Ambulance Transportation

Policy Number: BIP005.N
Effective Date: February 1, 2024

Instructions for Use

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Related Benefit Interpretation Policies

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Federal/State Mandated Regulations

Note: The most current federal/state mandated regulations for each state can be found in the links below.

California Health and Safety Code Section 1371.5 – Emergency Medical Transportation Services Coverage

http://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?lawCode=HSC&sectionNum=1371.5.

(a) No health care service plan that provides basic health care **services** shall require prior authorization or refuse to pay for any ambulance or ambulance transport services, referred to in paragraph (6) of subdivision (b) of Section 1345, provided to an enrollee as a result of a "911" emergency response system request for assistance if either of the following conditions apply:
  (1) The request was made for an emergency medical condition and ambulance transport services were required.
  (2) An enrollee reasonably believed that the medical condition was an emergency medical condition and reasonably believed that the condition required ambulance transport services.

(b) As used in this section, "emergency medical condition" has the same meaning as in Section 1317.1.

(c) The determination as to whether an enrollee reasonably believed that the medical condition was an emergency medical condition that required an emergency response shall not be based solely upon a retrospective analysis of the level of care eventually provided to, or a final discharge of, the person who received emergency assistance.

(d) A health care service plan shall not be required to pay for any ambulance or ambulance transport services if the health care service plan determines that the ambulance or ambulance transport services were never performed, an emergency condition did not exist, or upon findings of fraud, incorrect billings, the provision of services that were not covered under the member's current benefit plan, or membership that was invalid at the time services were delivered for the pending emergency claim.

California Health & Safety Code Section 1345(6) Definitions

http://leginfo.legislature.ca.gov/faces/codes_displayText.xhtml?lawCode=HSC&division=2.&title=&part=&chapter=2.2.&article=1.

(6) Emergency health care services, including ambulance and ambulance transport services and out-of-area coverage. "Basic health care services" includes ambulance and ambulance transport services provided through the "911" emergency response system.

California Code of Regulations Title 28 Section 1300.67(g) Scope of Basic Health Care Services

https://govt.westlaw.com/calregs/Document/I944154734C8A11ECA45D000D3A7C4BC3?viewType=FullText&listSource=Search&originationContext=Search+Result&transitionType=SearchItem&contextData=(sc.Search)&navigationPath=Search%2fv1%2fresults%2fnavigation%2fi0ad62d3400000188fab35c9c62591659%3fppcid%3ddbfc1c69222749418367aed7d4801415%26Nav%3dREGULATION_PUBLICVIEW%26fragmentIdentifier%3dI944154734C8A11ECA45D000D3A7C4BC3%26startIndex%3d1%26transitionType%3dSearchItem%26contextData%3d%2528sc.Default%2529%26originationContext%3dSearch%2520Result&list=REGULATION_PUBLICVIEW&rank=1&t_T2=1300.67&t_S1=CA+ADC+s

The basic health care services required to be provided by a health care service plan to its enrollees shall include, where medically necessary, subject to any copayment, deductible, or limitation of which the Director may approve:

(g) (1) Emergency health care services which shall be available and accessible to enrollees on a twenty-four hour a day, seven days a week, basis within the health care service plan area. Emergency health care services shall include ambulance services for the area served by the plan to transport the enrollee to the nearest twenty-four hour emergency facility with physician coverage, designated by the Health Care Service Plan.

Assembly Bill No. 651 Chapter 537

Section 1

Section 76000.10 of the Government Code is amended to read:

76000.10

http://leginfo.legislature.ca.gov/faces/billCompareClient.xhtml?bill_id=201920200AB2450&showamends=false

(a) This section shall be known, and may be cited, as the Emergency Medical Air Transportation Act.

