Priority Health	BILLING POLICY No. 126
AMBULANCE SERVICES	
Date of origin: Aug. 2025	**Review dates: 8/2025**

APPLIES TO

- Commercial
- Medicare follows CMS unless otherwise stated
- Medicaid follows MDHHS unless otherwise stated

DEFINITION

"Ambulance" includes a motor vehicle or aircraft that is primarily used or designated as available to provide transportation and basic life support, limited advanced life support, or advanced life support.

Emergent transportation is defined as dispatched by a 911 call, whether or not the patient agrees to be taken to the hospital.

Ambulance stabilization is defined as ambulance response, non-transport. The patient is treated and stabilized but no transport is made.

FOR MEDICARE

For indications that do not meet criteria of NCD, local LCD or specific medical policy a Pre-Service Organization Determination (PSOD) will need to be completed. Click here for additional details on PSOD.

POLICY SPECIFIC INFORMATION

Coding specifics

Ground transport

Ground transportation should be coded with appropriate mileage HCPCS.

- **A0425**: Ground mileage, per statute mile
- **A0426**: Ambulance service, advanced life support, non-emergency transport, level 1 (ALS1)
- **A0427**: Ambulance service, advanced life support, emergency transport, level 1 (ALS1-Emergency)
- **A0428**: Ambulance service, basic life support, non-emergency transport (BLS)
- **A0429**: Ambulance service, basic life support, emergency transport (BLS-Emergency)
- **A0433**: Advanced life support, level 2 (ALS2)
- **A0434**: Specialty care transport (SCT)
- **A0888**: Non-covered ambulance mileage, per mile (e.g., for miles traveled beyond closest appropriate facility)

Air transport

- **A0435**: Fixed wing air mileage, per statute mile
- **A0436**: Rotary wing air mileage, per statute mile
- **A0430**: Ambulance service, conventional air services, transport, one way (fixed wing) (FW)
- **A0431**: Ambulance service, conventional air services, transport, one way (rotary wing) (RW)

Stabilization

- **A0998**: Ambulance response and treatment, no transport (covered by Priority Health Medicare, not by Original Medicare); do NOT include modifier

ESRD transport

- **A0425**: Ground mileage, per statute mile
- **A0428**: Ambulance service, basic life support, non-emergency transport (BLS)

In alignment with CMS payment methodologies, we'll apply a payment reduction for ESRD related non-emergency basic life support transports to and from renal dialysis treatment. This reduction is applied both to hospital-based and freestanding renal dialysis treatment facilities. Refer to CMS for additional guidelines.

This reduction is driven by use of either modifier below in first or second position:

- **G**: Hospital-based ESRD facility
- **J**: Freestanding ESRD facility

Institution-based ambulance services billed on facility claims should use revenue code 0540.

Ambulance services are not separately payable when reported with a date of service within an admission and discharge date of an inpatient claim (inpatient hospital, SNF, etc.). The service is considered bundled to the inpatient stay and separate billing will be denied.

- Services reported on the day of admission or day of discharge of the inpatient stay can be separately reported.
- Ambulance services provided during an inpatient leave of absence (LOA) that have been denied with the edit may be reconsidered via the Reviews & Appeals process.
- In alignment with CMS, we won't separately reimburse for ambulance services for residents in a SNF. This service cannot be billed separately. Ambulance transport from one SNF facility to another SNF facility should be billed with modifier NN as this service is inclusive of the inpatient stay.

Ambulance services may be subject to bundling guidelines for equipment, supply, or service is not separately payable when reported with an ambulance transport code on the same date of service. Such supplies are considered part of the general ambulance service and included in the payment rate for the transport.

Diagnosis

Primary diagnosis should adequately describe the patient's medical conditions at the time of transport.

A secondary diagnosis code should be reported to:

- Identify circumstances related to the patient that could influence health care needs for or during transport
- Narrate why a patient was or will be managed in a certain way

Secondary ICD-10 codes include:

- **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
- **Z76.89**: Persons encountering health services in other specified circumstances

Documentation requirements

Complete and thorough documentation to substantiate the procedure performed is the responsibility of the Provider. In addition, the Provider should consult any specific documentation requirements that are necessary of any applicable defined guidelines.

It is the responsibility of the ambulance supplier to maintain, and furnish if requested, complete and accurate documentation of the member's condition to demonstrate the ambulance service is medically necessary and meets criteria.

