressure ulcer of contiguous site of back, buttock and hip, stage 4
M24.559	Contracture, unspecified hip
M24.569	Contracture, unspecified knee
M25.50	Pain in unspecified joint
M43.8X9	Other specified deforming dorsopathies, site unspecified
M53.9	Dorsopathy, unspecified
M54.50	Low back pain, unspecified
M54.51	Vertebrogenic low back pain
M54.89	Other dorsalgia
M54.9	Dorsalgia, unspecified
M79.601	Pain in right arm
M79.602	Pain in left arm
M79.604	Pain in right leg
M79.605	Pain in left leg
M79.609	Pain in unspecified limb
M79.89	Other specified soft tissue disorders
N17.9	Acute kidney failure, unspecified
N19	Unspecified kidney failure
O26.819	Pregnancy related exhaustion and fatigue, unspecified trimester
O26.899	Other specified pregnancy related conditions, unspecified trimester
O26.90	Pregnancy related conditions, unspecified, unspecified trimester
O75.9	Complication of labor and delivery, unspecified
O80	Encounter for full-term uncomplicated delivery
O99.891	Other specified diseases and conditions complicating pregnancy
O99.892	Other specified diseases and conditions complicating childbirth
O99.893	Other specified diseases and conditions complicating puerperium
R00.0	Tachycardia, unspecified
R00.2	Palpitations
R06.00	Dyspnea, unspecified
R06.02	Shortness of breath
R06.03	Acute respiratory distress
R06.3	Periodic breathing
R06.4	Hyperventilation
R06.82	Tachypnea, not elsewhere classified
R06.89	Other abnormalities of breathing
R06.9	Unspecified abnormalities of breathing
R07.1	Chest pain on breathing
R07.2	Precordial pain
R07.81	Pleurodynia
R07.82	Intercostal pain
R07.89	Other chest pain
R07.9	Chest pain, unspecified
R09.02	Hypoxemia
R09.1	Pleurisy
R09.2	Respiratory arrest
R09.89	Other specified symptoms and signs involving the circulatory and respiratory systems
R10.0	Acute abdomen
R10.10	Upper abdominal pain, unspecified

R10.11	Right upper quadrant pain
R10.12	Left upper quadrant pain
R10.13	Epigastric pain
R10.2	Pelvic and perineal pain
R10.30	Lower abdominal pain, unspecified
R10.31	Right lower quadrant pain
R10.32	Left lower quadrant pain
R10.33	Periumbilical pain
R10.817	Generalized abdominal tenderness
R10.819	Abdominal tenderness, unspecified site
R10.827	Generalized rebound abdominal tenderness
R10.829	Rebound abdominal tenderness, unspecified site
R10.84	Generalized abdominal pain
R10.9	Unspecified abdominal pain
R11.10	Vomiting, unspecified
R11.11	Vomiting without nausea
R11.2	Nausea with vomiting, unspecified
R19.00	Intra-abdominal and pelvic swelling, mass and lump, unspecified site
R19.07	Generalized intra-abdominal and pelvic swelling, mass and lump
R19.09	Other intra-abdominal and pelvic swelling, mass and lump
R19.30	Abdominal rigidity, unspecified site
R19.37	Generalized abdominal rigidity
R20.8	Other disturbances of skin sensation
R20.9	Unspecified disturbances of skin sensation
R23.0	Cyanosis
R23.1	Pallor
R25.0	Abnormal head movements
R26.1	Paralytic gait
R26.2	Difficulty in walking, not elsewhere classified
R27.0	Ataxia, unspecified
R27.8	Other lack of coordination
R27.9	Unspecified lack of coordination
R29.5	Transient paralysis
R29.810	Facial weakness
R29.818	Other symptoms and signs involving the nervous system
R40.0	Somnolence
R40.1	Stupor
R40.20	Unspecified coma
R40.2111	Coma scale, eyes open, never, in the field [EMT or ambulance]
R40.2121	Coma scale, eyes open, to pain, in the field [EMT or ambulance]
R40.2131	Coma scale, eyes open, to sound, in the field [EMT or ambulance]
R40.2141	Coma scale, eyes open, spontaneous, in the field [EMT or ambulance]
R40.2211	Coma scale, best verbal response, none, in the field [EMT or ambulance]
R40.2221	Coma scale, best verbal response, incomprehensible words, in the field [EMT or ambulance]
R40.2231	Coma scale, best verbal response, inappropriate words, in the field [EMT or ambulance]
R40.2241	Coma scale, best verbal response, confused conversation, in the field [EMT or ambulance]
R40.2251	Coma scale, best verbal response, oriented, in the field [EMT or ambulance]