(b) For purposes of this section:
- (1) "Department" means the State Department of Health Care Services.
- (2) "Director" means the Director of Health Care Services.
- (3) "Provider" means a provider of emergency medical air transportation services.
- (4) "Rotary wing" means a type of aircraft, commonly referred to as a helicopter, that generates lift through the use of wings, known as rotor blades, that revolve around a mast.
- (5) "Fixed wing" means a type of aircraft, commonly referred to as an airplane, that generates lift through the use of the forward motion of the aircraft and wings that do not revolve around a mast but are fixed in relation to the fuselage of the aircraft.
- (6) "Air mileage rate" means the per-mileage reimbursement rate paid for services rendered by rotary-wing and fixed-wing providers.

(c) (1) For purposes of implementing this section, a penalty of four dollars ($4) shall be imposed upon every conviction for a violation of the Vehicle Code or a local ordinance adopted pursuant to the Vehicle Code, except parking offenses subject to Article 3 (commencing with Section 40200) of Chapter 1 of Division 17 of the Vehicle Code.

(2) The penalty described in this subdivision is in addition to the state penalty assessed pursuant to Section 1464 of the Penal Code. However, this penalty shall not be included in the base fine used to calculate the state penalty assessment pursuant to subdivision (a) of Section 1464 of the Penal Code, the state surcharge levied pursuant to Section 1465.7 of the Penal Code, and the state court construction penalty pursuant to Section 70372 of this code, and to calculate the other additional penalties levied pursuant to this chapter.

(d) The court that imposed the fine shall, in accordance with the procedures set out in Section 68101, transfer moneys collected pursuant to this section to the Treasurer for deposit into the Emergency Medical Air Transportation and Children's Coverage Fund, which is hereby established in the State Treasury. Notwithstanding Section 16305.7, the Emergency Medical Air Transportation and Children's Coverage Fund shall include interest and dividends earned on money in the fund. Any law that references the Emergency Medical Air Transportation Act Fund, as previously established by this subdivision, shall be construed to reference the Emergency Medical Air Transportation and Children's Coverage Fund, effective January 1, 2018.

(e) (1) The Emergency Medical Air Transportation and Children's Coverage Fund shall be administered by the State Department of Health Care Services. Moneys in the Emergency Medical Air Transportation and Children's Coverage Fund shall be made available, upon appropriation by the Legislature, to the department for any of the following purposes:
- (A) For children's health care coverage.
- (B) For emergency medical air transportation provider payments, as follows:
  - (i) For payment of the administrative costs of the department in administering emergency medical air transportation provider payments.

(ii) Twenty percent of the appropriated money remaining after payment of administrative costs pursuant to clause (i) shall be used to offset the state portion of the Medi-Cal reimbursement rate for emergency medical air transportation services.

(iii) Eighty percent of the appropriated money remaining after payment of administrative costs pursuant to clause (i) shall be used to augment emergency medical air transportation reimbursement payments made through the Medi-Cal program, as set forth in paragraphs (2) and (3).

(2) If money in the Emergency Medical Air Transportation and Children's Coverage Fund is made available to the department for the purpose described in subparagraph (B) of paragraph (1), both of the following shall occur:

(A) The department shall seek to obtain federal matching funds by using the moneys in the Emergency Medical Air Transportation and Children's Coverage Fund for the purpose of augmenting Medi-Cal reimbursement paid to emergency medical air transportation providers.

(B) The director shall augment emergency medical air transportation provider payments in accordance with a federally approved reimbursement methodology. The director may seek federal approvals or waivers as may be necessary to implement this section and to obtain federal financial participation to the maximum extent possible for the payments under this section.

(3) (A) Upon appropriation by the Legislature, the department shall use moneys in the Emergency Medical Air Transportation and Children's Coverage Fund and any federal matching funds to do any of the following:

(i) Fund children's health care coverage.

(ii) Increase the Medi-Cal reimbursement for emergency medical air transportation services in an amount not to exceed normal and customary charges charged by the providers.

