Reimbursement Policy

Ambulance Services

REIMBURSEMENT POLICY NUMBER: 23

Effective Date: 6/1/2026

Last Review Date: 5/2026

Next Annual Review: 5/2027

INSTRUCTIONS FOR USE: Company reimbursement policies serve as guidance for the administration of plan benefits, reimbursement methodologies, and acceptable billing practices, intended to help health care providers submit claims accurately in order to reduce delays and ensure more accurate claim adjudication. Reimbursement policies do not constitute a guarantee of coverage. They allow for the consistent application of our member contracts, provider contracts, clinical edits, and medical policies. In the event of a conflict between one of these documents and a reimbursement policy, these documents will take precedent over the reimbursement policy. If contracts and policies are silent, the Company may defer to guidance from the Centers for Medicare & Medicaid Services (CMS) when available and applicable. In addition to correct billing practices, in order to qualify for reimbursement, all services, items, and procedures must be covered member benefits and must also meet applicable authorization and medical necessity guidelines. Company reimbursement policies are reviewed annually. The Companies reserve the right to determine the application of reimbursement policies and make revisions to reimbursement policies at any time.

SCOPE AND APPLICATION

Provider Type:

☒ Ambulance Claims

Plan Product:

☒ Commercial
☒ Medicare
☒ Medicaid/Oregon Health Plan (OHP)

POLICY STATEMENT

SCOPE: Providence Health Plan, Providence Health Assurance, and Providence Plan Partners as applicable (referred to individually as "Company" and collectively as "Companies").

NOTES:

- This policy addresses **reimbursement methodologies** for ambulance transports. For **medical necessity/coverage** determinations for ambulance transports, see separate Medical Policies in the "Cross References" section below.
- The Company has adopted Centers for Medicare and Medicaid Services (CMS) guidelines regarding ambulance services and billing.
- The policy applies to all lines of business, except when otherwise indicated.
- Provider contract language and payment methodology may vary.

I. Reimbursement for ambulance transport to the nearest appropriate facility includes payment for the following items and services:

A. Base rate payment.
B. Mileage payment.
C. All personnel supplies and services provided during the transport.

II. Vehicles used as an ambulance must have customary patient care equipment and first aid supplies, including reusable devices and equipment such as backboards, neckboards, and inflatable leg and arm splints. These are all considered an integral part of the general ambulance service and reimbursement for them is included in the payment rate for the transport itself. Therefore, the following items and services are included in the fee schedule payment for the ambulance transport and are **not** to be billed separately:

A. Oxygen (HCPCS (A0422)
B. IV drug therapy and drugs (A0394)
C. Other supplies (A0382, A0384, A0392, A0396, A0398)
D. Extra attendants (HCPCS A0424)
E. EKG testing (e.g., ancillary services)
F. Mileage for distance traveled **beyond** the closest appropriate facility (A0888).

III. All claims must be submitted with the HCPCS code that most accurately represents the service rendered. If no transport is provided, then a transport HCPCS code (e.g., A0428, A0429, etc.) should **not** be used. A HCPCS code for a non-transport service (e.g., A0998) should be used instead.

IV. Ambulance claims must use origin and destination modifiers in the *primary* position as appropriate to the transport provided **and** the modifier combination must represent a covered ambulance service.

A. The following modifier combinations are either **not** eligible for reimbursement ***or*** will under pre-payment review to confirm medical necessity and/or benefit eligibility of the transport: DD, DE, DP, DR, DS, ED, EE, EP, ER, ES, GD, GG, GI, GJ, GP, GS, GX, HD, HG, HP, HS, HX, ID, IE, IJ, IN, IP, IR, IS, IX, JD, JG, JI, JJ, JP, JS, JX, NI, NN, NP, NS, PD, PE, PG, PJ, PN, PP, PR, PS, PX, RD, RE, RP, RR, RS, SD, SE, SG, SJ, SN, SP, SR, SS, XD, XE, XG, XJ, XN, XP, XR, XS, XX *(Detailed rationale behind each modifier can be found in the Billing Guideline section below.)*