R40.2311	Coma scale, best motor response, none, in the field [EMT or ambulance]
R40.2321	Coma scale, best motor response, extension, in the field [EMT or ambulance]
R40.2331	Coma scale, best motor response, abnormal, in the field [EMT or ambulance]
R40.2341	Coma scale, best motor response, flexion withdrawal, in the field [EMT or ambulance]
R40.2351	Coma scale, best motor response, localizes pain, in the field [EMT or ambulance]
R40.2361	Coma scale, best motor response, obeys commands, in the field [EMT or ambulance]
R40.2410	Glasgow coma scale score 13-15, unspecified time
R40.2411	Glasgow coma scale score 13-15, in the field [EMT or ambulance]
R40.2412	Glasgow coma scale score 13-15, at arrival to emergency department
R40.2413	Glasgow coma scale score 13-15, at hospital admission
R40.2414	Glasgow coma scale score 13-15, 24 hours or more after hospital admission
R40.2420	Glasgow coma scale score 9-12, unspecified time
R40.2421	Glasgow coma scale score 9-12, in the field [EMT or ambulance]
R40.2422	Glasgow coma scale score 9-12, at arrival to emergency department
R40.2423	Glasgow coma scale score 9-12, at hospital admission
R40.2424	Glasgow coma scale score 9-12, 24 hours or more after hospital admission
R40.2430	Glasgow coma scale score 3-8, unspecified time
R40.2431	Glasgow coma scale score 3-8, in the field [EMT or ambulance]
R40.2432	Glasgow coma scale score 3-8, at arrival to emergency department
R40.2433	Glasgow coma scale score 3-8, at hospital admission
R40.2434	Glasgow coma scale score 3-8, 24 hours or more after hospital admission
R40.2440	Other coma, without documented Glasgow coma scale score, or with partial score reported, unspecified time
R40.2441	Other coma, without documented Glasgow coma scale score, or with partial score reported, in the field [EMT or ambulance]
R40.2442	Other coma, without documented Glasgow coma scale score, or with partial score reported, at arrival to emergency department
R40.2443	Other coma, without documented Glasgow coma scale score, or with partial score reported, at hospital admission
R40.2444	Other coma, without documented Glasgow coma scale score, or with partial score reported, 24 hours or more after hospital admission
R40.3	Persistent vegetative state
R40.4	Transient alteration of awareness
R41.0	Disorientation, unspecified
R41.2	Retrograde amnesia
R41.89	Other symptoms and signs involving cognitive functions and awareness
R42	Dizziness and giddiness
R44.2	Other hallucinations
R44.3	Hallucinations, unspecified
R45.89	Other symptoms and signs involving emotional state
R47.01	Aphasia
R47.02	Dysphasia
R47.81	Slurred speech
R47.89	Other speech disturbances
R50.81	Fever presenting with conditions classified elsewhere
R50.82	Postprocedural fever
R50.9	Fever, unspecified
R51.0	Headache with orthostatic component, not elsewhere classified