(B) Notwithstanding any other law, and pursuant to this section, if money in the Emergency Medical Air Transportation and Children's Coverage Fund is made available to the department for the purpose described in subparagraph (B) of paragraph (1), the department shall increase the Medi-Cal reimbursement for emergency medical air transportation services if both of the following conditions are met:

(i) Moneys in the Emergency Medical Air Transportation and Children's Coverage Fund will cover the cost of increased payments pursuant to clause (iii) of subparagraph (B) of paragraph (1).

(ii) The state does not incur any General Fund expense to pay for the Medi-Cal emergency medical air transportation services increase.

(f) The assessment of penalties pursuant to this section shall terminate on July 1, 2021. Penalties assessed before July 1, 2021, shall continue to be collected, administered, and distributed pursuant to this section until exhausted or until December 31, 2022, whichever occurs first. On December 31, 2022, moneys remaining unexpended and unencumbered in the Emergency Medical Air Transportation and Children's Coverage Fund shall be transferred to the General Fund, to be available, upon appropriation by the Legislature, for the purposes of augmenting Medi-Cal reimbursement for emergency medical air transportation and related costs, generally, or funding children's health care coverage.

(g) Notwithstanding the rulemaking provisions of Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2, the department may implement, interpret, or make specific this section and any applicable federal waivers and state plan amendments by means of all-county letters, plan letters, plan or provider bulletins, or similar instructions without taking regulatory action.

(h) This section shall become inoperative on July 1, 2024 , and as of January 1, 2025, that date is repealed.

Section 2

No reimbursement is required by this act pursuant to Section 6 of Article XIII B of the California Constitution because a local agency or school district has the authority to levy service charges, fees, or assessments sufficient to pay for the program or level of service mandated by this act, within the meaning of Section 17556 of the Government Code.

Section 3

This act is an urgency statute necessary for the immediate preservation of the public peace, health, or safety within the meaning of Article IV of the California Constitution and shall go into immediate effect. The facts constituting the necessity are:

- To protect the health and safety of Medi-Cal beneficiaries after the current penalty expires on July 1, 2020, this act is needed to continue the assessment and associated program, and it is necessary that this act take effect immediately.

Section 2

Section 1371.55 is added to the Health and Safety Code, to read:

Section 1371.55.

http://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=1371.55&lawCode=HSC
https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=201920200AB651

(a) (1) Notwithstanding Section 1367.11, a health care service plan contract issued, amended, or renewed on or after January 1, 2020, shall provide that if an enrollee receives covered services from a noncontracting air ambulance provider, the enrollee shall pay no more than the same cost-sharing amount that the enrollee would pay for the same covered services received from a contracting air ambulance provider. This amount shall be referred to as the "in-network cost-sharing amount."

(2) An enrollee shall not owe the noncontracting provider more than the in-network cost-sharing amount for services subject to this section. At the time of payment by the plan to the noncontracting provider, the plan shall inform the enrollee and the noncontracting provider of the in-network cost-sharing amount owed by the enrollee.

(b) The following shall apply for purposes of this section:

(1) Any cost sharing paid by the enrollee for the services subject to this section shall count toward the limit on annual out-of-pocket expenses established under Section 1367.006.

(2) Cost sharing arising from services subject to this section shall be counted toward any deductible in the same manner as cost sharing would be attributed to a contracting provider.

(3) The cost sharing paid by the enrollee pursuant to this section shall satisfy the enrollee's obligation to pay cost sharing for the health service.

(c) A noncontracting provider may advance to collections only the in-network cost-sharing amount, as determined by the plan pursuant to subdivision (a), that the enrollee failed to pay.

(d) A health care service plan or a provider may seek relief in any court for the purpose of resolving a payment dispute. A provider is not prohibited from using a health care service plan's existing dispute resolution processes.

(e) Air ambulance service providers remain subject to the balance billing protections for Medi-Cal beneficiaries under Section 14019.4 of the Welfare and Institutions Code.

Sections 1371.56, 1797.124, and 1797.232

Bill Text - AB-716 Ground medical transportation

Section 1

Section 1367.11 of the Health and Safety Code is repealed.

