Ambulance Services

Provider Manual

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III. Provider-Specific Policies

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CHAPTER III. PROVIDER-SPECIFIC POLICIES

A. CONDITIONS FOR PARTICIPATION

An ambulance provider is eligible to participate in Medicaid if it is certified eligible to participate as an ambulance provider in the Medicare program.

To be covered, ambulance services must be medically necessary and reasonable. The ambulance service must meet all program coverage criteria in order for payment to be made. That is, the transport must be to obtain a Medicaid covered service, or to return from such a service.

All definitions are based upon Medicare reference available on the Centers for Medicare and Medicaid Services (CMS).

All mileage must be submitted on the same claim as the base rate.

1. Ambulance Definitions

Advanced Life Support (ALS) personnel are individuals trained to the level of the Emergency Medical Technician-Intermediate (EMT-Intermediate), Advanced EMT, or EMT-Paramedic.

Assessment. An ALS assessment is performed by an ALS crew as part of an emergency response that is necessary because the patient's reported condition at the time of dispatch is such that only an ALS crew is qualified to perform the assessment. An ALS assessment alone does not necessarily result in a determination that the patient requires an ALS level of service.

Intervention. An ALS intervention is a procedure that is in accordance with state and local laws and required to be performed by an EMT-Intermediate, Advanced EMT, or EMT-Paramedic.

Emergency response. Emergency response is a Basic Life Support (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.

Medical necessity. Medical necessity is established as such that use of any other method of transportation is contraindicated by the patient's condition. In cases where some means of transportation, other than an ambulance, could be used without endangering the individual's health, whether or not such other transportation is actually available, no payment may be made for ambulance services.

Ambulance response and treatment, no transport A0998. This is the only code that will process without a modifier. This is also the only procedure code that does not require another service on the claim.

Non-emergent A0428. Basic Life Support (BLS) is transportation by ground ambulance vehicle and the provision of medically necessary supplies and services, including BLS ambulance services as defined by the State Emergency Medical Services (EMS) Treatment Protocols. The ambulance must be staffed at a minimum by an individual who is qualified in accordance with state and local laws as an EMT.

Emergency A0429. BLS emergency is transportation by a ground ambulance vehicle that has been provided in an immediate response to a 911 call or the equivalent. This includes the provision of medically necessary supplies and services as defined by the state EMS protocols.

2. Advanced Life Support, Level 1 (ALS1) Definitions

Non-emergent A0426. ALS1 non-emergent is the transportation by ground ambulance vehicle and the provision of medically necessary supplies and services including the provision of an ALS assessment or an ALS intervention.

Emergency A0427. ALS1 emergency requires an "emergency response" as defined above plus either a qualifying "ALS assessment" or an "ALS intervention." Assessments and interventions should be documented in the patient's reported condition. An ALS assessment alone does not necessarily result in a determination that the patient requires an ALS level of service.

3. Advanced Life Support, Level 2 (ALS2) Definition

Emergency A0433. The ALS2 is the transportation by ground ambulance vehicle and the provision of medically necessary supplies and services including:

a. At least three separate administrations of one or more medications by intravenous push/bolus or by continuous infusion (excluding crystalloid fluids), or

b. Ground ambulance transport, medically necessary supplies and services, and the provision of at least one of the ALS2 procedures listed below:

- Manual defibrillation/cardioversion,
- Endotracheal intubation,
- Central venous line,
- Cardiac pacing,
- Chest decompression,
- Surgical airway, or
- Intraosseous line.

B. COVERAGE OF SERVICES

The following sections explain coverage limits related to:

1. Ambulance Transport Guidelines

Medicaid will pay for ambulance transportation by an approved ambulance service to a hospital or skilled nursing facility only when transportation by any other means could endanger the member's health.

In order to receive payment, the provider must document the medical necessity of this transport on the run report. It is the responsibility of the ambulance supplier to furnish complete and accurate documentation to demonstrate that the ambulance service being furnished meets the medical necessity criteria.

