

CHAMPVA POLICY MANUAL

CHAPTER: 2
SECTION: 32.1
TITLE: AMBULANCE SERVICES

AUTHORITY: 38 CFR 17.270(a), 17.272(a), and 17.272(a)(59)

RELATED AUTHORITY: 32 CFR 199.4(d)(3)

I. EFFECTIVE DATE

October 25, 1984

II. PROCEDURE CODE(S)

A. CPT codes 93012 and 93270

B. HCPCS Level II codes A0225-A0384, A0392-A0398, A0422- A0436, and A0999

III. DESCRIPTION

Transportation by means of a specifically designed vehicle for transporting the sick and injured that contains a stretcher, linens, first aid supplies, oxygen equipment and such other safety and life saving equipment as is required by state and local law and is staffed by personnel trained to provide first aid treatment.

IV. POLICY

A. Ambulance service is covered and considered medically necessary when the patient's condition is such that the use of any other method of transportation is contraindicated. The following conditions are presumed to meet this requirement:

1. patient was transferred in an emergency situation, e.g., as a result of an accident, injury, or acute illness,
2. needed to be restrained,
3. was unconscious or in shock,
4. required oxygen or other emergency treatment enroute to a treatment facility,
5. immobilization was required because of a fracture or possible fracture,

6. patient sustained an acute stroke or myocardial infraction,
7. was experiencing severe hemorrhage,
8. was bed confined before and after the ambulance trip, or
9. could be moved only by stretcher.

Note: In the absence of any of the above, additional documentation should be obtained to establish medical necessity.

C. As a general rule, only local transportation by ambulance is covered. This means the patient must have been transported to the nearest institution with appropriate facilities for treatment of the injury or illness. Once medical necessity for the ambulance transfer has been established, unless the ambulance charge appears excessive or some other reason exists to question the location of the admitting hospital, it can be assumed the nearest hospital was used. Exceptions for ambulance destinations are as follows:

1. institution or hospital to the beneficiary's home when the home is within the locality of the institution or hospital considered the closest one with the appropriate facilities, or

2. institution to institution when a transfer of a patient is medically necessary and appropriate, or

3. round-trip ambulance service is covered for a hospital or skilled nursing facility inpatient to the nearest hospital or other treatment facility to obtain necessary diagnostic and/or therapeutic services (such as a CT scan or cobalt therapy) not available at the institution where the beneficiary is an inpatient. Round-trip ambulance services are limited to those cases where the transportation of the patient is less costly than bringing the service to the patient.

4. Ambulance service to a physician's office or clinic is covered only under the following circumstances:

- a. or other medical facility with the purpose to obtain diagnostic or therapeutic services not available at the primary facility, or

- b. while transporting a patient to a hospital, the ambulance stops at a physician's office or clinic because of the patient's dire need for professional attention, and once the patient is stabilized, continues on to the hospital, or

- c. the patient was bed confined before and after the ambulance trip,
or

- d. the patient could be moved only by stretcher.

D. Ambulance service by other than land vehicles (e.g., boat, aircraft) may be considered only when the point of pick-up is inaccessible by land vehicle, or great distance or other obstacles are involved in transporting the patient to the nearest hospital with appropriate facilities and the patient's medical condition warrants speedy admission or is such that transfer by other means is contraindicated.

E. Payment of services and supplies provided by ambulance personal at an accident scene may be allowed when the patient's condition warrants transfer to an inpatient acute setting and medical services and/or supplies are provided solely to stabilize the patient's condition while awaiting the arrival of a more urgent means of transfer such as air ambulance services.

V. POLICY CONSIDERATIONS

An individual is considered to have expired as of the time he or she is pronounced dead by a person who is legally authorized to make such a pronouncement, usually a physician. The following guidelines are to be followed when providing benefits for ambulance services to deceased beneficiaries:

1. Benefits cannot be provided if the beneficiary was pronounced dead by a legally authorized person before the ambulance was called.
2. Benefits can be provided if the beneficiary was pronounced dead after the ambulance was called but before pickup, the service to point of pickup is covered.
3. Benefits can be provided for the entire ambulance service to a beneficiary who was pronounced dead while enroute to or upon arrival at the destination.

VI. EXCLUSIONS

A. Ambulance service used when other means of transportation (e.g., taxi, personal auto) could have been utilized without endangering the patient's health.

B. The transport or transfer of a patient primarily for the purpose of having the patient nearer to home, family, friends, or personal physician. Transport must be to the closest appropriate facility by the least costly means.

C. Ambulances, medicabs, or ambicabs that function primarily as public passenger conveyances transporting patients from their residence to and from their physician's office for medical appointments.

END OF POLICY