R52	Pain, unspecified
R53.1	Weakness
R53.2	Functional quadriplegia
R53.81	Other malaise
R53.83	Other fatigue
R55	Syncope and collapse
R56.9	Unspecified convulsions
R57.9	Shock, unspecified
R58	Hemorrhage, not elsewhere classified
R61	Generalized hyperhidrosis
R68.0	Hypothermia, not associated with low environmental temperature
R68.11	Excessive crying of infant (baby)
S05.90XA	Unspecified injury of unspecified eye and orbit, initial encounter
S09.8XXA	Other specified injuries of head, initial encounter
S09.90XA	Unspecified injury of head, initial encounter
T07.XXXA	Unspecified multiple injuries, initial encounter
T14.8XXA	Other injury of unspecified body region, initial encounter
T14.90XA	Injury, unspecified, initial encounter
T14.91XA	Suicide attempt, initial encounter
T30.0	Burn of unspecified body region, unspecified degree
T50.901A	Poisoning by unspecified drugs, medicaments and biological substances, accidental (unintentional), initial encounter
T50.902A	Poisoning by unspecified drugs, medicaments and biological substances, intentional self-harm, initial encounter
T50.903A	Poisoning by unspecified drugs, medicaments and biological substances, assault, initial encounter
T50.904A	Poisoning by unspecified drugs, medicaments and biological substances, undetermined, initial encounter
T59.891A	Toxic effect of other specified gases, fumes and vapors, accidental (unintentional), initial encounter
T59.91XA	Toxic effect of unspecified gases, fumes and vapors, accidental (unintentional), initial encounter
T59.92XA	Toxic effect of unspecified gases, fumes and vapors, intentional self-harm, initial encounter
T59.93XA	Toxic effect of unspecified gases, fumes and vapors, assault, initial encounter
T59.94XA	Toxic effect of unspecified gases, fumes and vapors, undetermined, initial encounter
T65.91XA	Toxic effect of unspecified substance, accidental (unintentional), initial encounter
T65.92XA	Toxic effect of unspecified substance, intentional self-harm, initial encounter
T65.93XA	Toxic effect of unspecified substance, assault, initial encounter
T65.94XA	Toxic effect of unspecified substance, undetermined, initial encounter
T67.2XXA	Heat cramp, initial encounter
T67.5XXA	Heat exhaustion, unspecified, initial encounter
T68.XXXA	Hypothermia, initial encounter
T69.9XXA	Effect of reduced temperature, unspecified, initial encounter
T74.21XA	Adult sexual abuse, confirmed, initial encounter
T75.00XA	Unspecified effects of lightning, initial encounter
T75.1XXA	Unspecified effects of drowning and nonfatal submersion, initial encounter
T75.4XXA	Electrocution, initial encounter

T76.21XA	Adult sexual abuse, suspected, initial encounter
T78.2XXA	Anaphylactic shock, unspecified, initial encounter
T78.40XA	Allergy, unspecified, initial encounter
T81.89XA	Other complications of procedures, not elsewhere classified, initial encounter
T81.9XXA	Unspecified complication of procedure, initial encounter
T82.519A	Breakdown (mechanical) of unspecified cardiac and vascular devices and implants, initial encounter
T82.529A	Displacement of unspecified cardiac and vascular devices and implants, initial encounter
T82.539A	Leakage of unspecified cardiac and vascular devices and implants, initial encounter
T82.599A	Other mechanical complication of unspecified cardiac and vascular devices and implants, initial encounter
T83.198A	Other mechanical complication of other urinary devices and implants, initial encounter
T83.498A	Other mechanical complication of other prosthetic devices, implants and grafts of genital tract, initial encounter
T88.7XXA	Unspecified adverse effect of drug or medicament, initial encounter
Y71.0	Diagnostic and monitoring cardiovascular devices associated with adverse incidents
Y82.8	Other medical devices associated with adverse incidents
Z20.818	Contact with and (suspected) exposure to other bacterial communicable diseases

The following is a list of suggested ICD-10 codes that may be used as a primary diagnosis for post treatment transfer (e.g., transfer to home, nursing facility, SNF, IRF, IPP).

Note: A secondary diagnosis code is required.

Primary Diagnosis Post Treatment Transfer Codes:

ICD-10 Code	Description
C71.9	Malignant neoplasm of brain, unspecified
C80.1	Malignant (primary) neoplasm, unspecified
C80.2	Malignant neoplasm associated with transplanted organ
D49.0	Neoplasm of unspecified behavior of digestive system
D49.1	Neoplasm of unspecified behavior of respiratory system
D49.2	Neoplasm of unspecified behavior of bone, soft tissue, and skin
D49.3	Neoplasm of unspecified behavior of breast
D49.4	Neoplasm of unspecified behavior of bladder
D49.511	Neoplasm of unspecified behavior of right kidney
D49.512	Neoplasm of unspecified behavior of left kidney
D49.59	Neoplasm of unspecified behavior of other genitourinary organ
D49.6	Neoplasm of unspecified behavior of brain
D49.7	Neoplasm of unspecified behavior of endocrine glands and other parts of nervous system
D49.89	Neoplasm of unspecified behavior of other specified sites
F01.51	Vascular dementia with behavioral disturbance
F02.81	Dementia in other diseases classified elsewhere with behavioral disturbance
F03.91	Unspecified dementia with behavioral disturbance
F63.3	Trichotillomania
F63.89	Other impulse disorders
G30.9	Alzheimer's disease, unspecified
G37.9	Demyelinating disease of central nervous system, unspecified