Payment will be approved subject to the following conditions:

- The member must be transported to the nearest hospital with appropriate facilities.
- The member may be transported from one hospital to another only if there is a valid documented medical reason for transporting the member to the second hospital. The member's personal preference is not a valid medical reason for ambulance transport.

  EXAMPLE: The member requires inpatient hospital services that are not available at the first hospital.
- The member may be transported from home or hospital to a nursing facility. On discharge from the hospital, payment will be made for ambulance service to the nursing facility where the member is a resident.
- The member may be transported to the outpatient department of a hospital or to a physician's office for use of specialized services. The reason the member cannot travel independently must be documented.
- If more than one ambulance service is called to provide ground ambulance transport, payment will be made to only one ambulance company. When a paramedic from one ambulance service joins a ground ambulance company already in transport, coverage is not available for services and supplies provided by the paramedic.

2. Interpreter Services

Interpretative services may be covered, whether done orally or through sign language. Interpreters must provide only interpretation services for the agency. The services must facilitate access to Medicaid covered services.

In order for interpretation services to be covered by Iowa Medicaid, the services must meet the following criteria:

- Provided by interpreters who provide only interpretive services
- Interpreters may be employed or contracted by the billing provider
- The interpretive services must facilitate access to Medicaid covered services

Providers may only bill for these services if offered in conjunction with an otherwise Medicaid covered service. Medical staff that are bilingual are not reimbursed for the interpretation but only for their medical services.

a. Documentation of the Service

The billing provider must document in the member's record the:

- Interpreter's name or company,
- Date and time of the interpretation,
- Service duration (time in and time out), and
- Cost of providing the service.

b. Qualifications

It is the responsibility of the billing provider to determine the interpreter's competency. Sign language interpreters should be licensed pursuant to 645 IAC 361. Oral interpreters should be guided by the standards developed by the National Council on Interpreting in Health Care.

Following is the instruction for billing interpretive services when that service is provided by an outside commercial translation service:

- Bill code T1013
  - For telephonic interpretive services use modifier "UC" to indicate that the payment should be made at a per-minute unit.
  - The lack of the UC modifier will indicate that the charge is being made for the 15 minute face-to-face unit.
- Enter the number of minutes actually used for the provision of the service. The 15 minute unit should be rounded up if the service is provided for 8 minutes or more.

NOTE: Because the same code is being used but a conditional modifier may be necessary, any claim where the UC modifier is **NOT** used and the units exceed 24 will be paid at 24 units.

3. Medical Necessity for Emergency Transportation

Ambulance transport is indicated for emergency situations and when any other means of transport would be contraindicated (meaning they will further endanger the person's condition significantly).

Medical necessity is presumed if the record adequately documents one or more of the following:

- The member is in an emergency situation, such as injury resulting from an accident, or illness with acute symptoms. Examples include hemorrhaging, shock, chest pain, neurologic dysfunction, and respiratory distress.
- The member requires restraints by a professionally trained ambulance attendant. The provider shall describe why restraints are necessary. Examples include that the member is violent, psychotic, convulsing, or may be harmful to self or others. A simple diagnosis of senile, forgetful, Alzheimer's, etc. would not qualify.
- The member exhibits a newly developed state of altered consciousness, such as unconsciousness or unresponsiveness. Claims for members whose usual status is that of diminished consciousness should include documentation of the medical necessity of ambulance transport.
- The member requires oxygen during the transport. The administration of oxygen itself does not satisfy the requirement that a member needs oxygen. Documentation should reflect the need, such as hypoxemia, syncope, dyspnea, heart attack, chest pain, respiratory distress, pulmonary edema, carbon dioxide poisoning, shock, arrhythmia, airway obstruction, and tachypnea.

  Ambulance transport is not medically necessary if the only reason for the ambulance service is to provide oxygen during transport, and the member has a portable oxygen system available.
- Emergency measures or treatments are indicated. Examples include drugs, IV fluids, cardiopulmonary resuscitation, cardiac monitoring, oxygen, respiratory support, and control of life threatening hemorrhage.