V. Additional informational modifiers must be in the *secondary* position. These include, but

may not be limited to modifier GM. If these modifiers are billed in the primary position, it may result in a claim denial. *(**Exception**: If the QL modifier is required, an origin/destination modifier is not required; however, if an origin/destination modifier is used, it must be a valid modifier combination. See Criterion IV.A above for examples of invalid modifier combinations.)*

VI. Ambulance claims must use **one of the following** appropriate place of service (POS) codes:

A. 41: Ambulance - Land
B. 42: Ambulance – Air or water
C. 99: Other place of service not identified (for non-transport ambulance claims only)

VII. It is the provider's responsibility to supply the Plan with information that supports the condition of the member and that an ambulance transport was necessary. This includes the use of **ICD-10 diagnosis codes**. While EMTs/paramedics do not "diagnose" patient's, any ICD-10 diagnosis code(s) used should best describes the member's condition at the time of transport. When a diagnosis is not confirmed, it is recommended to use a symptom, finding, and/or injury code. Ambulance providers should avoid using ICD-10 codes to report "rule out" or "suspected" diagnoses.

VIII. Ambulance providers can also use **condition codes** on claims to demonstrate the condition of the member at the time of transport. Transport condition codes may include the following:

A. AK: Air ambulance required.
B. AL: Specialized treatment/bed unavailable.
C. AM: Non-emergency medically necessary stretcher transport required.
D. B2: Critical Access Hospital ambulance attestation that it meets criteria for exemption from ambulance fee schedule.

IX. Ambulance providers can be either hospital- (or institutional) -based **or** non-hospital based (e.g., an independently owned and operated ambulance service company, a volunteer fire and/or ambulance company, a local government run firehouse-based ambulance, etc.). For hospital-based ambulance providers, claims must be reported with the appropriate type of bill (13X, 22X, 23X, 83X, and 85X). For SNFs, ambulance cannot be reported on a 21X type of bill.

X. If air ambulance transport was used, but ground ambulance transport would have sufficiently met the clinical needs of the individual, payment for the air ambulance transport may be based on the payment amount for ground ambulance transport.

XI. If air ambulance transport was medically appropriate (i.e., ground transportation was contraindicated, and the patient required air transport to a facility), but the patient could have been treated at a facility **nearer** than the one to which they were transported, the air transport payment may be limited to the rate for the distance from the point of pickup to the nearer facility.

Ambulance Response and Treat, No Transport – Medicare Advantage Plan Members

XII. While Original Medicare does not cover "non-transport" services (aka, treat and release) (HCPCS A0998), Medicare Advantage Plan benefits **may** allow ambulance services received through the 911 emergency medical response system when the patient received treatment but do not ride in the ambulance (member copayment or coinsurance may apply). HCPCS code A0998 should be used instead of an unlisted code (A0999) for these non-transport situations.

Ambulance Services for Deceased Members

XIII. Calculation for reimbursement for **ground ambulance** services for deceased members may be determined as follows, based on when pronouncement of death took place:

A. Pronouncement made while enroute or upon arrival at the hospital or final destination: Payment is limited to the medically necessary level of service provided during the transport.
B. Pronouncement made ***after*** the ambulance call was made and ambulance dispatched, but ***prior to*** pick-up and loading: Payment is limited to BLS base rate only. No mileage or rural adjustment will be provided.

XIV. Calculation for reimbursement for **air ambulance** services for deceased members may be determined as follows, based on when pronouncement of death took place:

A. Pronouncement made ***after*** take-off, but ***before*** being loaded; Payment limited to air base rate only [i.e., fixed wing or rotary wing], no mileage or rural adjustment.
B. Pronouncement made ***after*** being loaded on board, but ***prior to or upon*** arrival at receiving facility: Coverage is unaffected. Claim is allowed as if the member hadn't passed away.

XV. Reimbursement may **not** be made for either ground or air ambulance transport for deceased members if IV or V above is not met.