Section 2

Section 1371.56 is added to the Health and Safety Code, to read:

(a) (1) Unless otherwise required by this chapter, a health care service plan contract issued, amended, or renewed on or after January 1, 2024, shall require an enrollee who receives covered services from a noncontracting ground ambulance provider to pay no more than the same cost-sharing amount that the enrollee would pay for the same covered services received from a contracting ground ambulance provider. This amount shall be referred to as the "in-network cost-sharing amount."

(2) An enrollee shall not owe the noncontracting ground ambulance provider more than the in-network cost-sharing amount for services subject to this section. At the time of payment by the plan to the noncontracting provider, the plan shall inform the enrollee and the noncontracting provider of the in-network cost-sharing amount owed by the enrollee and shall disclose whether or not the enrollee's coverage is regulated by the department or if the coverage is not state-regulated.

(b) (1) The in-network cost-sharing amount paid by the enrollee pursuant to this section shall count toward the limit on annual out-of-pocket expenses established under Section 1367.006.

(2) Cost sharing arising pursuant to this section shall count toward any deductible in the same manner as cost sharing would be attributed to a contracting provider.

(3) The in-network cost-sharing amount paid by the enrollee pursuant to this section shall satisfy the enrollee's obligation to pay cost sharing for the health service.

(c) A noncontracting ground ambulance provider shall only advance to collections the in-network cost-sharing amount, as determined by the plan pursuant to subdivision (a), that the enrollee failed to pay.

(1) A noncontracting ground ambulance provider, or an entity acting on its behalf, including a debt buyer or assignee of the debt, shall not report adverse information to a consumer credit reporting agency or commence civil action against the enrollee for a minimum of 12 months after the initial billing regarding amounts owed by the enrollee pursuant to subdivision (a).

(2) With respect to an enrollee, a noncontracting ground ambulance provider, or an entity acting on its behalf, including an assignee of the debt, shall not use wage garnishments or liens on primary residences as a means of collecting unpaid bills pursuant to this section.

(d) (1) Unless otherwise agreed to by the noncontracting ground ambulance provider and the health care service plan, the plan shall directly reimburse a noncontracting ground ambulance provider for ground ambulance services the difference between the in-network cost-sharing amount and an amount described, as follows:

(A) If there is a rate established or approved by a local government, at the rate established or approved by the governing body of the local government having jurisdiction for that area or subarea, including an exclusive operating area pursuant to Section 1797.85.

(B) If the local government having jurisdiction where the service was provided does not have an established or approved rate for that service, the amount established by Section 1300.71 (a)(3)(B) of Title 28 of the California Code of Regulations.

(2) A local government has jurisdiction over the ground ambulance transport if either of the following applies:

(A) The ground ambulance transport is initiated within the boundaries of the local government's regulatory jurisdiction.

(B) In the case of ground ambulance transports provided on a mutual or automatic aid basis into another jurisdiction, the local government where the noncontracting ground ambulance provider is based.

(3) A payment made by the health care service plan to the noncontracting ground ambulance provider for services as required in subdivision (a), plus the applicable cost sharing owed by the enrollee, shall constitute payment in full for services rendered.

(4) Notwithstanding any other law, the amounts paid by a health care service plan for services under this section shall not constitute the prevailing or customary charges, the usual fees to the general public, or other charges for other payers for an individual ground ambulance provider.

(e) A health care service plan or a provider may seek relief in any appropriate court for the purpose of resolving a payment dispute. A ground ambulance provider may use a health care service plan's existing dispute resolution processes.

(f) Ground ambulance service providers remain subject to the balance billing protections for Medi-Cal beneficiaries under Section 14019.4 of the Welfare and Institutions Code.

(g) This section does not apply to a Medi-Cal managed health care service plan or any entity that enters into a contract with the State Department of Health Care Services pursuant to Chapter 7 (commencing with Section 14000), Chapter 8 (commencing with Section 14200), and Chapter 8.75 (commencing with Section 14591) of Part 3 of Division 9 of the Welfare and Institutions Code.

