Ambulance

Ambulance transportation is emergency or non-emergency medical transportation provided to Medicaid enrollees to and/or from a Medicaid ~~provider for a medically necessary Medicaid~~ covered service or VAB by ground or air ambulance when the enrollee's condition is such that use of any other method of transportation is contraindicated or would make the enrollee susceptible to injury. ~~The MCO shall not cover ambulance services when another means of transportation could be utilized without endangering the individual's health.~~

To participate in the Medicaid program, ambulance providers must meet the requirements of La. R.S. 40:1135.3. Licensing by the LDH Bureau of Emergency Medical Services is also required. Services must be provided in accordance with state law and regulations governing the administration of these services. Additionally, licensure is required for the medical technicians and other ambulance personnel by the LDH Bureau of Emergency Medical Services.

Reimbursement to ambulance providers shall be no less than the published Medicaid FFS rate in effect on the date of service, unless mutually agreed upon by the MCO or its transportation broker and the transportation provider in the provider agreement.

Terms utilized in the published Medicaid fee schedule are defined as follows:

- ***Basic Life Support (BLS)***[1]: Emergency medical care administered to the EMT-basic scope of practice.
- ***Advanced Life Support (ALS)***[2]: Emergency medical care administered to at least the level of an emergency medical technician-paramedic's scope of practice.
- ***Specialty Care Transport***[3]: Interfacility transportation of a critically injured or ill beneficiary by a ground ambulance vehicle, including medically necessary supplies and services, at a level of service beyond the scope of the EMT-Paramedic.

The MCO shall reimburse ambulance providers for mileage to the nearest appropriate facility. Reimbursement for mileage will vary depending on whether the transport is for an emergency or non-emergency event. Reimbursement for mileage shall be limited to actual mileage from point of pick up to point of delivery. Mileage can only be reimbursed for miles traveled with the enrollee in the ambulance.

Refer to the *Hospital Services* section of this Manual for policies related to hospital-based ambulance services.

Emergency Ambulance Transportation

Emergency ambulance transportation is provided for a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in any of the following:

[1] Defined by *Louisiana Administrative Code*, Title 48, Part I, Section 6001.
[2] Defined by *Louisiana Administrative Code*, Title 48, Part I, Section 6001. Refer to 42 C.F.R. §414.605 for the distinction between ALS levels 1 and 2.
[3] Defined by 42 C.F.R. §414.605.

- ❖ Placing the health of the enrollee (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
- ❖ Serious impairment to bodily functions; or
- ❖ Serious dysfunction of any bodily organ or part.

An enrollee may also require emergency ambulance transportation if he or she is psychiatrically unmanageable or needs restraint.

The MCO shall ensure that ambulance providers retain documentation that appropriately supports that at least one of these criteria was met and that the enrollee would be susceptible to injury using any other method of transportation. An ambulance trip that does not meet at least one of these criteria would be considered a nonemergency service and must be coded and billed as such.

The MCO may not require prior review or authorization for emergency ambulance transportation.

The MCO shall reimburse for oxygen and disposable supplies separately when medically necessary.

~~Ambulance~~ Treatment-in-Place

Physician directed treatment-in-place service is the facilitation of a telehealth visit by an ambulance provider.

Each paid treatment-in-place ambulance claim must have a separate and corresponding paid treatment-in-place telehealth claim, and each paid treatment-in-place telehealth claim must have a separate and corresponding paid treatment-in-place ambulance claim or a separate and corresponding paid ambulance transportation claim. The MCO may not reimburse for both an emergency transport to a hospital and an ambulance treatment-in-place service for the same incident.~~Ambulance providers that are dispatched by an emergent call for service may determine upon the scene that a telehealth visit with a licensed medical professional, who is enrolled in Medicaid, is more appropriate than transportation to an emergency department. In this case, the treatment-in-place service may be rendered.~~

~~NOTE: Treatment in place is classified as an emergency transportation service. All provisions, including criteria and documentation to support the emergency determination, from the preceding section apply.~~

~~Both the telehealth claim and the ambulance treatment-in-place claim shall be payable by the MCO. If the ambulance provider bills on behalf of the telehealth provider, the MCO shall ensure that the ambulance provider bills the telehealth service separately from the treatment-in-place service and in accordance with the requirements below.~~