POLICY GUIDELINES

BACKGROUND

Reimbursement is made for ambulance services based on CMS fee schedule amounts.[1] Oregon Health Plan (OHP) or Medicaid may also use the OHP Fee-for-Service Fee Schedule.[2]

Not all ambulance services may be eligible as a covered benefit, and some ambulance services may not be separately reimbursable. Ambulance vehicles are required to have customary patient care equipment and first aid supplies, including but not limited to: reusable devices and equipment such as backboards, neckboards, and inflatable leg and arm splints. **Equipment on an ambulance is considered an integral part of the general ambulance service and reimbursement for the use of such equipment is included in**

the payment rate for the transport itself. The purpose of this policy is to assist ambulance providers with appropriate billing for ambulance services.

Member plan benefits allow coverage for ambulance services for both emergency and non-emergency situations to the nearest appropriate facility that can provide care if they are furnished to a member whose medical condition is such that other means of transportation could endanger the person's health or if authorized by the plan.

When ambulance services are not for an emergency situation, it should be documented that the member's condition is such that other means of transportation could endanger the person's health and that transportation by ambulance is medically required.

This applies to air ambulance (fixed and rotary wing), as well as ground ambulance services. Water ambulance services are also included, and considered "ground" ambulance services according to Medicare.

DEFINITIONS

Ambulance. Any vehicle used as an ambulance must be designed and equipped to respond to medical emergencies and, in nonemergency situations, be capable of transporting individuals with acute medical conditions. The vehicle must comply with State or local laws governing the licensing and certification of an emergency medical transportation vehicle. At a minimum, the ambulance must contain a stretcher, linens, emergency medical supplies, oxygen equipment, and other lifesaving emergency medical equipment and be equipped with emergency warning lights, sirens, and telecommunications equipment as required by State or local law. This should include, at a minimum, one 2-way voice radio or wireless telephone.

BLS. BLS, or basic life support, is transportation by ground ambulance vehicle and the provision of medically necessary supplies and services.

ALS. ALS, or advanced life support, is sorted by "level" or service rendered.

> ALS Level 1 (ALS1) is the transportation by ground ambulance vehicle and the provision of medically
> necessary supplies and services, including the provision of an ALS assessment by ALS personnel or at least one ALS intervention.
>
> ALS Assessment is an assessment performed by an ALS crew as part of an emergency response that was necessary because the patient's reported condition at the time of dispatch was such that only an ALS crew was qualified to perform the assessment. An ALS assessment does not necessarily result in a determination that the patient requires an ALS level of service. In the case of an appropriately dispatched ALS Emergency service, as defined below, if the ALS crew completes an ALS Assessment, the services provided by the ambulance transportation service provider or supplier shall be covered at the ALS emergency level, regardless of whether the patient required ALS intervention services during the transport, provided that ambulance transportation itself was medically reasonable and necessary.

ALS Intervention is a procedure that is in accordance with state and local laws, required to be done by an emergency medical technician-intermediate (EMT-Intermediate) or EMT-Paramedic. An ALS intervention must be medically necessary to qualify as an intervention for payment for an ALS level of service. An ALS intervention applies only to ground transports.

ALS Level 1 (ALS1) – Emergency is the provision of ALS1 services, as described above, in the context of an emergency response.

Advanced Life Support, Level 2 (ALS2) is the transportation by ground ambulance vehicle and the provision of medically necessary supplies and services including (1) at least three separate administrations of one or more medications by intravenous (IV) push/bolus or by continuous infusion (excluding crystalloid fluids) or (2) ground ambulance transport, medically necessary supplies and services, and the provision of at least one of the ALS2 procedures listed below:

a. Manual defibrillation/cardioversion;
b. Endotracheal intubation;
c. Central venous line;
d. Cardiac pacing;
e. Chest decompression;
f. Surgical airway; or
g. Intraosseous line.

To qualify for the ALS2 level of payment, medications must be administered intravenously. Medications that are administered by other means, for example: intramuscularly, subcutaneously, orally, sublingually, or nebulized do not support payment at the ALS2 level rate.

