Ambulance Payment Policy

The following payment policy applies to Tufts Health Plan contracted ambulance and transportation providers.

This policy applies to Commercial¹ and Tufts Health Freedom Plan products. For information on Tufts Medicare Preferred HMO and Tufts Health Plan Senior Care Options, click here.

Note: Audit and disclaimer information is located at the end of this document.

POLICY
Tufts Health Plan covers emergency ambulance, air and water transport services, excluding chair car and wheelchair van transports. Non-emergency ambulance and transportation services are subject to medical necessity review.

GENERAL BENEFIT INFORMATION²
Services and subsequent payment are based on the member’s benefit plan document. Providers and their office staff should use self-service channels to verify effective dates and copayments for Commercial members prior to initiating services.

Refer to the Electronic Services section of our website for our self-service channel options. Benefit specifics should be verified prior to initiating services by logging on to our website or by contacting Provider Services.

MEMBER RESPONSIBILITY
Copayments, deductible and/or coinsurance may apply pursuant to the member’s benefit plan specifics.

Tufts Health Plan recommends not billing the member for the coinsurance and/or deductible amount until the claim has processed so that the appropriate member responsibility can be determined. Both the provider’s Explanation of Payment (EOP) and the Electronic Remittance Advice (ERA) will reflect the member’s responsibility amount.

AUTHORIZATION REQUIREMENTS

Services Requiring Prior Authorization
While you may not be the provider responsible for obtaining prior authorization, as a condition of payment you will need to make sure that prior authorization has been obtained.

Refer to the Authorization Policy for specific referral and authorization requirements.

For authorization information and/or prior authorization requirements for members using the PHCS (also known as MultiPlan) network, contact American Health Holding.

Wheelchair Van Transports
Wheelchair van transports are not a covered benefit, regardless of circumstances. Members can only be held liable for non-covered services if they agreed to pay in advance for the non-covered services after being informed the services were non-covered and confirming their understanding by signing an acknowledgement of liability.

Air and Water Ambulance
All non-emergency air and water transportation services require prior authorization before services are rendered. The Tufts Health Plan Care Manager (CM) or Delegated Care Manager (DCM) will review these requests with a Medical Director and provide authorization when the service is determined to be medically necessary.

¹ Commercial products include HMO, POS, PPO, & CareLink™ when Tufts Health Plan is the Primary Administrator.
² Eligibility may be subject to retroactive reporting of disenrollment.
**Emergency Ground Ambulance**
Authorization is not required for emergency ground ambulance.

**Non-Emergency Ambulance Services**
The submission of medical necessity forms and trip sheets are not required for non-emergency ambulance transportation claims billed with the following origin and destination modifiers:

- **DH** (Diagnostic or therapeutic site other than 'P' or 'H' to Hospital)
- **EH** (Residential, domiciliary, custodial facility (nursing home, not skilled nursing facility) to Hospital)
- **GH** (Hospital-based dialysis facility (hospital or hospital-related) to hospital)
- **HD** (Hospital to diagnostic or therapeutic site other than 'P' or 'H')
- **HG** (Hospital to hospital-based dialysis facility (hospital or hospital-related))
- **HH** (Hospital to hospital)
- **HJ** (Hospital to non-hospital based dialysis facility)
- **JH** (Non-hospital based dialysis facility to hospital)
- **NR** (Skilled Nursing Facility to Residence)
- **PH** (Physician's office (includes HMO non-hospital based facility, clinic, etc.) to hospital)
- **RH** (Residence to hospital)
- **RN** (Residence to Skilled Nursing Facility)

**Note:** When billing with origin and destination modifiers HD or DH and you know that the member is inpatient, in an acute care facility (i.e. excluding rehab hospitals and skilled nursing facilities); bill the facility directly for that transportation. If you do not know the member’s status, claims billed to the plan for these members will be denied and you will be directed to the ordering facility for payment.

All other origin and destination modifier combinations billed for non-emergency ambulance and/or scheduled ground transportation services are subject to retrospective review in accordance with Medicare guidelines prior to claims payment. A completed medical necessity form used by the provider’s organization must be received by Tufts Health Plan for appropriate claims adjudication. For additional information, refer to the Non-Emergency Ambulance Transportation: Ground Medical Necessity Guidelines for Commercial members.