  The medical necessity for intravenous infusion would include the following:

  - Emergency rehydration for hypotension or shock
  - An intravenous access route for potential use of emergency drugs
  - An intravenous access route for actual use of indicated drugs

Medical necessity for cardiac monitoring might include:

- Cardiac arrest
- Cardiac rhythm disturbance
- Chest pain
- Drug overdose with cardio toxic drugs
- Dyspnea not due to known lung disease
- Electrical injury
- Hypertensive crisis
- Pulmonary edema
- Serious head injury
- Severe respiratory distress
- Shock
- Stroke
- Syncope
- Unexplained coma or unconsciousness
- Unexplained discomfort or pain in arms, neck, or jaw

♦ Immobilization of the member is necessary in order to prevent complications because of a fracture that has not been set. The presence of a possible compound fracture, or the presence of severe pain, requiring immobilization or pain medication, would usually indicate the need for ambulance transport.

Simple upper-extremity fractures or ankle injuries without apparent complications generally would not require an ambulance. If there is suspicion of neurologic injury and head or spine immobilization is needed, ambulance transport is reasonable.

♦ A member is transferred between institutions for necessary services not available at the transferring institution, and the member meets any of the criteria listed above. Examples are members with cardiac disease requiring cardiac catheterization or coronary bypass not available at the transferring institution, or members requiring emergency admission for which a bed is unavailable at the transferring institution.

4. Medical Necessity for Nonemergency Transportation

Ambulance transport is indicated for nonemergency situations in which bed confinement is necessary before and after the ambulance trip, and a one way or round trip is for medically necessary reasons. The term “stretcher” is valid only if used to describe the movement of a bed-confined member to an ambulance, and therefore is not a reason for transporting a member by ambulance.

For Medicaid purposes, "bed-confined" means that a member cannot ambulate in any way on the member's own volition, both before and after the ambulance trip. It does not include a member who is restricted to bed rest on physician's instructions due to short-term illness.

Other reasons to allow transport are as follows:

- There is a risk of physical injury to self or others; the member needs restraint or needs other trained attendant.
- The member requires ongoing intravenous medicine or fluids (and a heparin or saline lock is contraindicated).
- The member requires oxygen and does not have a portable system.
- Isolation is required for contagious life threatening disease, such as uncontrolled bleeding in an HIV- or hepatitis-positive member.

Round-trip ambulance service is covered for a hospital or participating skilled nursing facility inpatient to the nearest hospital or nonhospital treatment facility to obtain necessary diagnostic or therapeutic services not available at the institution where the person is an inpatient.

The round trip ambulance service benefit is subject to all existing coverage requirements and is limited to cases where the transportation of the member is less costly than bringing the service to the member.

5. Transfer From One Nursing Facility to Another

It may be necessary to transfer a member from one nursing facility to another or from a nursing facility to a custodial facility because:

- The facility is closing.
- The person no longer requires nursing care.

The county Department of Human Services office will authorize the transfer. The requirements for medical necessity and distance do not apply. The Iowa Medicaid Enterprise (IME) will approve payment without a determination of medical necessity.

Submit the regular claim form with the county office authorization attached to the IME. Do **not** submit the claim to Medicare, even if the member is a Medicare beneficiary.

When such a transfer is made, the following rate schedule applies:

One member	Normal allowances
Two members	3/4 normal allowance per member
Three members	2/3 normal allowance per member
Four members	5/8 normal allowance per member

6. Exclusions and Limitations on Coverage

Payment will *not* be approved for the following:

- A routine trip to return the member home, when the member had been transported to the hospital.
- An ambulance trip to a funeral home.
- Transfer from a hospital that has appropriate facilities and staff for treatment to another hospital. Examples include transfers to accommodate the member or family preference to receive care by a personal physician or in a particular facility.
- Transportation from one private home to another.
- Transportation of a member from home or a nursing facility to a hospital outpatient department, unless it is established that there was an emergency or the trip was otherwise medically necessary.
- Transportation of a member from home or a nursing facility to a hospital outpatient department for treatment that could have been performed elsewhere (such as the member's home or nursing home).
- Transportation of a member from home or a nursing facility to a physician's office or a freestanding or hospital-based clinic and back for routine medical care.
- Transportation of a member to University Hospitals at Iowa City, unless it is established that the University Hospitals is the nearest hospital with facilities necessary to take care of the member.
- Transportation of an ambulatory member.
- Transportation to receive services of a specific physician, unless medical necessity is established.