G89.29	Other chronic pain
G89.3	Neoplasm related pain (acute) (chronic)
I25.9	Chronic ischemic heart disease, unspecified
I42.9	Cardiomyopathy, unspecified
I50.9	Heart failure, unspecified
I67.89	Other cerebrovascular disease
I69.910	Attention and concentration deficit following unspecified cerebrovascular disease
I69.911	Memory deficit following unspecified cerebrovascular disease
I69.912	Visuospatial deficit and spatial neglect following unspecified cerebrovascular disease
I69.913	Psychomotor deficit following unspecified cerebrovascular disease
I69.914	Frontal lobe and executive function deficit following unspecified cerebrovascular disease
I69.915	Cognitive social or emotional deficit following unspecified cerebrovascular disease
I69.918	Other symptoms and signs involving cognitive functions following unspecified cerebrovascular disease
I69.941	Monoplegia of lower limb following unspecified cerebrovascular disease affecting right dominant side
I69.942	Monoplegia of lower limb following unspecified cerebrovascular disease affecting left dominant side
I69.943	Monoplegia of lower limb following unspecified cerebrovascular disease affecting right non-dominant side
I69.944	Monoplegia of lower limb following unspecified cerebrovascular disease affecting left non-dominant side
I69.949	Monoplegia of lower limb following unspecified cerebrovascular disease affecting unspecified side
I69.951	Hemiplegia and hemiparesis following unspecified cerebrovascular disease affecting right dominant side
I69.952	Hemiplegia and hemiparesis following unspecified cerebrovascular disease affecting left dominant side
I69.953	Hemiplegia and hemiparesis following unspecified cerebrovascular disease affecting right non-dominant side
I69.954	Hemiplegia and hemiparesis following unspecified cerebrovascular disease affecting left non-dominant side
I69.959	Hemiplegia and hemiparesis following unspecified cerebrovascular disease affecting unspecified side
J43.9	Emphysema, unspecified
J44.9	Chronic obstructive pulmonary disease, unspecified
L89.133	Pressure ulcer of right lower back, stage 3
L89.134	Pressure ulcer of right lower back, stage 4
L89.143	Pressure ulcer of left lower back, stage 3
L89.144	Pressure ulcer of left lower back, stage 4
L89.153	Pressure ulcer of sacral region, stage 3
L89.154	Pressure ulcer of sacral region, stage 4
L89.313	Pressure ulcer of right buttock, stage 3
L89.314	Pressure ulcer of right buttock, stage 4
L89.323	Pressure ulcer of left buttock, stage 3
L89.324	Pressure ulcer of left buttock, stage 4
L89.43	Pressure ulcer of contiguous site of back, buttock and hip, stage 3
L89.44	Pressure ulcer of contiguous site of back, buttock and hip, stage 4