Refer to the CareLink<sup>®</sup> Prior Authorization List for a list of procedures, services and items requiring prior authorization for CareLink members. For a complete description of Tufts Health Plan’s Commercial authorization requirements, refer to the Authorization section within the Tufts Health Plan Commercial Provider Manual.

**BILLING INSTRUCTIONS**
- Submit the most updated industry-standard codes.
- Submit a modifier, when applicable, with the corresponding CPT and/or HCPCS procedure code(s).
- Submit the appropriate modifier as indicated in the Origin and Destination Modifier Table on page 4.
- For more information regarding modifiers refer to the Modifier Payment Policy.
- Submit non-emergency ambulance and/or scheduled ground transportation claims with a completed medical necessity form. Non-emergency ambulance and/or scheduled ground transportation electronic or paper claims submitted without a medical necessity form will deny as provider responsibility.
- Electronic submitters must fax a copy of the completed medical necessity form to the Precertification Department at 617.972.9409 for non-emergency ambulance and/or scheduled ground transportation the same day the claim is submitted.
- Non-emergency ambulance and/or scheduled ground transportation claims submitted on paper must have the completed medical necessity form accompanying the claim.
- Tufts Health Plan will accept medical necessity forms that are used by the ambulance provider for non-emergency and/or scheduled ground transportation claims.
Note: Annually and quarterly, HIPAA medical code sets undergo revision by CMS, AMA and CCI. Revisions typically include adding, deleting or redefining the description or nomenclature of new HCPCS, CPT procedure and ICD-CM diagnosis codes. As these revisions are made public, Tufts Health Plan will update its system to reflect these changes.

EDI Claim Submitter Information
- Submit claims in HIPAA compliant 837P format for non-hospital owned transportation services.
- Submit the appropriate Revenue Code (540-549) with the appropriate HCPCS procedure code listed in the following table for hospital-owned transportation services. Claims should be submitted electronically with non-standard codes will reject.
- Submit the completed medical necessity form to the Precertification Department via fax at 617. 972.9409 for non-emergency ambulance and/or scheduled ground transportation claims. Non-emergency ambulance and/or scheduled ground transportation claims submitted without a medical necessity form will deny as provider responsibility.

Note: EDI submitters must fax the medical necessity form the same day the claim is submitted.

To view the status of submitted authorizations and claims, log on to our secure website.

Paper Claim Submitter Information
- Submit claims on an official claim form for non-hospital owned transportation services.
- Ambulance origin and destination modifiers should be listed in boxes 24D of the CMS 1500 form.
- Submit the appropriate Revenue Code (540-549) with the appropriate HCPCS procedure code listed in the following table for hospital-owned transportation services. Claims should be submitted on a UB-04 form for hospital-owned transportation services. Ambulance origin and destination modifiers should be listed in box 80 in the remarks section of the UB-04 form.
- A completed medical necessity form must accompany non-emergency ambulance and/or scheduled ground transportation claims submitted. Non-emergency ambulance and/or scheduled ground transportation claims submitted without a completed medical necessity form will deny as provider responsibility.
- All paper claims must be submitted on official, standard red claim forms. Black and white versions of these forms, including photocopied and faxed versions, will not be accepted and will be returned with a request to submit on the proper claim form.
- Submitted forms deemed incomplete will be rejected and returned to the submitter. The rejected claim and a letter stating the reason for rejection will be returned to the submitter, and a new claim with the required information must be resubmitted for processing.

The HCPCS procedure codes listed in the following table are the only reimbursable procedure codes, per the Ancillary Provider Agreement. Hospital-owned providers are subject to their respective contracts. Submit the most appropriate HCPCS procedure codes when billing for services.

Note: HCPCS procedure code A0998 (ambulance response and treatment; no transport), if billed, will deny as not covered, member responsibility.

Tufts Health Plan does not separately compensate for facility transportation services codes A0021-A0999 if billed with procedure code S0208.

The modifiers listed in the following Origin and Destination Modifier table are required for billing, as applicable. The first letter should indicate the transport’s place of origin, and the second letter should indicate the destination.

