Chapter 1 Section 14

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)
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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 Defense Health Agency (DHA) 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 shall 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 shall be developed for each type.

3.1.3 BLS versus 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 shall recognize the difference and allow payment to be based upon the level of services rendered rather than the type of vehicle and crew. In other words, in an all ALS environment where the provider has

established different billing patterns based on the level of care (e.g., emergency vs. non-emergency), the contractor shall 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 determines the amount allowed by the TRICARE Program. 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 shall 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 shall be paid if the patient's condition was such that BLS would have sufficed. There shall 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 shall be shared among the contractors 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 contractors 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 1, paragraph 4.2.14.5.4 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. DHA 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). DHA will follow Medicare Claims Processing Manual, Chapter 15, and reimbursement will be based on Medicare's AFS, except as provided under paragraph 3.2.1 during DHA's transition to the fully phased-in Medicare AFS or as found in paragraph 3.5.3 (reimbursement of joint response where there is no agreement between the BLS and ALS provider) and in paragraph 3.6.6 (treat-and-release). 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/afspuf.html.

3.2.1 TRICARE Program Transition to Medicare AFS for Air Ambulance Services

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. For each subsequent year of transition, 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 x 0.85) of the base year rate; beginning January 1, 2017, 61.4%

(0.85 x 0.85 x 0.85) etc.) Once the provisional CMAC equals the AFS, the transition period is over and air ambulance services shall 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 the TRICARE Program 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
- 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 shall 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 https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AmbulanceFeeSchedule/.

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

In general, if the beneficiary dies before being transported, then no TRICARE payment shall be made. Thus, in a situation where the beneficiary dies, whether any payment under the TRICARE ambulance benefit shall 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.

3.2.6 Effect of Beneficiary Death on TRICARE Payment for Air Ambulance Transports

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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 Pilot's 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, DHA 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 shall 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 shall 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 (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 ALS Paramedic Intercept (PI) services (see paragraph 3.4) and Joint Response (see paragraph 3.5).

3.4 PI

3.4.1 PI services are ALS services provided by an entity that does not provide the ambulance transport. This type of service is most often provided for an emergency ambulance transport in which a local volunteer ambulance that can provide only BLS level of service is dispatched to transport a patient. If the patient needs ALS services such as EKG monitoring, chest decompression, or Intravenous (IV) therapy, another entity dispatches a paramedic to meet the BLS ambulance at the scene or once the ambulance is on the way to the hospital. The ALS paramedics then provide services to the patient.

This tiered approach to life saving is cost effective in many areas because most volunteer ambulances do not charge for their services and one paramedic service can cover many communities. These PI services shall be payable separate from the ambulance transport, subject to the requirements specified below:

- Furnished in a rural area;
- Furnished under a contract with one or more volunteer ambulance services; and
- Medically necessary based on the condition of the beneficiary receiving the ambulance service.

3.4.1.1 In addition, the volunteer ambulance service involved shall:

- Meet the Program's certification requirements for furnishing ambulance services;
- Furnish services only at the BLS level at the time of the intercept; and
- Be prohibited by State law from billing anyone for any service.

3.4.1.2 The entity furnishing the ALS PI service shall:

- Meet the Program's certification requirements for furnishing ALS services; and
- Bill all recipients who receive ALS PI services from the entity, regardless of whether or not those recipients are TRICARE beneficiaries.

3.4.2 For the purposes of the PI benefit, a rural area is an area that is designated as rural by a State law or regulation or any area outside of a Metropolitan Statistical Area (MSA) or in New England, outside a New England County Metropolitan Area as defined by the Office of Management and Budget (OMB). The current list of these areas is periodically published in the **Federal Register**.

3.5 Joint Response (BLS/ALS)

3.5.1 In situations where a BLS entity provides the transport of the beneficiary and an ALS entity provides a service that meets the fee schedule definition of an ALS intervention (e.g., ALS assessment, PI services, etc.), the BLS supplier may bill the TRICARE Program the ALS rate provided that a written agreement between the BLS and ALS entities exists prior to submitting the TRICARE claim. Providers/ suppliers shall provide a copy of the agreement or other such evidence (e.g., signed attestation) as determined by the TRICARE contractor. DHA does not regulate the compensation between the BLS entity and the ALS entity when there is an agreement between the two entities.

3.5.2 Prior to September 13, 2018, if there is no agreement between the BLS ambulance supplier and the ALS entity furnishing the service, then only the BLS level of payment shall be made. In this situation, the ALS entity's services are not covered, and the beneficiary is liable for the expense of the ALS services to the extent that these services are beyond the scope of the BLS level of payment.