M24.551	Contracture, right hip
M24.552	Contracture, left hip
M24.561	Contracture, right knee
M24.562	Contracture, left knee
M25.50	Pain in unspecified joint
R26.0	Ataxic gait
R26.1	Paralytic gait
R26.89	Other abnormalities of gait and mobility
R26.9	Unspecified abnormalities of gait and mobility
R27.0	Ataxia, unspecified
R27.8	Other lack of coordination
R27.9	Unspecified lack of coordination
R29.5	Transient paralysis
R40.0	Somnolence
R40.1	Stupor
R40.20	Unspecified coma
R40.3	Persistent vegetative state
R40.4	Transient alteration of awareness
R52	Pain, unspecified
R64	Cachexia
S12.9XXA	Fracture of neck, unspecified, initial encounter
S13.29XA	Dislocation of other parts of neck, initial encounter
S13.9XXA	Sprain of joints and ligaments of unspecified parts of neck, initial encounter
S22.9XXA	Fracture of bony thorax, part unspecified, initial encounter for closed fracture
S23.0XXA	Traumatic rupture of thoracic intervertebral disc, initial encounter
S23.20XA	Dislocation of unspecified part of thorax, initial encounter
S24.9XXA	Injury of unspecified nerve of thorax, initial encounter
S32.9XXA	Fracture of unspecified parts of lumbosacral spine and pelvis, initial encounter for closed fracture
S33.0XXA	Traumatic rupture of lumbar intervertebral disc, initial encounter
S33.30XA	Dislocation of unspecified parts of lumbar spine and pelvis, initial encounter
S72.91XA	Unspecified fracture of right femur, initial encounter for closed fracture
S72.92XA	Unspecified fracture of left femur, initial encounter for closed fracture

The following codes are secondary diagnosis codes that must be reported in addition to a primary diagnosis.

Secondary Diagnosis Codes:

ICD-10 Codes	Description
Z74.01	Bed confinement status
Z74.3*	Need for continuous supervision
Z78.1*	Physical restraint status
Z99.89*	Dependence on other enabling machines and devices

Note: Use code Z74.3 to denote cardiac/hemodynamic monitoring required en route.

Note: Use code Z78.1 to denote patient safety: danger to self and others – monitoring other and unspecified reactive psychosis.

Note: Use code Z99.89 to denote the need for continuous IV fluid(s), "active airway management," or the need for multiple machines/devices.

ICD-10 Codes that DO NOT Support Medical Necessity

Note: Z76.89 should be reported for patients who were transported by ambulance, but did NOT require the services of an ambulance crew. Modifier GY should be appended.

ICD-10 Code	Description
Z76.89	Persons encountering health services in other specified circumstances

Medical necessity and coverage of ambulance services are not based solely on the presence of a specific diagnosis. Payment for ambulance transportation may be made only for those patients whose condition at the time of transport is such that ambulance transportation is necessary. For example, it is insufficient that a patient merely has a diagnosis such as pneumonia, stroke, or fracture to justify ambulance transportation. In each of those instances, the condition of the patient must be such that transportation by any other means is medically contraindicated. In the case of ambulance transportation, the condition necessitating transportation is often that an accident or injury has occurred giving rise to a clinical suspicion that a specific condition exists (for instance, fractures may be strongly suspected based on clinical examination and history of a specific injury).

Highmark Wholecare recognizes limitations of usual ambulance personnel for establishing a diagnosis and recognizes, therefore, that diagnosis coding of a patient's condition using ICD-10-CM codes when reporting ambulance services may be less specific than for services reported by other professional providers. Also, selected ICD-10-CM diagnosis codes from the CMS condition code list are included with instructions to use them in a manner that is contrary to usual ICD-10-CM coding conventions. Providers who submit ICD-10-CM diagnosis codes should choose the code that best describes the patient's condition at the time of transport. (Please refer to Local Coverage Article A54574 for a list of "suggested" ICD-10 codes that may be reported.)

Reporting ambulance services certifies to Highmark Wholecare that the ambulance provider believes the code description reasonably reflects the condition of the patient at the time of transport and that the patient's condition was consistent with the requirements of the ambulance transportation benefit.

The contractor recognizes that ambulance suppliers are currently not required to submit ICD-10-CM codes on their claims if filing on a 1500 claim form or utilizing an electronic version other than the 5010 version of the 837P, though their doing so facilitates timely claim adjudication. The CPT/HCPCS codes included in this medical policy will be subjected to limited "procedure to diagnosis" editing. Claims without an ICD-10-CM diagnosis code are adjudicated manually utilizing the information contained in the claim's narrative field and/or medical records (the trip report and any other records supplied to Highmark Wholecare by the provider upon our request). Ambulance suppliers utilizing the 5010 version of the 837P are required to submit ICD-10-CM diagnosis code(s).

Due to the increased specificity of ICD-10 and the large number of possible covered diagnoses codes, the Contractor is not providing a comprehensive list of covered diagnosis codes for HCPCS codes A0425, A0426, A0427, A0428, A0429, A0433 and A0434.