The IV medications are administered in standard doses as directed by local protocol or online medical direction. It is not appropriate to administer a medication in divided doses in order to meet the ALS2 level of payment. For example, if the local protocol for the treatment of supraventricular tachycardia (SVT) calls for a 6 mg dose of adenosine, the administration of three 2 mg doses in order to qualify for the ALS 2 level is not acceptable.

The administration of an intravenous drug by infusion qualifies as one intravenous dose. For example, if a patient is being treated for atrial fibrillation in order to slow the ventricular rate with diltiazem and the patient requires two boluses of the drug followed by an infusion of diltiazem, then the infusion would be counted as the third intravenous administration and the transport would be billed as an ALS 2 level of service.

The fractional administration of a single dose (for this purpose, meaning a “standard” or “protocol” dose) of a medication on three separate occasions does not qualify for ALS2 payment. In other words, the administering 1/3 of a qualifying dose 3 times does not equate to three qualifying doses to support claiming ALS2-level care.

ALS Personnel are individuals trained to the level of the emergency medical technician-intermediate (EMT-Intermediate) or paramedic.

EMT-Intermediate. EMT-Intermediate is an individual who is qualified, in accordance with state and local laws, as an EMT-Basic and who is also certified in accordance with state and local laws to perform essential advanced techniques and to administer a limited number of medications.

EMT-Paramedic. EMT-Paramedic possesses the qualifications of the EMT-Intermediate and, in accordance with state and local laws, has enhanced skills that include being able to administer additional interventions and medications.

Specialty Care Transport (SCT). SCT is the interfacility transportation of a critically injured or ill beneficiary by a ground ambulance vehicle, including the provision of medically necessary supplies and services, at a level of service beyond the scope of the EMT-Paramedic. SCT is necessary when a beneficiary's condition requires ongoing care that must be furnished by one or more health professionals in an appropriate specialty area, for example, emergency or critical care nursing, emergency medicine, respiratory care, cardiovascular care, or an EMT-Paramedic with additional training.

Interfacility Transportation. For purposes of SCT payment, Medicare defines an interfacility transportation as one in which the origin and destination are one of the following: a hospital or skilled nursing facility that participates in the Medicare program or a hospital-based facility that meets Medicare's requirements for provider-based status.

Paramedic Intercept (PI). PI services are ALS services provided by an entity that does not provide the ambulance transport. This type of service is most often provided for an emergency ambulance transport in which a local volunteer ambulance that can provide only BLS level of service is dispatched to transport a patient. If the patient needs ALS services such as EKG monitoring, chest decompression, or IV therapy, another entity dispatches a paramedic to meet the BLS ambulance at the scene or once the ambulance is on the way to the hospital. The ALS paramedics then provide services to the patient.

Emergency Response. Under Medicare, "emergency response" is a BLS or ALS1 level of service that has been provided in immediate response to a 911 call or the equivalent. An immediate response is one in which the ambulance provider/supplier begins as quickly as possible to take the steps necessary to respond to the call. The nature of an ambulance's response (whether emergency or not) does not independently establish or support medical necessity for an ambulance transport. Rather, coverage always depends on, among other things, whether the service(s) furnished is actually medically reasonable and necessary based on the patient's condition at the time of transport.

Bed-confinement. A patient is considered bed-confined if he/she is:

- Unable to get up from bed without assistance; **and**
- Unable to ambulate; **and**
- Unable to sit in a chair or wheelchair.

Note that the term "bed confined" is **not** synonymous with "bed rest" or "nonambulatory."