Section 3

Section 1797.124 is added to the Health and Safety Code, to read:

Section 1797.124

(a) On or before March 1, 2024, and on or before each January 1 thereafter, the authority shall annually develop and publish on its internet website a report showing the allowable maximum rates for ground ambulance transportation services in each county, including trending the rates by county. If feasible, this report shall include the applicable Medicare rate for the year.

(b) The authority shall annually submit each report to the Department of Insurance and the Department of Managed Health Care for purposes of rate review, as well as to the Office of Health Care Affordability.

Section 4

Section 1797.232 is added to the Health and Safety Code, to read:

Section 1797.232

(a) A ground ambulance provider shall not require an uninsured patient or self-pay patient to pay an amount more than the established payment by Medi-Cal or Medicare fee-for-service amount, whichever is greater.

(b) (1) A ground ambulance provider shall only advance to collections the Medicare or Medi-Cal payment amount, as determined pursuant to subdivision (a), that the uninsured or self-pay patient failed to pay.

(2) The ground ambulance provider, or an entity acting on its behalf, including a debt buyer or assignee of the debt, shall not report adverse information to a consumer credit reporting agency or commence civil action against the individual for a minimum of 12 months after the initial billing regarding amounts owed by the individual pursuant to subdivision (a).

(3) With respect to an uninsured patient or self-pay patient, the ground ambulance provider, or an entity acting on its behalf, including an assignee of the debt, shall not use wage garnishments or liens on primary residences as a means of collecting unpaid bills pursuant to this section.

(c) Ground ambulance service providers remain subject to balance billing protections for Medi-Cal beneficiaries under Section 14019.4 of the Welfare and Institutions Code.

Section 5

Section 10126.66 is added to the Insurance Code, to read:

Section 10126.66

(a) (1) Unless otherwise required by this chapter, a health insurance policy issued, amended, or renewed on or after January 1, 2024, shall require an insured who receives covered services from a noncontracting ground ambulance provider to pay no more than the same cost-sharing amount that the insured would pay for the same covered services received from a contracting ground ambulance provider. This amount shall be referred to as the "in-network cost-sharing amount."

(2) An insured shall not owe the noncontracting ground ambulance provider more than the in-network cost-sharing amount for services subject to this section. At the time of payment by the insurer to the noncontracting provider, the insurer shall inform the insured and the noncontracting provider of the in-network cost-sharing amount owed by the insured and shall disclose whether or not the insured's coverage is regulated by the department or if the coverage is not state-regulated.

(b) (1) The in-network cost-sharing amount paid by the insured pursuant to this section shall count toward the limit on annual out-of-pocket expenses established under Section 10112.28.

(2) Cost sharing arising pursuant to this section shall count toward any deductible in the same manner as cost sharing would be attributed to a contracting provider.

(3) The in-network cost-sharing amount paid by the insured pursuant to this section shall satisfy the insured's obligation to pay cost sharing for the health service.

(c) A noncontracting ground ambulance provider shall only advance to collections the in-network cost-sharing amount, as determined by the insurer pursuant to subdivision (a), that the insured failed to pay.

(1) A noncontracting ground ambulance provider, or an entity acting on its behalf, including a debt buyer or assignee of the debt, shall not report adverse information to a consumer credit reporting agency or commence civil action against the insured for a minimum of 12 months after the initial billing regarding amounts owed by the insured pursuant to subdivision (a).

(2) With respect to an insured, a noncontracting ground ambulance provider, or an entity acting on its behalf, including an assignee of the debt, shall not use wage garnishments or liens on primary residences as a means of collecting unpaid bills pursuant to this section.