All ambulance transports require dual diagnosis codes as described in the policy.

Bill Type Codes:
Contractors may specify Bill Types to help providers identify those Bill Types typically used to report this service. Absence of a Bill Type does not guarantee that the policy does not apply to that Bill Type. Complete absence of all Bill Types indicates that coverage is not influenced by Bill Type and the policy should be assumed to apply equally to all claims.

012x	Hospital Inpatient (Medicare Part B only)
013x	Hospital Outpatient
022x	Skilled Nursing - Inpatient (Medicare Part B only)
023x	Skilled Nursing - Outpatient
083x	Ambulatory Surgery Center
085x	Critical Access Hospital

Revenue Codes:
Contractors may specify Revenue Codes to help providers identify those Revenue Codes typically used to report this service. In most instances Revenue Codes are purely advisory. Unless specified in the policy, services reported under other Revenue Codes are equally subject to this coverage determination. Complete absence of all Revenue Codes indicates that coverage is not influenced by Revenue Code and the policy should be assumed to apply equally to all Revenue Codes.

054X	Ambulance – General Classification

General Information

Documentation Requirements

1. All documentation must be maintained in the patient's medical record and made available to the contractor upon request.
2. Every page of the record must be legible and include appropriate patient identification information (e.g., complete name, dates of service(s)). The documentation must include the legible signature of the physician or non-physician practitioner responsible for and providing the care to the patient.
3. The submitted records must support the use of the selected diagnoses listed in the Coding Requirements section. The submitted CPT/HCPCS code must describe the service performed.
4. The medical record documentation must support the medical necessity of the services as directed in this policy. It is the responsibility of the ambulance supplier to maintain (and furnish to Highmark Wholecare upon request) complete and accurate documentation of the patient's condition to demonstrate the ambulance service being furnished meets the medical necessity criteria. Documentation must be legible or identifiable (submitted with a signature log). The documents required for this purpose include the following:
    - A PCS (for those services for which the physician certification is required (see *Physician's Certification Statement* section). The certification itself is not the sole factor used in determining whether payment for ambulance services will be allowed:
        - The PCS may be completed and signed by the following medical professionals: the patient's attending physician (MD or DO), or for instances in which the physician signature is not available, a PA, NP, CNS, RN, or discharge planner employed by the hospital facility where the patient is treated with knowledge of the patient's condition at the time the transport was ordered or the service was rendered. This is applicable to non-emergency, non-scheduled transports. Repetitive non-emergency scheduled transports must be signed by the attending physician.

- A particular form or format is not required for the certification. Suppliers and physicians may develop their own certification form.
- Ambulance company employees should not complete forms on behalf of these individuals.
- For repetitive services, the PCS may include the expected length of time ambulance transport would be required but may not exceed 60 days.
- Signature of the medical professional completing the PCS must also be legible (or accompanied by a typed or printed name) and include credentials.
- Signatures on the PCS must be dated at the time they are completed.

- Trip record:
  - A detailed description of the patient's condition at the time of transport.
  - The trip record must "paint a picture" of the patient's condition and must be consistent with documentation found in other supporting medical record documentation (including the physician's certification). The trip record must include:
    - A concise explanation of symptoms reported by the patient or other observers and details of the patient's physical assessments that clearly demonstrate that the patient requires ambulance transportation and cannot be safely transported by an alternate mode.
    - An objective description of the patient's physical condition in sufficient detail to demonstrate that the patient's condition or functional status at the time of transport meets limitation of coverage for ambulance services.
    - Description of the traumatic event when trauma is the basis for suspected injuries.
    - A detailed description of existing safety issues.
    - A detailed description of special precautions taken (if any) and explanation of the need for such precautions.
    - A description of specific monitoring and treatments required, ordered, and performed/administered. That a treatment (such as oxygen) or monitoring (such as cardiac rhythm monitoring) was performed absent sufficient description of the patient's condition (to demonstrate that the treatment or monitoring was medically necessary) is inadequate on its own merit to justify payment for the ambulance service. For example, when oxygen is supplied as a basis for ambulance transportation, the patient's pretreatment capillary blood oxygen saturation and clinical respiratory description must be recorded. The two must be consistent with oxygen need.
- Statements such as the following, absent supporting information in relevant bullets above, are insufficient to justify payment for ambulance services:
  - Patient complained of shortness of breath
  - History of stroke
  - Past history of knee replacement
  - Hypertension
  - Chest pain
  - Generalized weakness/ pain
  - Is bed confined
- Coverage will not be allowed if the trip record contains an insufficient description of the patient's condition at the time of transfer to reasonably determine that other means of transportation are contraindicated. Coverage will not be allowed if the description of the patient's condition is limited to conclusory statements or opinions, such as the following:
  - "Patient is non-ambulatory."

