Ambulance response and treatment without transport

Applies to:

Blue Cross Blue Shield of Michigan

A nonprofit corporation and independent licensee of the Blue Cross and Blue Shield Association

☐ **Medicare Plus Blue℠ PPO** ☐ **Medicare Plus Blue℠ Group PPO** ☒ **Both**

Ambulance response and treatment without transport

Ambulance response and treatment without transport covers emergency medical services even if the member isn't transported to a facility. EMS providers are dispatched as first responders to provide patient aid, dispense medical supplies and care for basic and advanced life support services, as needed. If the EMS providers stabilize the patient at home or another location, they aren't required to transport the patient to a hospital or facility.

Original Medicare

Medicare Part B (medical insurance) covers ground ambulance transportation when traveling in any other vehicle could endanger your health, and you need medically necessary services from one of the facilities below:

- Hospital
- Critical access hospital
- Rural emergency hospital
- Skilled nursing facility

Medicare may pay for emergency ambulance transportation in an airplane or helicopter if you need immediate and rapid transport that ground transportation can't provide. In some cases, Medicare may pay for limited, medically necessary, non-emergency ambulance transportation if you have a written order from your doctor stating the transportation is medically necessary. Medicare will only cover ambulance services to the nearest appropriate medical facility that is able to provide the care needed.

Medicare Plus Blue℠ PPO enhanced benefit

Medicare Plus Blue is a Medicare Advantage plan that provides at least the same level of benefit coverage as Original Medicare (Part A and Part B) and may provide enhanced benefits beyond the scope of Original Medicare within a single health care plan. This flexibility allows Blue Cross to offer enriched plans by using Original Medicare as the base program and adding desired benefit options.

Coverage for ambulance treatment without transport is provided to members under Medicare Plus Blue individual and select Medicare Plus Blue Group PPO plans. Members are able to call emergency services for treatment without being transported to the hospital. Since Original Medicare doesn't cover ambulance treatment without transport, the scope of the benefit, reimbursement methodology, maximum allowable payment amounts and member cost sharing are determined by Blue Cross for individual coverage and by the group for those with group-based coverage.

Conditions for payment

The table below specifies payment conditions for ambulance treatment without transport.

Conditions for payment	
Eligible provider	Ambulance providers
Payable location	Home and off site
Frequency	Based on CPT codes billed
CPT/HCPCS codes	A0998
Diagnosis restrictions	No restrictions
Age restrictions	No restrictions

Reimbursement

Medicare Plus Blue plans' maximum payment amount to providers for ambulance treatment without transport is available on our provider website on the Medicare Plus Blue enhanced benefits **fee schedule**. The provider will be paid the lesser of the allowed amount or the provider's charge, minus the member's cost share. This represents payment in full and providers aren't allowed to bill the member for the difference between the allowed amount and the charge.

Member cost sharing

- Medicare Plus Blue providers should collect the applicable cost sharing from the member at the time of the service when possible. Cost sharing refers to a flat dollar copayment, a percentage coinsurance or a deductible. Providers can only collect the appropriate Medicare Plus Blue cost-sharing amounts from the member.
- If the member elects to receive a noncovered service, he or she is responsible for the entire charge associated with that service.
- Providers may not have members sign an Advance Beneficiary Notice to accept financial responsibility for noncovered items or services. If there is any question about whether an item or service is covered, seek a coverage determination from Blue Cross before providing the item or service to the member. If a provider provides a noncovered item or service to a member without first obtaining a coverage determination, the member must be held harmless for all charges except for any applicable cost share.

To verify benefits and cost share, providers may utilize our provider portal or call 1-866-309-1719.

Billing instructions for providers

1. Bill services on the CMS 1500 (02/12) claim form for all payable locations, except for Federally Qualified Health Center (FQHC) providers; which should be billed on the CMS UB-04 claim form.
2. Use the Medicare Advantage PPO unique billing requirements.
3. Report CPT/HCPCS codes and diagnosis codes to the highest level of specificity.
4. Report your National Provider Identifier number on all claims.
5. Submit claims to your local Blue Cross plan.
6. Use electronic billing:
   a. Michigan providers
      Copies of the ANSI ASCX 12N 837 and 835 Institutional Health Care Claim Payment/Advice (Blue Cross Electronic Data Interchange (EDI) Institutional 837/835 Companion Documents) are available on the Blue Cross website under the reference library section at ***bcbsm.com/providers/help/edi***.
   b. Providers outside of Michigan should contact their local Blue Cross plan.

Revision history

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