CENTERS FOR MEDICARE AND MEDICAID SERVICES (CMS)

As of 4/6/2026, the following Centers for Medicare & Medicaid (CMS) guidance was identified which addresses ambulance services:

- Medicare Claims Processing Manual, Chapter 15 - Ambulance
- Medicare Benefit Policy Manual, Chapter 10 – Ambulance Services
- Centers for Medicare & Medicaid Services (CMS). Ambulance Fee Schedule.
- Ambulance Fee Schedule - Medical Conditions List and Transportation Indicators
- Ambulance Fee Schedule - Medical Conditions List *(NOTE: According to the "Medical Conditions List and Transportation Indicators" reference above, this list was last updated in February 2007, and therefore, includes ICD-9 codes, rather than the ICD-10 codes used today. For ICD-10 codes, see next entry.)*
- ICD-10-CM Cross Walk for Medical Conditions List
- Noridian J-F web page for Ambulance Billing
- Noridian J-F web page for Ambulance Origin/Destination Modifiers
- Noridian J-F web page for Place of Service.
- 42 CFR 410.40(e)(3).
- Noridian J-F web page for Ambulance Automated Prepayment Edits

The above policy statements are consistent with the CMS guidance regarding ambulance services and billing. Member benefit language and provider contracts supersede reimbursement policy.

Oregon Health Plan (OHP)/Medicaid references include, but may not be limited to, the following:

- OAR 410-141-3945. Transportation: Ground and Air Ambulance Transports
- Oregon Health Authority (OHA). Medical Transportation Services Provider Guide.

BILLING AND CODING GUIDELINES

GENERAL

HCPCS codes and modifiers used on ambulance claims tell a story about the ambulance services that were rendered.

- The **HCPCS** code(s) identify what ambulance service was rendered (i.e., ground vs. air transport, basic vs. advanced life support, emergency vs. non-emergency transport, etc.).
- The **modifier** combination identifies the site of pick-up and drop-off (i.e., hospital-to-hospital, residence-to-physician office, scene of event-to-hospital, etc.).

Together, they describe the larger picture of the ambulance transport.

Additional modifiers may also be used to relay even more information, such as if multiple patients were transported at the same time, or if a patient was deceased after the ambulance was called.

Finally, ambulance transportation indicators also provide information regarding the status of the patient or the circumstances around the use of a specific type of ambulance transport.

HCPCS Codes[3]

Ambulance services are reported using available HCPCS codes which represent the transportation service provided, and the vehicle-type that was used. **Table 1** includes a list of HCPCS codes applicable to ambulance and transportation services.

Medicare bundles into the base rate payment all items and services furnished within the ambulance benefit. This eliminates billing on an itemized basis for any items and services related to the ambulance service (for example, oxygen, drugs, extra attendants, and EKG testing). Therefore, only the base rate code and the mileage code are used for billing purposes, as all services and supplies rendered during the course of the transport are included in the transport payment.

Table 1: Comprehensive List of Ambulance HCPCS Codes

Note: Inclusion of a code on this list does **NOT** imply guaranteed coverage of that code or the service/item it represents.

Ambulance HCPCS	
HCPCS	**Description**
A0021	Ambulance service, outside state per mile, transport (Medicaid only)
A0080	Non-emergency transportation, per mile - vehicle provided by volunteer (individual or organization), with no vested interest
A0090	Non-emergency transportation, per mile - vehicle provided by individual (family member, self, neighbor) with vested interest
A0100	Non-emergency transportation; taxi
A0110	Non-emergency transportation and bus, intra or inter state carrier
A0120	Non-emergency transportation: mini-bus, mountain area transports, or other transportation systems
A0130	Non-emergency transportation: wheelchair van
A0140	Non-emergency transportation and air travel (private or commercial) intra or inter state
A0160	Non-emergency transportation: per mile - case worker or social worker
A0170	Transportation ancillary: parking fees, tolls, other
A0180	Non-emergency transportation: ancillary: lodging-recipient
A0190	Non-emergency transportation: ancillary: meals-recipient
A0200	Non-emergency transportation: ancillary: lodging escort
A0210	Non-emergency transportation: ancillary: meals-escort
A0225	Ambulance service, neonatal transport, base rate, emergency transport, one way
A0380	BLS mileage (per mile)
A0382	Bls routine disposable supplies
A0384	BLS specialized service disposable supplies; defibrillation (used by ALS ambulances and BLS ambulances in jurisdictions where defibrillation is permitted in BLS ambulances)
A0390	ALS mileage (per mile)
A0392	ALS specialized service disposable supplies; defibrillation (to be used only in jurisdictions where defibrillation cannot be performed in BLS ambulances)
A0394	ALS specialized service disposable supplies; IV drug therapy
A0396	ALS specialized service disposable supplies; esophageal intubation

