


<b>MEDICAL POLICY</b>	<b>Temporary Policy Emergency Provisions for: Ambulance Transport</b>	
<b>Effective Date: 60 day effective period beginning 4/1/2021</b>   <div style="text-align: right;">4/1/2021</div>	Section: UM	Policy No: 386
	Medical Policy Committee Approved Date: 5/95; 7/97; 5/98; 10/98; 5/99; 5/00; 10/01; 11/02; 9/03; 8/04; 7/05; 11/05; 3/07; 3/08; 5/2010; 8/12; 7/13; 10/14; 5/15; 10/15, 5/16; 7/17; 3/18; 8/19; 2/2020; 4/2020; 7/2020; 9/2020	
Medical Officer	Date	

**NEED AND DURATION OF EMERGENCY PROVISIONS**

1. **Need for the temporary Provisions: COVID-19 public health emergency**
2. **Documents or source relied upon: Centers for Medicare & Medicaid Interim Rules for the COVID-19 Public Health Emergency**
3. **Initial Effective Date: 3/1/2020**
4. **Re-review dates: 5/27/2020; 7/22/2020; 9/23/2020; 11/30/2020; 2/3/2021; 3/31/2021**
5. **Termination Date: 6/1/2021**
6. **Next Reassessment Date determined at Companies sole discretion: 5/26/2021**

**POLICY ADDENDUM**

COVID-19 Public Health Emergency

On April 7, 2020, Medicare released expanded coverage of necessary ambulance transport during the COVID-19 public health emergency. This [interim rule](#) states:

*A patient suspected of having COVID–19 that requires a medically necessary transport may be transported to a testing facility to be tested for COVID–19 instead of a hospital in an effort to prevent possible exposure to other patients and medical staff.*

*Home may be an appropriate destination for a COVID–19 patient who is discharged from the hospital to home to be under quarantine (as noted above, there must be a medically necessary ground ambulance transport of a patient in order for an ambulance service to be covered).*

*During the COVID-19 Public Health Emergency, Medicare will cover a medically necessary emergency and non-emergency ground ambulance transportation from any point of origin to a destination that is equipped to treat the condition of the patient consistent with state and local Emergency Medical Services (EMS) protocols where the services will be furnished.*

**On an interim basis, CMS is expanding the list of destinations that may include but are not limited to:**

- *Any location that is an alternative site determined to be part of a hospital, Critical Access Hospital (CAH), or Skilled Nursing Facility (SNF)*

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- *Community mental health centers*
- *Federally Qualified Health Centers (FQHCs)*
- *Rural health clinics (RHCs)*
- *Physicians' offices*
- *Urgent care facilities*
- *Ambulatory Surgery Centers (ASCs)*
- *Any location furnishing dialysis services outside of an End-Stage Renal Disease (ESRD) facility when an ESRD facility is not available*
- *Beneficiary's home*

Applicability date: 3/1/2020

**SCOPE:**

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

**APPLIES TO:**

All lines of business

**BENEFIT APPLICATION**

Medicaid Members

*Oregon:* Services requested for Oregon Health Plan (OHP) members follow the OHP Prioritized List and Oregon Administrative Rules (OARs) as the primary resource for coverage determinations. Medical policy criteria below may be applied when there are no criteria available in the OARs and the OHP Prioritized List.

<b>POLICY CRITERIA</b>	
<p>The following Centers for Medicare &amp; Medicaid Service (CMS) guidelines should be utilized for ambulance transport coverage determinations for <b>all lines of business</b>. Click the link provided in the table below to access applicable coverage criteria. All listed guidelines apply.</p>	
<b>Service</b>	<b>Medicare Guidelines</b>

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<i>Ambulance Transport</i>	Centers for Medicare & Medicaid Services (CMS) <a href="#">Medicare Benefit Policy Manual; Chapter 10 – Ambulance Services and the Medicare Learning Network Booklet: Medicare Ambulance Transports.</a> <sup>1</sup>
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**INSTRUCTIONS FOR USE**

Company Medical Policies serve as guidance for the administration of plan benefits. Medical policies do not constitute medical advice nor a guarantee of coverage. Company Medical Policies are reviewed annually and are based upon published, peer-reviewed scientific evidence and evidence-based clinical practice guidelines that are available as of the last policy update. The Companies reserve the right to determine the application of Medical Policies and make revisions to Medical Policies at any time. Providers will be given at least 60-days’ notice of policy changes that are restrictive in nature.

The scope and availability of all plan benefits are determined in accordance with the applicable coverage agreement. Any conflict or variance between the terms of the coverage agreement and Company Medical Policy will be resolved in favor of the coverage agreement.

**REGULATORY STATUS**

Mental Health Parity Statement

Coverage decisions are made on the basis of individualized determinations of medical necessity and the experimental or investigational character of the treatment in the individual case.

**REFERENCES**

- Centers for Medicare & Medicaid Services (CMS) Medicare Benefit Policy Manual; Chapter 10 – Ambulance Services; Accessed on 11/15/2019; [Link](#).