<table>
<thead>
<tr>
<th>Modifier</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>D</td>
<td>Diagnostic or therapeutic site other than ‘P’ or ‘H’</td>
</tr>
<tr>
<td>E</td>
<td>Residential, domiciliary, custodial facility (nursing home, not skilled nursing facility)</td>
</tr>
<tr>
<td>G</td>
<td>Hospital-based dialysis facility (hospital or hospital-related)</td>
</tr>
<tr>
<td>H</td>
<td>Hospital</td>
</tr>
</tbody>
</table>

3 HIPAA medical code sets include HCPCS, CPT Procedure and ICD-CM diagnosis codes.
4 Applies to hospital-based ambulance services only.
<table>
<thead>
<tr>
<th>Modifier</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>I</td>
<td>Site of transfer (for example, airport or helicopter pad) between types of ambulance)</td>
</tr>
<tr>
<td>J</td>
<td>Non-hospital based dialysis facility</td>
</tr>
<tr>
<td>N</td>
<td>Skilled Nursing Facility</td>
</tr>
<tr>
<td>P</td>
<td>Physician’s office (includes HMO non-hospital based facility, clinic, etc.)</td>
</tr>
<tr>
<td>R</td>
<td>Residence</td>
</tr>
<tr>
<td>S</td>
<td>Scene of accident or acute event</td>
</tr>
<tr>
<td>X</td>
<td>Intermediate stop at physician’s office en route to the hospital. Note: Modifier X can only be used as a designation code in the second position of a modifier.</td>
</tr>
</tbody>
</table>

**COMPENSATION/REIMBURSEMENT INFORMATION**

Providers are compensated according to the Tufts Health Plan contracted network rates regardless of the address where the service is rendered. Claims are subject to payment edits that are updated at regular intervals and generally based on CMS, specialty society guidelines, and the National Correct Coding Initiative (CCI).

**Procedure Code Guidelines**

Tufts Health Plan will not compensate for inappropriately-coded services, based on CPT/HCPCS Procedure Code Guidelines.

**Additional Supplies and Services Ground Services**

Tufts Health Plan will not reimburse ECG Tracing, drugs, intubation, and pulse oximetry services when billed with ground ambulance transport services. Refer to the CMS Internet Only Manual for additional information.

**Ambulance Waiting Time**

Tufts Health Plan will deny ambulance waiting time when billed separately from an ambulance service, unless there are exceptional circumstances. Refer to the CMS Internet Only Manual for additional information.

**Non-emergency Ambulance Ground Transportation and Acute Care Inpatient Services**

Tufts Health Plan will not compensate for non-emergency ground ambulance when a member is admitted to an acute care inpatient facility and needs to be transported via ground ambulance to another facility outside the hospital setting for services that cannot be provided in the acute care hospital but would otherwise be covered under the inpatient payment to the facility, for example HD (Hospital to Diagnostic or Therapeutic site) or DH (Diagnostic or Therapeutic site to Hospital). Responsibility for paying for such service rests with the acute care inpatient facility and the ambulance provider should bill the acute care inpatient facility for those services.

**Non-emergency Ambulance Ground Transportation Services Not Medically Necessary**

There are two instances when non-emergency ambulance ground transportation services will deny as not medically necessary.

1.) If a provider deems a non-emergency ambulance ground transportation service as not medically necessary and the ambulance provider is aware the service is not medically necessary and submits the non-emergency ambulance ground transportation claim to Tufts Health Plan, Tufts Health Plan will not compensate the ambulance provider’s claim and the member may not be held responsible for payment.

In the event that an ambulance provider must submit a claim for a service where the member has acknowledged liability via the acknowledgement noted below, submit a medical necessity form indicating the service is not a covered service with a valid acknowledgement indicating that the member has been notified in writing that the service is not covered and the member has assumed liability. This will help to ensure accurate claim adjudication to denote that the member is responsible for payment.

2.) If an ambulance provider submits a non-emergency ambulance ground transportation service with a medical necessity form and Tufts Health Plan’s determines through the retrospective review process
that the service is not medically necessary, the ambulance provider’s claim will not be compensated and the member may not be held responsible for payment.

**Note:** Providers rendering non-covered ambulance services should note that members can only be held liable if all of the following conditions are met prior to rendering the service: (1) the provider informs the member in writing that the ambulance service is not covered under the plan, and (2) after being so informed, the member agrees in writing to pay for the non-covered services.