- "Patient moved by drawsheet."
- "Patient could only be moved by stretcher."
- "Patient is unable to sit, stand, or walk."

5. Signatures, including credentials, from the provider(s) who render(s) the services documented: Services provided/ordered must be authenticated by the author. The method used must be a handwritten or electronic signature. *Note that additional information regarding patient signature requirements related to ambulance services, may be found in IOM Pub. 100-02, Medicare Benefit Policy Manual, Chapter 10, Section 20.1.2, and CFRs referenced in this policy.*
   - If the signature is found to be illegible or missing from the medical documentation, a signature log or attestation statement to determine the identity of the author may be requested.
   - A signature log includes the typed or printed name and usual signature of the author associated with initials or an illegible signature.
   - An attestation statement is required when a signature is missing from the documentation; it must be signed and dated by the author of the medical record entry and must contain sufficient information to identify the patient, date of service, and be specific to the service documented.
   - Providers should not add late signatures to the documentation.
6. Point of pick-up/destination (identify place and complete address).
7. For hospital-to-hospital transports, the trip record must clearly indicate the precise treatment or procedure (or medical specialist) that is available only at the receiving hospital. Non-specific or vague statements such as "needs cardiac care" or "needs higher level of care" are insufficient.
8. Any additional available documentation that supports medical necessity of ambulance transport (for example, emergency room report, SNF record, End Stage Renal Disease (ESRD) facility record, hospital record).
9. Dispatch record.
10. Documentation supporting the number of loaded miles billed. See FAQ for Ambulance posted on Novitas website. Documentation may include odometer reading, trip odometer reading, GPS system, navigation computer, mapping programs, and will need to be available if requested.

Utilization Guidelines
Utilization of these services should be consistent with locally acceptable standards of practice.
Most patients who require ambulance transportation have a short-term need due to an acute illness or injury. Longer term repetitive or frequent ambulance transportation is medically necessary for relatively few patients. Highmark Wholecare expects that more than eight covered ambulance trips per year will rarely be medically necessary for an individual patient and will cover no more than 12 ambulance trips per patient per year without review of the patient's medical record.

Note: This medical policy imposes utilization guideline limitations that support automated frequency denials. Despite allowing up to these maximums, each patient's condition and response to treatment must medically warrant the number of services reported for payment. Highmark Wholecare requires the medical necessity for each service reported to be clearly demonstrated in the patient's medical record. Highmark Wholecare expects that patients will not routinely require the maximum allowable number of services.

Reimbursement

Participating facilities will be reimbursed per their Highmark Wholecare℠ contract.

Reference Sources

Centers for Medicare & Medicaid Services (CMS). Medicare Benefit Policy Manual. Chapter 10: Ambulance Services. Revised April 13, 2018. Accessed on June 28, 2022.

Centers for Medicare & Medicaid Services (CMS). Medicare Claims Processing Manual Chapter 15 – Ambulance. Revised April 28, 2022. Accessed on June 28, 2022.

Centers for Medicare & Medicaid Services (CMS). Local Coverage Determination (LCD) Ambulance Services (Ground Ambulance) (L35162). Original Effective date October 1, 2015. Revision Effective date January 1, 2020. Accessed on June 28, 2022.

Centers for Medicare & Medicaid Services (CMS). Local Coverage Article (LCA) Billing and Coding: Ambulance Services (Ground Ambulance) (A54574). Original Effective date October 1, 2015. Revision Effective Date October 1, 2021. Accessed on June 28, 2022.