Ambulance and Transportation Services Payment Policy

Draft annual review

Applies to the following CarePartners of Connecticut products:

☒ CareAdvantage Preferred

☒ CarePartners Access

The following payment policy applies to providers who render ambulance and transportation services to members of the CarePartners of Connecticut plans selected above.

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

Policy

CarePartners of Connecticut reimburses licensed ambulance companies for the provision of emergency and non-emergency ambulance transport services, in accordance with the member's benefits, Medicare coverage guidelines and the information contained in this policy. These services are comprised of advanced life-support (ALS), basic life-support (BLS), wheelchair van or air ambulance services. Refer to the CMS Benefit Policy Manual for more information.

Note: All ambulance transport providers must participate in the Medicare (Title XVIII) program to be eligible to render services to CarePartners of Connecticut members.

General Benefit Information

Services and subsequent payment are pursuant to the member's benefit plan document. Member eligibility and benefit specifics should be verified prior to initiating services by logging on to the secure Provider portal or by contacting CarePartners of Connecticut Provider Services at 888-341-1508.

CarePartners of Connecticut follows Medicare coverage guidelines and also offers a limited number of non-Medicare-covered items as supplemental benefits. CarePartners of Connecticut cannot cover items and services not covered under the member's benefit plan.

Note: Supplemental benefits are subject to change each calendar year.

Wheelchair Van Transports

Wheelchair van transportation, even if provided by an ambulance company, is not the same as ambulance transportation. Wheelchair van transports are **not a covered benefit** under any circumstances. If a member requests chair car services, the member or treating provider must request an organization determination in advance, following the process outlined in the Referrals, Prior Authorizations, and Notifications chapter of the CarePartners of Connecticut Provider Manual.

Note: If a provider arranges noncovered wheelchair van transportation services, the ordering party will be held financially responsible.

Nonemergency Ambulance Transportation

CarePartners of Connecticut follows applicable Medicare guidelines when determining coverage of and compensation for nonemergency ambulance and transportation services. For more information, refer to the CMS Benefit Policy Manual, as applicable.

Referral/Prior Authorization/Notification Requirements

Certain procedures, items and/or services may require prior authorization. While you may not be the provider responsible for obtaining prior authorization, as a condition of payment you must confirm that prior authorization has been obtained. For more information, refer to the Referrals, Prior Authorizations, and Notifications chapter of the CarePartners of Connecticut Provider Manual.

No referrals, prior authorizations or inpatient notifications are required for emergency ambulance transportation services for in-network services; however, in certain circumstances, CarePartners of Connecticut may retrospectively review ambulance claims for medical necessity. Referrals are required for out-of-network services rendered for HMO members.

Billing Instructions

Unless otherwise stated, CarePartners of Connecticut follows industry-standard coding guidelines. Refer to current industry-standard coding guidelines for a complete list of ICD, CPT/HCPCS, revenue codes, modifiers, and their usage. Providers may only bill the procedure code(s) in accordance with the applicable financial exhibits of their provider agreements and applicable fee schedules.

- Submit the appropriate origin and destination modifier combination when billing for ambulance transport services using the modifiers listed below. The first digit should indicate the transport's place of origin and the second digit should indicate the destination. Claims submitted without the appropriate origin and destination modifiers may deny.
- If submitting a claim for noncovered services, ambulance providers should submit a medical necessity form indicating the service is noncovered. Claims submitted without a medical necessity form will deny as provider responsibility. For more information on medical necessity, refer to the CMS Benefit Policy Manual.
- Claims billed with **HD** or **DH** for an inpatient member in an acute care facility (excluding rehabilitation hospitals and SNFs) should be billed directly to the ordering facility. Claims billed to CarePartners of Connecticut will be denied.
- Bill round-trip ambulance transport on two separate lines, line one for the initial transportation and line two for the return transportation

Claim Submission Information

	Transportation providers not affiliated with a contracting hospital	**Transportation providers affiliated with a contracting hospital**
EDI Claims	Submit claim in 837P format	Submit revenue codes (540-549) with the appropriate HCPCS code in 837I format
Paper Claims	Submit CMS-1500 form with appropriate origin and destination modifiers in box 24D	Submit revenue codes (540-549) with the appropriate HCPCS code on a UB-04 in box 80 in the remarks section