**Note:** A general statement agreeing to pay for services not paid by the insurer is not sufficient. Below is an example of acceptable acknowledgement language:

“I have been advised by __________ that this non-emergency ambulance transport service may not be a covered service. If, as a result, my insurance company does not pay for this service, I agree to be personally and fully responsible for payment.” [Member signature]

Tufts Health Plan strongly recommends incorporating this acknowledgement language into your forms.

**Explanation of Payment (EOP)**
The EOP provides information on the status of the claim(s) submitted to Tufts Health Plan. The EOP indicates status of claims payments, denials, and pending claims.

**Electronic Remittance Advice (ERA)**
The HIPAA compliant 835 ERA is an EDI transaction that providers may request to electronically post paid and denied claims information to their accounts receivable system.

**DOCUMENT HISTORY**

- September 2015: Template conversion, template updates
- May 2013: Template conversion
- January 2013: Template update
- August 2012: Added information regarding A0021-A0999 if billed with procedure code S0208, effective for claims adjudicated on or after October 1, 2012.
- April 2012: Added example to non-emergency ground transportation and acute care inpatient services language and removed HR and HE destination modifier combinations from table of combinations that do not require medical necessity forms and trip sheets for non-emergency ambulance transportation, template updates.
- January 2008: Removed Tufts Medicare Preferred benefit exception transition information
- February 2008: Revised general benefit information with self-service channels information
- September 2008: Revised non-emergency ambulance and/or scheduled ground transportation services with information on the retrospective review process.
- March 2012: Updated CareLink disclaimer language.
- October 2011: Reviewed policy, added information regarding destination modifier combinations that do not require medical necessity forms and trip sheets for non-emergency ambulance transportation, template updates. Also added information regarding paper Statements of Account and the Summary of Account on Tufts Health Plan’s secure Provider website, effective January 1, 2012.
- May 2010: Added code S0208 to list of reimbursable procedure codes for hospital-based ambulance services only.
- February 2010: Removed the following as this is no longer effective: Non-Ambulance Life Support Services
  - Codes Q3019 and Q3020 are to be used for basic ambulance transport when only ambulance life support (ALS) vehicles are available but no ALS services are rendered. Tufts Health Plan will not reimburse ALS supplies for basic ambulance transport. Refer to the CMS Medicare Carriers Manual for additional information.
  - December 2009: Revised non-emergency ambulance ground transportation information with the following: Effective for dates of service on or after January 1, 2010, the retrospective review process will no longer apply for non-emergency transportation claims billed with the following origin and destination modifiers: HH, HN, HD, DH, HG, GH, HJ, & JH and medical necessity forms and trip sheets will no longer be required for processing and payment of claims billed with these modifier combinations.
  - September 2008: Revised non-emergency ambulance and/or scheduled ground transportation services with information on the retrospective review process.
  - February 2008: Revised general benefit information with self-service channels information.
January 2008: Removed Tufts Medicare Preferred benefit exception transition information.

**AUDIT AND DISCLAIMER INFORMATION**

Tufts Health Plan reserves the right to conduct audits on any provider and/or facility to ensure compliance with the guidelines stated in this payment policy. If such an audit determines that your office/facility did not comply with this payment policy, Tufts Health Plan will expect your office/facility to refund all payments related to non-compliance. For more information about Tufts Health Plan’s audit policies, refer to our website.

This policy provides information on Tufts Health Plan claims adjudication processing guidelines. As every claim is unique, the use of this policy is neither a guarantee of payment nor a final prediction of how specific claim(s) will be adjudicated. Claims payment is subject to member eligibility and benefits on the date of service, coordination of benefits, referral/authorization and utilization management guidelines when applicable, adherence to plan policies and procedures and claims editing logic.

This policy does not apply to Tufts Medicare Preferred HMO, Tufts Health Plan Senior Care Options, Tufts Health Public Plans or the Private Health Care Systems (PHCS) network (also known as Multiplan). This policy applies to CareLink for providers in the Massachusetts and Rhode Island service areas. Providers in the New Hampshire service area are subject to Cigna’s provider agreements with respect to CareLink members.