(d) (1) Unless otherwise agreed to by the noncontracting ground ambulance provider and the health insurer, the insurer shall directly reimburse a noncontracting ground ambulance provider for ground ambulance services the difference between the in-network cost-sharing amount and an amount described, as follows:

(A) If there is a rate established or approved by a local government, at the rate established or approved by the governing body of the local government having jurisdiction for that area or subarea, including an exclusive operating area pursuant to Section 1797.85 of the Health and Safety Code.

(B) If the local government having jurisdiction where the service was provided does not have an established or approved rate for that service, the reasonable and customary value for the services rendered, based upon statistically credible information that is updated at least annually and takes into consideration all of the following:

(i) The ambulance provider's training, qualifications, and length of time in practice.

(ii) The nature of the services provided.

(iii) The fees usually charged by the ambulance provider.

(iv) Prevailing ground ambulance provider rates charged in the general geographic areas in which the services were rendered.

(v) Other aspects of the economics of the ambulance provider's practice that are relevant.
(vi) Any unusual circumstances in the case.

(2) A local government has jurisdiction over the ground ambulance transport if either of the following applies:
(A) The ground ambulance transport is initiated within the boundaries of the local government's regulatory jurisdiction.
(B) In the case of ground ambulance transports provided on a mutual or automatic aid basis into another jurisdiction, the local government where the noncontracting ground ambulance provider is based.

(3) A payment made by the health insurer to the noncontracting ground ambulance provider for services as required in subdivision (a), plus the applicable cost sharing owed by the insured, shall constitute payment in full for services rendered.

(4) Notwithstanding any other law, the amounts paid by a health insurer for services under this section shall not constitute the prevailing or customary charges, the usual fees to the general public, or other charges for other payers for an individual ground ambulance provider.

(e) A health insurer or ground ambulance provider may seek relief in any appropriate court for the purpose of resolving a payment dispute. A ground ambulance provider may use a health insurer's existing dispute resolution process under Section 10123.137.

(f) This section does not affect the balance billing protections for Medi-Cal beneficiaries under Section 14019.4 of the Welfare and Institutions Code.

Section 6

Section 10352 of the Insurance Code is repealed.

Section 7

No reimbursement is required by this act pursuant to Section 6 of Article XIII B of the California Constitution because the only costs that may be incurred by a local agency or school district will be incurred because this act creates a new crime or infraction, eliminates a crime or infraction, or changes the penalty for a crime or infraction, within the meaning of Section 17556 of the Government Code, or changes the definition of a crime within the meaning of Section 6 of Article XIII B of the California Constitution.

Section 10126.65 is added to the Insurance Code, to read:

Section 10126.65

https://law.justia.com/codes/california/2021/code-ins/division-2/part-2/chapter-1/article-1/section-10126-65/

(a) (1) Notwithstanding Section 10352, a health insurance policy issued, amended, or renewed on or after January 1, 2020, shall provide that if an insured or subscriber receives covered services from a noncontracting air ambulance provider, the insured or subscriber shall pay no more than the same cost sharing that the insured or subscriber would pay for the same covered services received from a contracting air ambulance provider. This amount shall be referred to as the "in-network cost-sharing amount."

(2) A subscriber or insured shall not owe the noncontracting provider more than the in-network cost-sharing amount for services subject to this section. At the time of payment by the insurer to the noncontracting provider, the insurer shall inform the insured or subscriber and the noncontracting provider of the in-network cost-sharing amount owed by the insured or subscriber.

(b) The following shall apply for purposes of this section:
(1) Any cost sharing paid by the insured or subscriber for the services subject to this section shall count toward the limit on annual out-of-pocket expenses established under Section 10112.28.
(2) Cost sharing arising from services subject to this section shall be counted toward any deductible in the same manner as cost sharing would be attributed to a contracting provider.
(3) The cost sharing paid by the insured or subscriber pursuant to this section shall satisfy the insured's or subscriber's obligation to pay cost sharing for the health service.

(c) A noncontracting provider may advance to collections only the in-network cost-sharing amount, as determined by the insurer pursuant to subdivision (a), that the insured or subscriber failed to pay.