Origin and Destination Modifier Table

Modifier	Description
D	Diagnostic or therapeutic site other than 'P' or 'H'
E	Residential, domiciliary, custodial facility (nursing home, not SNF)
G	Hospital-based dialysis facility (hospital or hospital-related)
H	Hospital
I	Site of transfer (e.g., airport or helicopter pad) between types of ambulance
J	Nonhospital based dialysis facility
N	Skilled nursing facility (SNF)
P	Physician's office (includes HMO non-hospital-based facility, clinic, etc.)
R	Residence
S	Scene of accident or acute event
X	Intermediate stop at physician's office en route to the hospital. **Note:** Modifier X may only be used as a designation code in the second position of a modifier. A physician's office is not a Medicare-covered destination for ambulance services, except as a temporary stop when the transport is en route to a Medicare-covered destination and the member is in dire need of professional attention.

The following modifiers are considered secondary modifiers. Do not bill these modifiers in the first position.

Code	Description
GM	Multiple patients on one trip
QL	Patient pronounced dead after ambulance called (non-covered for Senior Products)
QM	Ambulance service provided under arrangement by a provider of services
QN	Ambulance service furnished directly by a provider of services

Compensation/Reimbursement Information

Providers are compensated according to the applicable contracted rates and applicable fee schedules, in accordance with CMS regulations.

HCPCS procedure code A0998 (ambulance response/treatment; no transport), if billed, will deny as not covered and the member may be held responsible for payment.

CarePartners of Connecticut does not routinely compensate for the following:

- Ambulance services billed without a qualifying origin and destination modifier combination
- Ambulance services and transportation billed with modifier QL (patient pronounced dead after ambulance called), as this is not a covered procedure.
- Ancillary transportation fees including parking fees and tolls, or other associated fees for lodging or meals for either the recipient or an escort, unless otherwise indicated in plan documents
- Items and services which include, but are not limited to oxygen, supplies, EKG services, and/or drugs. These services are considered included in the reimbursement rate for the transport and are not reimbursed separately
- Non-emergent ambulance services provided to a member during an inpatient/outpatient admission. Non-emergent ambulance services are included as part of the facility reimbursement rate and should be billed to the facility
- Non-emergency transportation including but not limited to taxi, bus, mini-bus, mountain area transports, or other transportation systems, private or commercial air travel or vehicles provided by a volunteer with no vested interest or a vehicle provided by an individual with vested interest. (**Note:** Some non-emergency transportation services may be reimbursed according to applicable authorization requirements and benefit plan documents)
- Transportation for the purpose of receiving an excluded or non-covered service
- Transportation provided by an ambulance company that is not licensed or by non-licensed personnel
- Unlisted ambulance service(s)
- Extra ambulance attendant
- Ambulance mileage (or ambulance mileage when reported with response and treatment only) if an ambulance transport code has not been billed for the same date of service or has been denied by another policy
- Ambulance waiting time billed separately from ambulance services

Additional Resources

- Modifiers Payment Policy

Document History

- May 2025: Annual review: administrative edits
- July 2024: Annual review; added secondary modifiers and additional resources; updated compensation information
- September 2023: Annual policy review; administrative updates
- June 2022: Annual policy review; administrative updates
- April 2021: Reviewed by committee; removed codes and referred to provider agreements
- December 2020: Added applicable CarePartners Access PPO content, effective for dates of service on or after January 1, 2021
- October 2019: Policy reviewed by committee; clarified authorization and medical necessity requirements
- January 2019: Policy created

Audit and Disclaimer Information

CarePartners of Connecticut 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 a provider/facility did not comply with this payment policy, CarePartners of Connecticut will expect the provider/facility to refund all payments related to noncompliance.

This policy provides information on CarePartners of Connecticut claims adjudication processes. As every claim is unique, this policy is neither a guarantee of payment, nor a final indication 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 requirements (when applicable), adherence to plan policies and procedures, and claims editing logic. An authorization is not a guarantee of payment. Claims for services subject to authorization may be reviewed for accuracy and compliance with payment policies.

This policy applies to the CarePartners of Connecticut products identified by the checkboxes on page one. CarePartners of Connecticut reserves the right to amend a payment policy at its discretion.