A0398	ALS routine disposable supplies
A0420	Ambulance waiting time (ALS or BLS), one half (1/2) hour increments
A0422	Ambulance (ALS or BLS) oxygen and oxygen supplies, life sustaining situation
A0424	Extra ambulance attendant, ground (ALS or BLS) or air (fixed or rotary winged); (requires medical review)
A0425	Ground mileage, per statute mile
A0426	Ambulance service, Advanced Life Support (ALS), non-emergency transport, Level 1
A0427	Ambulance service, ALS, emergency transport, Level 1
A0428	Ambulance service, Basic Life Support (BLS), non-emergency transport
A0429	Ambulance service, Basic life support (BLS), emergency transport
A0430	Ambulance service, conventional air services, transport, one way, (fixed wing)
A0431	Ambulance service, conventional air services, transport, one way (rotary wing)
A0432	Paramedic ALS intercept (PI), rural area transport furnished by a volunteer ambulance company, which is prohibited by state law from billing third party payers
A0433	Ambulance service, advanced life support, level 2 (ALS2)
A0434	Specialty care transport (SCT)
A0435	Fixed wing air mileage, per statute mile
A0436	Rotary wing air mileage, per statute mile
A0888	Noncovered ambulance mileage, per mile (e.g., for miles traveled beyond closest appropriate facility)
A0998	Ambulance response and treatment, no transport
A0999	Unlisted ambulance service
S0207	Paramedic intercept, non-hospital-based ALS service (non-voluntary), non-transport
S0208	Paramedic intercept, hospital-based als service (non-voluntary), non-transport
S0209	Wheelchair van, mileage, per mile
S0215	Non-emergency transportation; mileage, per mile
S9960	Ambulance service, conventional air service, nonemergency transport, one way (fixed wing)
S9961	Ambulance service, conventional air service, nonemergency transport, one way (rotary wing)
T2001	Non-emergency transportation; patient attendant/escort
T2002	Non-emergency transportation; per diem
T2003	Non-emergency transportation; encounter/trip
T2004	Non-emergency transport; commercial carrier, multi-pass
T2005	Non-emergency transportation; stretcher van
T2007	Transportation waiting time, air ambulance and non-emergency vehicle, one-half (1/2) hour increments

HCPCS S-Codes

Like all S-codes, the *National Physician Fee Schedule Relative Value File (NPFSRVF)*, which is published by Medicare[4], indicates HCPCS codes S0207-S0209, S0215, and S9960-S9961 have all been assigned a Status Indicator of "I." This is defined as "Not valid for Medicare purposes." In addition, all S-codes codes, including S-codes for ambulance or transportation services, are not recognized as valid codes for claim submission as indicated in the relevant Company Coding Policy *(HCPCS S-Codes and H-Codes,* 22.0*).* Providers need to use alternate available CPT or HCPCS codes to report for the service. If no specific CPT or HCPCS code is available, then an unlisted code may be used. Note that unlisted codes are

reviewed for medical necessity, correct coding, and pricing at the claim level. Thus, if an unlisted code is billed related to a non-covered service, it will also be denied.

Modifiers

Origin and Destination Modifiers[5]

For ambulance service claims, an origin and destination modifier must be reported for each ambulance trip provided. *(Medicare Claims Processing Manual, Ch. 15, 30.A)*

These modifiers are created by combining two alpha characters together. 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.