Detailed documentation to allow reconstruction of what transpired for each ambulance service is necessary to support services billed. Documentation should include:

- Transportation by ambulance was done by an approved supplier
- The condition suffered by the patient was of severity that contraindicated transportation by other means. This should include description of symptoms, functional status, traumatic events, existing safety issues, any special precautions taken or special monitoring undertaken.
- The point of pick up; number of miles and dispatch record
- When required, Physician certification of medical necessity. For repetitive services, this certification should be dated no earlier than 60 days before the date of the service.
- Bed confinement is not a sole criterion in determining medical necessity of ambulance transportation. It is one factor that is considered in medical necessity determinations. To be considered as bed confined, the following criteria must be met:
    - Inability to get up from the bed without assistance.
    - Inability to ambulate.
    - Inability to sit in a chair or a wheelchair.

Modifiers

Priority Health follows standard billing and coding guidelines which include CMS NCCI. Modifiers should be applied when applicable based on this guidance and only when supported by documentation.

Incorrect application of modifiers will result in denials. The modifier list below may not be an all-inclusive list. Please see our provider manual page for modifier use here.

Ambulance origin and destination modifiers must be appended to ambulance services for both professional and institution-based ambulance claims. Ambulance codes missing origin and destination modifiers will be denied.

- **Exception**: an ambulance service will not be denied for missing origin and destination modifiers if modifier QL is appended to indicate the patient was pronounced dead after the ambulance was called.

- Origin and destination codes are not required for HCPCS A0998 (Ambulance response and treatment, no transport)

Origin and destination modifiers used for ambulance services are created by combining two alpha characters. Each alpha character, with the exception of "X", represents an origin code or a destination code. The pair of alpha codes creates one modifier. The first position alpha code equals origin; the second position alpha code equals destination. Origin and destination codes and their descriptions are listed below, and on the WPS website (Note: Do NOT include a modifier with A0998):

- **D**: Diagnostic or therapeutic site other than P or H when these are used as origin codes
- **E**: Residential, domiciliary, custodial facility (other than 1819 facility)
- **G**: Hospital-based ESRD facility
- **H**: Hospital
- **I**: Site of transfer (e.g. airport or helicopter pad) between modes of ambulance transport
- **J**: Freestanding ESRD facility
- **N**: Skilled nursing facility
- **P**: Physician office
- **R**: Residence
- **S**: Scene of accident or acute event
- **TN**: Rural/outside provider's customary service area
- **X**: Intermediate stop at physician office on way to hospital (destination code only)

The modifiers below are required on facility ambulance service claims in addition to original and destination modifiers:

- **QM**: Ambulance service provided under arrangement by a provider of services; or
- **QN**: Ambulance service furnished directly by a provider of services

Reimbursement rates

Find reimbursement rates for the codes listed on this page in our standard fee schedules for your contract. Go to the fee schedules (login required)

Reimbursement specifics

Ambulance services coverage

Transport services

In a medical emergency, all plans cover EMT and ambulance transport to the nearest medical facility that can provide medical emergency care.

Non-emergent transportation, including medically necessary transfer between facilities, is covered without prior authorization.

Non-transport stabilization services

Covered for commercial, Medicare and Medicaid members.

In alignment with CMS, Priority Health does not pay for mileage beyond the closest facility. This mileage should be billed with **A0888**.

Exception: CAH ambulance claims reporting condition code B2 to attest that there is no other provider or supplier of ambulance services located within a 35-mile drive of the CAH.

Medicare coverage

Medicare covers ambulance services, including fixed wing and rotary wing ambulance services, only if they are furnished to a beneficiary whose medical condition is such that other means of transportation are contraindicated. The beneficiary's condition must require the ambulance transportation itself and the level of service provided in order for the billed service to be considered medically necessary. Payment of services is based on the level of service provided which must be supported by documentation.

Ambulance services are divided into different levels of ground (including water) and air ambulance services based on the medically necessary treatment during transport.

Medicaid coverage

Medicaid plans cover some services that other plans do not, such as EMT/ambulance treatment on scene without transport. Refer to the Medicaid Provider Manual.

Ambulance service authorizations

Prior authorization is required for:

- Fixed-wing transports, emergent and non-emergent

Authorization is not required for:

- Emergency ground and helicopter ambulance services
- Ambulance stabilization, non-transport, for Priority Health Medicare Advantage members

Billing details

Ambulance services billing

Ambulance services provided to Priority Health members, must be reported with the appropriate ambulance HCPCS code. Transport services claims must include the correct origin and destination modifiers or the service will be denied. Use the Health Care Procedure Coding System (HCPCS) procedure codes below to describe the type and level of services rendered by the ambulance crew.