- Transportation of, but not transfer of, an inpatient to another hospital or provider. If it is necessary to transport (but not transfer) the member to another hospital or provider for treatment, with the member remaining an inpatient at the originating hospital after that treatment, the originating hospital shall bear all costs incurred by that member for:
  - The medical treatment furnished to the member by the other provider, and
  - The ambulance transportation between the originating hospital and the other provider.

Hospital-based ambulances transporting a member admitted to their hospital, excluding Critical Access Hospitals (CAH), cannot bill separately for ambulance services. These are part of the hospital's inpatient claim. CAHs will no longer be subject to the 72-hour rule. Outpatient services before the date of admission must be billed as such and on a separate bill from inpatient services. Outpatient services rendered on the date of admission are still billed and paid separately as outpatient services.

Air ambulance service is covered only when:

- The point of pick-up is inaccessible by land vehicle.
- Transportation by land ambulance is contraindicated, such as cases where great distances or other obstacles are involved in getting the member to the nearest hospital with appropriate facilities and speedy admission is essential.

All other conditions for coverage must also be met.

C. BASIS OF PAYMENT

The basis of payment is a fee schedule. **NOTE:** Providers must agree to accept the payment made by the Medicaid program as payment in full and make no additional charges to the member or others. For example, in cases where Medicaid pays only for a ground ambulance rate as opposed to the air ambulance rate, the member cannot be billed for the remainder of this amount.

Payment will not be made on any claim where the amount of time that has elapsed between the date of service rendered and the date IME receives the initial claim exceeds 365 days. The IME must receive a provider's request for an adjustment to a paid claim within one year from the date when the claim was paid in order to consider the adjustment.

D. PROCEDURE CODES AND NOMENCLATURE

Medicaid recognizes Medicare's National Level II Healthcare Common Procedure Coding System (HCPCS) and Current Procedural Terminology (CPT) codes. However, all HCPCS and CPT codes are not covered. The base rate line should be the first line on the claim. Each claim should also contain the mileage.

Click here to refer to the fee schedule for ambulance services.

It is the provider's responsibility to select the code that best describes the item dispensed and level of service provided. Claims submitted without a procedure code will be denied. Refer coverage questions to the IME.

While personnel aboard the ambulance are unable to diagnosis a patient's condition, they are required to record the signs, symptoms, and complaints of the patient. The signs, symptoms, and complaints are then used to add a diagnosis to the claim for submission purposes.

All ambulance base rate codes require an additional two-letter modifier code. Use the first letter to identify the location of the pick-up and the second letter to identify the destination. Valid codes are as follows:

Modifier	Description
D	Diagnostic or therapeutic site other than "P" or "H" when these codes are used as origin codes
E	Residential, domiciliary, or custodial facility
G	Hospital-based dialysis facility
H	Hospital
I	Site of transfer between types of ambulance vehicles (e.g., airport or helicopter pad)
J	Non-hospital-based dialysis facility
N	Skilled nursing facility (SNF)
P	Physician's office (includes HMO non-hospital facility, clinics, etc.)
R	Residence
S	Scene of accident or acute event
X	(Destination code only) intermediate stop at physician's office on the way to the hospital (includes HMO non-hospital facility, clinic, etc.)

EXAMPLE: An air ambulance transports a person from the scene of an accident to the hospital. The procedure code on the claim form is A0430 SH.

E. BILLING POLICIES AND CLAIM FORM INSTRUCTIONS

Claims for ambulance providers are billed on federal form CMS-1500, *Health Insurance Claim Form*.

Click here to view a sample of the CMS-1500.

Click here to view billing instructions for the CMS-1500.

Refer to Chapter IV. Billing Iowa Medicaid for claim form instructions, all billing procedures, and a guide to reading the Iowa Medicaid Remittance Advice statement.