Table 2: Ambulance Origin and Destination Alpha Characters and Descriptions

Primary Ambulance Modifiers		
Alpha	**Description**	**Notes**
D	Diagnostic or therapeutic site other than P or H when these are used as origin codes	Origin **and** destination
E	Residential, domiciliary, custodial facility	Origin **and** destination
G	Hospital based ESRD facility	Origin **and** destination
H	Hospital	Origin **and** destination
I	Site of transfer (e.g. airport or helicopter pad) between modes of ambulance transport	Origin **and** destination
J	Freestanding ESRD facility	Origin **and** destination
N	Skilled nursing facility	Origin **and** destination
P	Physician's office	Origin **and** destination
R	Residence	Origin **and** destination
S	Scene of accident or acute event	Origin **and** destination
X	Intermediate stop at physician's office on way to hospital (destination code only)	Destination only

Non-Covered Modifier Combinations

Some modifier combinations may represent a potentially non-covered transport, while others may require review. Below are examples of such modifier combinations and why they are not covered/eligible for reimbursement or why they may require review.

> **Modifiers DD, DE, DP, DR, ED, EE, ER, GD, GG, GI, GJ, GP, GX, HD, HG, HX, ID, IE, IJ, IN, IP, IR, IX, JD, JG, JI, JJ, JP, JX, NI, NN, PD, PG, PJ, PP, PX, RD, RE:** These modifier combinations have a high probability of not meeting coverage criteria for medically necessary, covered ambulance services, and therefore will deny as not eligible for reimbursement. Denials may be reconsidered on appeal; documentation must support both medical necessity **and** a covered benefit. (Modifier "NN" is a transport from SNF-to-SNF. Depending on the SNF provider contract and circumstances of the stay/transfer, these transports may not be eligible to be reported separately as payment for the transport may be included in the SNF PPS payment rate.)

Modifiers DS, ES, GS, HS, IS, JS, NS, PS, RS, SS, XS: Modifier "S" represents a scene of accident or acute event, and thus, it would not be appropriate for use as a "destination" modifier. If "S" is used as the 2nd modifier, the transport is not eligible for reimbursement.

Modifiers EP, PE, NP, PN, PR, RP: These modifiers are not typically allowed by Original Medicare, but they may be eligible for coverage by the Plan. While no formal prior authorization is required, claims received for ambulance services using these modifiers are subject to pre-payment review. Documentation must support both medical necessity **and** a covered benefit.

Modifier HP: Modifier combination "HP" represents a trip from a hospital to a physician's office. This modifier combination is not eligible for reimbursement. If a medically necessary transport from a hospital to another location was underway, and the patient's condition changed during travel, resulting in a dire need for the patient to obtain professional assistance, and the ambulance stops at a physician's office, the correct destination modifier to use would be "X."

Modifier RR: Modifier "R" represents a residence, so it should never be used as both an origin and destination for the same transport.

Modifiers SD, SE, SG, SJ, SN, SP, SR: Modifier "S" represents a scene of accident or acute event, so when the origin modifier is "S," if the 2nd modifier is not a hospital or similar acute care facility, the transport would not be eligible for reimbursement. If transport is needed from the scene of an accident or acute event to a location ***other than*** a hospital (e.g., residence, physician office, etc.), documentation must support that the service is both medically necessary and a covered benefit under the member's plan, as well as include an explanation why another mode of transportation was not used.

Modifiers XD, XE, XG, XJ, XN, XP, XR, XX: Modifier "X" is to be used as a destination modifier only. Therefore, any use of "X" in an "origin" position would be incorrect, and the transport would not be eligible for reimbursement.

Table 3 includes additional informational modifiers which can also be used to relay details regarding the transport.

Table 3: Additional Ambulance Modifiers

Additional Ambulance Modifiers		
Modifier	**Description**	**Notes**
GM	Multiple patients on one trip	Use **in addition to** origin & destination modifiers
QL	Patient pronounced dead after ambulance called	Origin/destination modifiers not required
QM	Ambulance service provided under arrangement by a provider of services	Use **in addition to** origin & destination modifiers
QN	Ambulance service furnished directly by a provider of services	Use **in addition to** origin & destination modifiers
TK	Extra patient or passenger, non-ambulance	Use **in addition to** origin & destination modifiers

TQ	Basic life support transport by a volunteer ambulance provider	Use **in addition to** origin & destination modifiers

Ambulance Place of Service Codes[6]

For all claims, a place of service code must be reported for each ambulance service, and it must align with the ambulance service billed.