Payable

For emergent transport, when correctly authorized, if necessary (see above), and when the correct origin and destination modifier combination are submitted next to the procedure code

For ambulance stabilization, non-transport, do NOT include modifier

Not payable
When fixed-wing and non-emergency ambulance services are not authorized in advance

When codes/modifiers are missing

When any submitted diagnosis code on the claim has a description that includes the word "unspecified"

When the following origin and destination modifiers are used:
DD, DE, DG, DJ, DP, DS, ED, EE, EP, ES, GD, GG, GJ, GP, GS, HP, HS, ID, IE, IG, IJ, IN, IP, IR, IS, JD, JJ, JP, JS, NP, NS, PD, PE, PG, PJ, PP, PR, PS, RD, RE, RP, RR, RS, SD, SE, SG, SJ, SN, SP, SR, SS, XD, XE, XG, XH, XI, XJ, XN, XP, XR, XS, XX

Place of Service
Coverage will be considered for services furnished in the appropriate setting to the patient's medical needs and condition. Authorization may be required. Click here for additional information.

Ambulance services should be coded with place of service (POS) 41 or 42.

- **POS 41**: Ambulance – Land
- **POS 42**: Ambulance – Air or Water

Rural/Super Rural reimbursement guidelines:

- TN modifier needs to be reported in addition to the origin and destination modifiers
- Reimbursement may be adjusted if the Point of Pick-up zip code is considered rural or super-rural.

Related denial language:
- E4M – Not a covered service

REFERENCES

- IOM 100-02, Chapter 10, Section 10.3
- IOM 100-04, Chapter 15, Section 30.A
- HCPCS Level II Manual

DISCLAIMER
Priority Health's billing policies outline our guidelines to assist providers in accurate claim submissions and define reimbursement or coding requirements if the service is covered by a Priority Health member's benefit plan. The determination of visits, procedures, DME, supplies and other services or items for coverage under a member's benefit plan or authorization isn't being determined for reimbursement. Authorization requirements and medical necessity requirements appropriate to procedure, diagnosis and frequency are still required. We use Current Procedural Terminology (CPT), Centers for Medicare and Medicaid Services (CMS), Michigan Department of Health and Human Services (MDHHS) and other defined medical coding guidelines for coding accuracy.

An authorization isn't a guarantee of payment when proper billing and coding requirements or adherence to our policies aren't followed. Proper billing and submission guidelines must be followed. We require industry standard, compliant codes defined by CPT, HCPCS and revenue codes for all claim submissions. CPT, HCPCPS, revenue codes, etc., can be reported only when the service has been performed and fully documented in the medical record to the highest level of specificity. Failure to

document for services rendered or items supplied will result in a denial. To validate billing and coding accuracy, payment integrity pre- or post-claim reviews may be performed to prevent fraud, waste and abuse. Unless otherwise detailed in the policy, our billing policies apply to both participating and non-participating providers and facilities.

If guidelines detailed in government program regulations, defined in policies and contractual requirements aren't followed, Priority Health may:

- Reject or deny the claim
- Recover or recoup claim payment

An authorization on file for an item or services doesn't supersede coding, billing or reimbursement requirements.

These policies may be superseded by mandates defined in provider contracts or state, federal or CMS contracts or requirements. We make every effort to update our policies in a timely manner to align to these requirements or contracts. If there's a delay in implementation of a policy or requirement defined by state or federal law, as well as contract language, we reserve the right to recoup and/or recover claim payments to the effective dates per our policy. We reserve the right to update policies when necessary. Our most current policy will be made available in our Provider Manual.

CHANGE / REVIEW HISTORY

Date	Revisions made
Aug 12, 2025	Moved existing information on the provider manual Addition of modifiers not covered for transportation DD, DE, DG, DJ, DP, DS, ED, EE, EP, ES, GD, GG, GJ, GP, GS, HP, HS, ID, IE, IG, IJ, IN, IP, IR, IS, JD, JJ, JP, JS, NP, NS, PD, PE, PG, PJ, PP, PR, PS, RD, RE, RP, RR, RS, SD, SE, SG, SJ, SN, SP, SR, SS, XD, XE, XG, XH, XI, XJ, XN, XP, XR, XS, XX