(d) A health insurer or a provider may seek relief in any court for the purpose of resolving a payment dispute. A provider is not prohibited from using a health insurer's existing dispute resolution processes.

State Market Plan Enhancements

None

Covered Benefits

Important Note: Covered benefits are listed in *Federal/State Mandated Regulations*, *State Market Plan Enhancements*, and *Covered Benefits* sections. Always refer to the *Federal/State Mandated Regulations* and *State Market Plan Enhancements* sections for additional covered services/benefits not listed in this section.
Note: Refer to the member's Evidence of Coverage (EOC)/Schedule of Benefit (SOB) for additional information.

- Ambulance transportation by ground or air to the nearest appropriate facility when medically necessary (refer to the Benefit Interpretation Policies titled Emergency and Urgent Services and Medical Necessity).
  Note: The use of an ambulance (land or air) is covered without prior authorization when the member reasonably believes there is an emergency medical or psychiatric condition that requires ambulance transport to access emergency health care services.
  - Ground ambulance transportation using a basic life support or an advanced life support ambulance for the following transfers when medical necessity for ground ambulance transport is met:
    - Inter-hospital or skilled nursing facility transfers (skilled care only);
    - Hospital and renal dialysis facility;
    - Skilled nursing facility and dialysis facility (skilled care only);
    - Skilled nursing facility and radiation therapy (skilled care only);
    - Skilled nursing facility (SNF) and hospital and member's home.
  - Air ambulance transportation is a covered benefit only when:
    - The member's destination is an acute care hospital;
    - The member's condition is such that the ground ambulance would endanger the member's life or health;
    - Inaccessibility to ground ambulance transport or extended length of time required to transport the member via ground transport could endanger the member;
    - Weather or traffic conditions make ground transport impractical, impossible or overly time consuming.
  - Out-of-area ambulance service (ground or air) in conjunction with out-of-area care as listed above.
- Ambulance transportation for the member that is requested by public entities (e.g., police, school, and social services) is covered if one of the following criteria is met:
  - Reasonably complete and accurate documentation by the ambulance supplier demonstrates that the transportation furnished was medically necessary;
  - UnitedHealthcare independently determines that the transportation was medically necessary.
- Use of an ambulance for a non-emergency health care service is covered only when it is authorized by the member's network medical group or UnitedHealthcare.

Not Covered

- Any ambulance service to provide member transport for routine care when transport by other means would not endanger the member's health except as indicated in the *Covered Benefits* section.
- Any ambulance service when the member is unable to locate another form of transport and the member's health would not be compromised.
- Any ambulance service that serves only as a convenience for either the member or his/her family.
- Wheelchair transportation services (e.g., a private vehicle or taxi fare).
- Ambulance service (ground or air) to the coroner's office or mortuary.
- Personal transportation costs such as gasoline costs for a private vehicle or taxi fare.
- Inter-hospital or skilled nursing facility transportation due to a member request or convenience.
- Any ambulance service from one contracting facility to another contracting facility **unless the transfer is necessary to deliver medical services when a higher level of care is required**.

- For members out-of- country, transportation back to the United States when there is a foreign facility that is capable of managing the member's condition.
- Transportation is not a covered benefit except for ambulance transportation as defined in the *Covered Benefits* section.

Policy History/Revision Information

Date	Summary of Changes
02/01/2024	**Federal/State Mandated Regulations** • Added language pertaining to *Assembly Bill 716* **Supporting Information** • Archived previous policy version BIP005.M

Instructions for Use

Covered benefits are listed in three (3) sections: *Federal/State Mandated Regulations*, *State Market Plan Enhancements*, and *Covered Benefits*. All services must be medically necessary. Each benefit plan contains its own specific provisions for coverage, limitations, and exclusions as stated in the member's Evidence of Coverage (EOC)/Schedule of Benefits (SOB). If there is a discrepancy between this policy and the member's EOC/SOB, the member's EOC/SOB provision will govern.