Ambulance Transportation

Policy Number: BIP006.K
Effective Date: September 1, 2023

Instructions for Use

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Related Benefit Interpretation Policies

- Dialysis Services
- Emergency and Urgent Services
- Medical Necessity
- Transplantation Services

Federal/State Mandated Regulations

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

Oklahoma

Oklahoma Administrative Code 365:40-5-21-Supplemental Health Care Services

https://regulations.justia.com/states/oklahoma/title-365/chapter-40/subchapter-5/part-5/section-365-40-5-21/
https://www.oid.ok.gov/wp-content/uploads/2019/10/091517_C40S5.pdf

Supplemental health care services of an HMO may include the following:

(8) Ambulance services, unless medically necessary.

Title 36 Oklahoma Statutes §6907

Title 36 Insurance §36-6058. Newly-Born Children - Health Insurance Benefits

https://law.justia.com/codes/oklahoma/2014/title-36/section-36-6058/

(B) The coverage for newly born children shall consist of coverage of injury or sickness including the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities. Such coverage shall also include transportation necessary for the provision of medical care for such newly born children when (1) the newly born is transported to the nearest hospital capable of providing the medically necessary treatment on a timely basis, and (2) the mode of transportation is the most economical consistent with the well-being of the newly born. Transportation coverage shall not exceed the reasonable costs of providing such service and an itemized statement of costs shall accompany each claim.

Oregon

Oregon Revised Statutes 743A.014 Payments for Ambulance Care and Transportation

https://www.oregonlaws.org/ors/743A.014

(1) As used in this section, “health benefit plan” has the meaning given that term in ORS 743B.005 (Definitions)

(2) Notwithstanding ORS 743.543 (Payment of benefits under blanket health insurance policies), with respect to a health benefit plan or a Medicare supplement insurance policy that provides coverage for ambulance care and transportation, the insurer shall indemnify directly the provider of the ambulance care and transportation. [Formerly 743.718; 2013 c.91 §1; 2015 c.588 §4]

Texas

Texas Administrative Code Title 28 Part 1 Chapter 11 Subchapter F § 11.508: Basic Health Care Services and Mandatory Benefit Standards: Group, Individual, and Conversion Agreements

https://texreg.sos.state.tx.us/public/readtac$ext.TacPage?sl=R&app=9&p_dir=&p_rloc=&p_tloc=&p_ploc=&pg=1&p_tac=&ti=28&pt=1&ch=11&rl=508

(a) Each evidence of coverage providing basic health care services must provide the following basic health care services when they are provided by network physicians or providers, or by non-network physicians and providers as set out in §11.506(b)(9) or §11.506(b)(14) of this title (relating to Mandatory Contractual Provisions: Group, Individual, and Conversion Agreement and Group Certificate):

(1) (J) Emergency services as required by Insurance Code §1271.155 (concerning Emergency Care), including emergency transport in an emergency medical services vehicle licensed under Health and Safety Code Chapter 773 (concerning Emergency Medical Services), which is considered emergency care if it is provided as part of the evaluation and stabilization of medical conditions of a recent onset and severity, including severe pain, that would lead a prudent layperson possessing an average knowledge of medicine and health to believe that the individual's condition, sickness, or injury is of such a nature that failure to get immediate care through emergency transport could place the individual's health in serious jeopardy, result in serious impairment to bodily functions, result in serious dysfunction of a bodily organ or part, result in serious disfigurement, or for a pregnant woman, result in serious jeopardy to the health of the fetus;

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 preauthorization when the member, as a Prudent Layperson, 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.

- Use of an Ambulance for non-Emergency Health Care Services is covered only when specifically 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	State(s) Affected	Summary of Changes
09/01/2023	All	• Routine review; no change to benefit coverage guidelines • Archived previous policy version BIP006.J

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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.