

Ambulance Transport Services

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Coverage Policy Medical 105
Version 4

All requests for authorization for the services described by this medical policy will be reviewed per Early and Periodic Screening, Diagnostic and Treatment (EPSDT) guidelines. These services may be authorized under individual consideration for Medicaid members under the age of 21-years if the services are judged to be medically necessary to correct or ameliorate the member's condition. Department of Medical Assistance Services (DMAS), Supplement B - EPSDT (Early and Periodic Screening, Diagnosis and Treatment) Manual.*.

Purpose:

This policy addresses the medical necessity of - Ambulance Transport Services.

Description & Definitions:

An ambulance is a transport vehicle that is able to provide medical care and treatment up to and including life-saving interventions. This vehicle can either be on the ground or through the air.

Criteria:

Ambulance services are considered medically necessary for **1 or more of the following**:

- Ground Transportation and **All of the following**:
 - The ambulance must have the necessary equipment and supplies to address the needs of the individual.
 - The individual is transported to a destination that is **1 or more** of the following:
 - The destination participates (PAR) with Sentara Health Plans
 - The destination does not participate (Non-PAR) with Sentara Health Plans and **All of the following**:
 - Sentara Health Plan Medical Director has approved the transport.
 - The individual is at a facility that is non-participating (Non-PAR) with Sentara Health Plan and the continued length of stay is expected to be extensive.
 - The individual has a medical condition which indicates that any other form of transportation would be medically contraindicated and **1 or more of the following**:
 - Transportation to/ from one medical facility to another medical facility or skilled nursing facility
 - Transportation to/from residence or facility for diagnostic or therapeutic treatment (e.g. dialysis center, radiation therapy, imaging studies, surgical intervention, etc.) and **All of the following**:
 - The diagnostic or therapeutic treatment is medically necessary.

- If transport is from a facility, the diagnostic or therapeutic treatment cannot be available at that facility.
- Transfer from an acute care facility to a patient's home or skilled nursing facility that is medically necessary.
- Transportation to/from residence for a medically necessary visit to a physician's office
- Air Transportation and **All of the following**:
 - The ambulance must have the necessary equipment and supplies to address the needs of the individual.
 - Individual meets **1 or more** of the following criteria:
 - The individual's location is such that accessibility is only feasible by air or water.
 - The individual has a medical condition which indicates that any other form of transportation would be medically contraindicated and **1 or more of the following**:
 - Transportation to/ from one medical facility to another medical facility or skilled nursing facility
 - The individual is transported to a destination that is **1 or more** of the following:
 - The destination participates (PAR) with Sentara Health Plans
 - The destination does not participate (Non-PAR) with Sentara Health Plans and **All of the following**:
 - Sentara Health Plan Medical Director has approved the transport.
 - The individual is at a facility that is non-participating (Non-PAR) with Sentara Health Plan and the continued length of stay is expected to be extensive.
 - Transportation to/from facility for diagnostic or therapeutic treatment (e.g. dialysis center, radiation therapy, imaging studies, surgical intervention, etc.) and **All of the following**:
 - The diagnostic or therapeutic treatment is medically necessary.
 - If transport is from a facility, the diagnostic or therapeutic treatment cannot be available at that facility.

Ambulance Transport Services is considered not medically necessary for any use other than those indicated in clinical criteria, to include but not limited to:

- When the transport is primarily for the convenience of the individual, individual's family, or physician.
- The services are for a transfer of a deceased individual to a funeral home, morgue, or hospital, when the individual was pronounced dead at the scene.
- Transfers from a hospital capable of treating an individual to another hospital primarily for the convenience of the individual or individual's family or physician.
- Transportation to a hospital other than the nearest one with appropriate facility
- Air transport when land transportation is available, and the time required to transport individual by land does not endanger the his/her life or health.
- Some other means of transportation could have been used without endangering the individual's health.
- Ambulance transportation was denied by the individual after response and treatment at scene.

Coding:

Medically necessary with criteria:

Coding	Description
A0425	Ground mileage, per statute mile.
A0426	Ambulance service, advanced life support, nonemergency transport, level 1 (ALS1).
A0428	Ambulance service, basic life support, nonemergency transport (BLS).
A0430	Ambulance service, conventional air services, transport, one way (fixed wing).

A0431	Ambulance service, conventional air services, transport, one way (rotary wing).
A0432	Paramedic intercept (PI), rural area, transport furnished by a volunteer ambulance company which is prohibited by state law from billing third-party payers.
A0434	Specialty care transport (SCT).
A0435	Fixed wing air mileage, per statute mile.
A0436	Fixed wing air mileage, per statute mile.

Considered Not Medically Necessary:

Coding	Description
A0998	Ambulance response and treatment, no transport

U.S. Food and Drug Administration (FDA) - approved only products only.

Document History:

Revised Dates:

- 2022: February, April
- 2021: October
- 2020: January, July
- 2015: February
- 2014: August
- 2013: August
- 2010: November
- 2008: October

Reviewed Dates:

- 2023: February
- 2020: April
- 2018: November
- 2017: December
- 2016: July
- 2015: July
- 2014: July
- 2013: July
- 2012: August
- 2011: October
- 2010: October
- 2009: October

Effective Date:

- December 2007

References:

Including but not limited to: Specialty Association Guidelines; Government Regulations; Winifred S. Hayes, Inc; UpToDate; Literature Review; Specialty Advisors; National Coverage Determination (NCD); Local Coverage Determination (LCD).

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Special Notes: *

This medical policy express Sentara Health Plan's determination of medically necessity of services, and they are based upon a review of currently available clinical information. These policies are used when no specific guidelines for coverage are provided by the Department of Medical Assistance Services of Virginia (DMAS). Medical Policies may be superseded by state Medicaid Plan guidelines. Medical policies are not a substitute for clinical judgment or for any prior authorization requirements of the health plan. These policies are not an explanation of benefits.

Medical policies can be highly technical and complex and are provided here for informational purposes. These medical policies are intended for use by health care professionals. The medical policies do not constitute medical advice or medical care. Treating health care professionals are solely responsible for diagnosis, treatment and medical advice. Sentara Health Plan members should discuss the information in the medical policies with their treating health care professionals. Medical technology is constantly evolving and these medical policies are subject to change without notice, although Sentara Health Plan will notify providers as required in advance of changes that could have a negative impact on benefits.

The Early and Periodic Screening, Diagnostic and Treatment (EPSDT) covers services, products, or procedures for children, if those items are determined to be medically necessary to "correct or ameliorate" (make better) a defect, physical or mental illness, or condition (health problem) identified through routine medical screening or examination, regardless of whether coverage for the same service or support is an optional or limited service under the state plan. Children enrolled in the FAMIS Program are not eligible for all EPSDT treatment services. All requests for authorization for the services described by this medical policy will be reviewed per EPSDT guidelines. These services may be authorized under individual consideration for Medicaid members under the age of 21-years if the services are judged to be medically necessary to correct or ameliorate the member's condition. *Department of Medical Assistance Services (DMAS), Supplement B - EPSDT (Early and Periodic Screening, Diagnosis and Treatment) Manual.*

Keywords:

Ambulance transport, medical 105, air, ground, paramedics, transportation, als, bls