1. Billing Requirements, Procedures, and Guidelines

Claims will be adjudicated based on the level of services being billed. Claims are accepted both on the paper claim and electronically with no documentation.

Pre-pay review will be required for claims that contain more than one base rate code and any claim that contains a modifier beginning with an "H." Supporting documentation "run" report is required. If this documentation is not submitted, the claim will be denied.

The IME conducts post-pay review on paid ambulance claims to ensure the level of service billed was appropriate. Post-pay review will confirm the level of care, as defined.

Regardless of the necessity to submit the "run" report, the provider must document the medical necessity of the transport. This documentation must be retained for no less than seven years. It is the responsibility of the ambulance supplier to maintain complete and accurate documentation to demonstrate that the ambulance service being furnished meets the medical necessity and level of service criteria.

a. Ambulance Report

The provider must document the medical necessity of the transport in the ambulance or "run" report. This documentation must be retained for no less than seven years. It is the responsibility of the ambulance supplier to maintain complete and accurate documentation to demonstrate that the ambulance service being furnished meets the medical necessity and level of service criteria.

Supporting information to establish medical necessity can include, but is not limited to:

- Medical status upon arrival to emergency and interventions taken
- Medical status during transport and interventions taken
- Medical status upon arrival to hospital or nursing facility (transfer)
- Chief medical complaint
- Medical history related to the chief medical complaint
- Vitals assessment
- Pain scale
- Medications
- Stroke scale, if applicable

b. Other Supporting Documentation

The agency will assess if additional information or documentation needs to be submitted to support the medical need for the ambulance transport. Submitting this information with the original claim will avoid additional time required to send additional information later. Other supporting documentation could include:

- The emergency room record.
- Brief statement that explains why ambulance transport was necessary as opposed to other means of transport.
- A "key" to abbreviations which has been developed for the organization that includes abbreviations that are not standard or commonly recognized in the ambulance community.
- Physician's notes.
- Other documentation that supports and explains the medical necessity of the ambulance transport.

c. Electronic Claims

Ambulance claims submitted electronically that require documentation, must use the *Claim Attachment Control*, form 470-3969. A cover sheet must accompany any submitted documentation related to an electronic claim. Click here to access the form online.

The same attachment control number included on the electronic claim must be entered onto the *Claim Attachment Control* form. This will allow the *Claim Attachment Control* form and the ambulance run report to be matched for Medical Services review and claim processing.

2. Common EOB Denial Codes for Ambulance Claims

Below is a list of the most common denial codes issued for ambulance claims prior to submission for ambulance reimbursement:

Procedure Code	Reason
925	**Missing information** No reason was provided for the ambulance transfer to a different hospital
926	**Not legible** Any handwritten documents must be able to be read by Medical Services Prepayment Review.
990	**Duplicate claim** The claim is an exact duplicate of a previously paid claim.
944	**Medical need for the ambulance was not provided** Additional documentation is needed to make the determination that the ambulance transport was medically necessary. The ambulance provider must determine what additional documentation can support the medical need. It may be one or several of the types of documentation listed in Other Information/Documentation, or it may be another piece of documentation that clarifies the medical need.
954	**More specific procedure code required** Most commonly, this code is used for members who are found deceased upon ambulance arrival. Use code A0998 for this circumstance. An ambulance provider cannot bill mileage because transport did not occur.
979	**Incorrect modifier used** Use the correct modifiers to identify location where the member was picked up and the location to which the member was transferred.
984	**Missing ambulance report** An ambulance run report must be submitted with the CMS-1500 claim form.

If an ambulance claim is denied for any of the manual denial codes listed, the provider shall submit a paper version of the CMS-1500 with the additional information and documentation to the following address:

Medicaid Claims
PO Box 150001
Des Moines, IA 50315

If an ambulance claim denies for additional required information, the provider shall submit a *Provider Inquiry*, form 470-3744. See Chapter IV. Billing Iowa Medicaid.

In order to obtain ambulance reimbursement, do not file a DHS appeal for the denial of an ambulance claim unless a resolution cannot be found through the provider inquiry process.