3.5.3 Effective for services provided on or after September 13, 2018, if there is no agreement between the BLS ambulance supplier and the ALS entity furnishing the service, then only the BLS level of payment shall be made to the BLS ambulance supplier. In this situation, the ALS entity's services shall be payable separate from the ambulance transport, subject to the requirements specified below.

3.5.3.1 The ALS provider meets the Program's certification requirements for furnishing ALS services and is otherwise a TRICARE-authorized ambulance company.

3.5.3.2 The ALS provider bills all recipients who receive ALS services from the entity, regardless of whether or not those recipients are TRICARE beneficiaries, with exception of ambulance membership programs. ALS entities which offer ambulance membership programs may bill the TRICARE Program for ALS services provided the beneficiary has not purchased a subscription (see paragraph 4.1 for more information on ambulance membership programs) and provided the ALS entity bills all non-subscribing recipients who receive ALS services from the entity, regardless of whether or not those recipients are TRICARE beneficiaries.

3.5.3.3 The services of an ALS provider were medically necessary based on the condition of the beneficiary receiving the ambulance service.

3.5.3.4 The ALS provider bills using either Healthcare Common Procedure Coding System (HCPCS) code S0207 or S0208, as appropriate.

3.5.3.5 The BLS ambulance supplier bills at the BLS rate.

3.5.4 The contractor shall reimburse HCPCS codes S0207 and S0208 at a rate equivalent to Medicare's rate for HCPCS code A0432, and shall update that rate every time Medicare updates the rate for HCPCS code A0432. Prior to reimbursement, the contractor shall verify that all requirements of paragraph 3.5 have been met, to include that no other entity has been paid for ALS level-of-service for the episode-of-care and that the ALS entity is not entitled to payment under paragraph 3.4.

3.6 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)(5)).

3.6.1 Ambulance transfers from a beneficiary's place of residence, accident scene, or other location to a civilian hospital, Military Treatment Facility (MTF)/Enhanced Multi-Service Market (eMSM), Department of Veterans Affairs (DVA)/Veterans Health Administration (VHA) hospital, or SNF shall be cost-shared on an outpatient basis. Transfers from a hospital or SNF to a patient's residence shall also be considered an outpatient service for reimbursement under the Program. A separate cost-share does not apply to ambulance transfers to or from an SNF, if the costs for ambulance transfer are included in the SNF PPS rate (see Chapter 8, Section 1, paragraph 4.2.14.5.4).

3.6.2 Ambulance transfers between hospitals (acute care, general, and special hospitals; psychiatric hospitals; and long-term hospitals) and SNFs shall be cost-shared on an inpatient basis.

3.6.3 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.

3.6.4 Transfers to an MTF/eMSM, DVA/VHA hospital, or SNF after treatment at, or admission to, an emergency room or civilian hospital shall be cost-shared on an inpatient basis, if ordered by either civilian or military personnel.

3.6.5 Medically necessary ambulance transfers from an Emergency Room (ER) to a hospital more capable of providing the required level of care shall 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.

3.6.6 Effective for services provided on or after September 13, 2018, DHA added coverage for "treat-and-release" services. Treat-and-release occurs when an ambulance responds to a call and provides medically necessary services, but transport is not provided due to patient stabilization or patient refusal of transport. Treat-and-release coverage is provided when all of the following conditions are met.

3.6.6.1 The ambulance entity meets the Program's certification requirements for furnishing ambulance services and is otherwise a TRICARE-authorized ambulance company. No payment shall be made to paramedics or other first responders independent of the responding ambulance.

3.6.6.2 The ambulance supplier bills all recipients of treat-and-release services, regardless of whether or not those recipients are TRICARE beneficiaries.

3.6.6.3 Treat-and-release services were medically necessary based on the condition of the beneficiary receiving the ambulance service. No payment shall be made if medically necessary services were not provided.

3.6.6.4 Failure to provide transport resulted from either a determination that the patient's condition had stabilized and transportation to the hospital was no longer required, or the beneficiary refused transport after receiving services.

3.6.6.5 The ambulance entity bills using HCPCS code A0998.

3.6.7 The contractor shall reimburse HCPCS code A0998 at a rate equivalent to the BLS non-emergency HCPCS code A0428, which does not include mileage. The contractor shall update the reimbursement rate for HCPCS code A0998 each time Medicare updates the rate for HCPCS code A0428. The contractor shall be responsible for determining the medical necessity of the treat-and-release call.

3.6.8 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 shall be at the lesser of the billed amount (flat fee) or the statewide prevailing for HCPCS codes A0426 through A0429 subject to applicable beneficiary cost-sharing.

4.3 The CMAC reimbursement methodology used to reimburse professional services does not apply to ambulance claims. The above reimbursement guidelines shall 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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