Reimbursement for Deceased Members

Payment for ambulance service claims for deceased members will be based on whether or not a transport was medically reasonable and necessary and when the individual was officially pronounced dead.[7]

Transportation Indicators

Ambulance transportation indicators are also used to communicate additional information about the transport services. While they may look like a modifier, transportation indicators are entered into the "narrative" field of the claim.

Table 5: Ambulance Transportation Indicators

Transportation Indicators	
Indicator	**Description**
Used for Ground and Air Ambulance Claims	
C1	Interfacility transport (to a higher level of care) determined necessary by the originating facility based upon the Emergency Medical Treatment and Active Labor Act (EMTALA) regulations and guidelines. The patient's condition should also be reported on the claim with a code selected from either the emergency or non-emergency category on the list.
C2	Patient is being transported from one facility to another because a service or therapy required to treat the patient's condition is not available at the originating facility. The patient's condition should also be reported on the claim with a code selected from either the emergency or non-emergency category on the list. In addition, the information about what service the patient requires that was not available should be included in the narrative field of the claim.
C3	Secondary code where a response was made to a major incident or mechanism of injury. All such responses are appropriately Advanced Level Service responses. A code that describes the patient's condition found on scene should also be included on the claim, but use of this modifier is intended to indicate that the highest level of service available response was medically justified.
C4	Indicates that an ambulance provided a medically necessary transport, but the number of miles on the claim form appears to be excessive. This should be used only if the facility is on divert status or a particular service is not available at the time of transport only. The provider or supplier must have documentation on file clearly showing why the beneficiary was not transported to the nearest facility and may include this information in the narrative field.
Used for Ground Ambulance Claims Only	

C5	Indicates situations where a patient with an ALS-level condition is encountered, treated and transported by a BLS-level ambulance with no ALS level involvement whatsoever. This situation would occur when ALS resources are not available to respond to the patient encounter.
C6	Indicates situations when an ALS-level ambulance would always be the appropriate resource chosen based upon medical dispatch protocols to respond to a request for service. Claims including this transportation indicator should contain two primary codes. The first condition will indicate the BLS-level condition corresponding to the patient's condition found on- scene and during the transport. The second condition will indicate the ALS-level condition corresponding to the information at the time of dispatch that indicated the need for an ALS- level response based upon medically appropriate dispatch protocols.
C7	Indicates circumstances where IV medications were required en route. The patient's condition should also be reported on the claim with a code selected from the list.
Used for Air Ambulance Claims Only	
D1	Long Distance: patient's condition requires rapid transportation over a long distance.
D2	Under rare and exceptional circumstances, traffic patterns preclude ground transport at the time the response is required.
D3	Time to get to the closest appropriate hospital due to the patient's condition precludes transport by ground ambulance. Unstable patient with need to minimize out-of hospital time to maximize clinical benefits to the patient.
D4	Pick up point not accessible by ground transportation

Round Trip Claims

Charges for ambulance services should **not** be reported as a "round trip" on a single line item.

Example: Member is transported round trip between their home (or residence) and a physician's office.

Incorrect:

- Appropriate HCPCS code for level of transport service + RR
- HCPCS code for mileage + modifier RR

Correct:

- Residence to physician's office
  - Appropriate HCPCS code for level of transport service + RP
  - HCPCS code for mileage + modifier RP
- Physician's office to residence
  - Appropriate HCPCS code for level of transport service + modifier PR
  - HCPCS code for mileage + modifier PR

Both legs of the round trip may be reported on the same claim, but each leg must be reported as a separate line item.

CROSS REFERENCES

Medical Policies

- Company: Ambulance Transport, MP118
- Medicare: Ambulance Transport, MP386

Coding Policies

- HCPCS S-Codes and H-Code, CP22.0

The full Company portfolio of current Reimbursement Policies is available online and can be accessed here.

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POLICY REVISION HISTORY

Date	Revision Summary
8/4/2025	New reimbursement policy
4/2026	Interim update; add statements regarding origin/destination modifiers and transportation indicators
6/2026	Annual review, no criteria changes