~~Ambulance Telemedicine/Telehealth Claims~~

~~The ambulance provider's NPI must be enrolled in Medicaid as a Professional Service (claim type 04) billing provider.~~

~~The rendering provider's NPI must be reported on the claim and enrolled in Medicaid as a licensed physician, physician assistant, or advanced practice registered nurse.~~

~~The claim must indicate place of service 02 and modifier 95.~~

~~Approved telemedicine/telehealth procedure codes for ambulance telemedicine/telehealth claims are listed in the following table:~~

~~*Category*~~	~~Service~~	~~CPT Codes~~
~~*Evaluation and Management, Office or Other Outpatient Service*~~	~~New Patient~~	~~99201, 99202, 99203, 99204, 99205~~
	~~Established Patient~~	~~99211, 99212, 99213, 99214, 99215~~

~~Ambulance~~ Treatment-in-Place Ambulance Services~~Claim~~

The MCO shall restrict payment of treatment-in-place ambulance services to those identified on the Physician Directed Ambulance Treatment-in-Place Fee Schedule and edit claims for non-payable procedure codes as follows:~~The ambulance provider's NPI must be enrolled in Medicaid as an Ambulance Service (claim type 07) billing provider.~~

~~Supply codes A0382 and A0398 are payable, but mileage (A0425) and other ambulance transportation services are not payable. Claims billed with non-payable ambulance treatment in place services shall be denied.~~

- If a~~Claims must indicate~~ treatment-in-place ambulance claim is billed with mileage, ~~destination code "W" in the destination position of~~ the MCO shall deny the entire claim document~~origin/destination modifier combination~~.
- If an unpayable procedure code, that is not mileage, is billed on a treatment-in-place ambulance claim, the MCO shall deny only the line with the unpayable code.

Valid treatment-in-place ambulance claim modifiers include: ~~for treatment in place are listed in the following table:~~

Modifier	Origination Site	Destination
DW	Diagnostic or therapeutic site other than P or H when these are used as origin codes	Tx-in-Place
EW	Residential, domiciliary, custodial facility (other than 1819 facility)	Tx-in-Place
GW	Hospital based ESRD facility	Tx-in-Place
HW	Hospital	Tx-in-Place
IW	Site of transfer (e.g., airport or helicopter pad) between modes of ambulance transport	Tx-in-Place
JW	Freestanding ESRD facility	Tx-in-Place
NW	Skilled nursing facility	Tx-in-Place
PW	Physician's office	Tx-in-Place
RW	Residence	Tx-in-Place
SW	Scene of accident or acute event	Tx-in-Place

~~Emergency Transportation to Hospital During Treatment in Place~~

If an~~the~~ enrollee being treated-in-place has a real-time deterioration in their~~his or her~~ clinical condition necessitating~~which necessitates~~ immediate transport to an emergency department, the ambulance provider cannot bill for both the treatment-in-place ambulance service and the ~~shall~~ transport to~~the enrollee if appropriate.~~

~~In no instance may~~ the emergency department. In this situation, **the ambulance provider shall bill for the emergency department** ~~MCO reimburse for both an emergency~~ **transport only**. The MCO shall require ambulance providers to submit pre-~~a~~ hospital care summary reports to prevent payment of ~~and an ambulance~~ treatment-in-

place ambulance claims and emergency ambulance transportation claims ~~service~~ for the same occurrence.~~incident.~~

Treatment-in-Place Telehealth Services

The MCO shall restrict payment of treatment-in-place telehealth services to those identified on the Treatment-in-Place Telehealth Services Fee Schedule.

Valid rendering providers are licensed physicians, advanced practice registered nurses, and physician assistants.

Ambulance Service Exclusions

Medicaid does not cover "Ambulance 911-Non-emergency" services (i.e., procedure code A0226). If the enrollee's medical condition does not present itself as an emergency in accordance with the criteria in this M~~m~~anual, the service may be considered a non-covered service by Medicaid.

The MCO may allow ambulance providers to bill enrollees for non-covered services only if the enrollee was informed prior to transportation, verbally and in writing, that the service would~~was~~ not be covered by Medicaid and the enrollee agreed to accept the responsibility for payment. The MCO shall ensure that the provider obtains a signed statement or form which documents that the enrollee was verbally informed of the out-of-pocket expense.

Non-Emergency Ambulance Transportation

Non-emergency ambulance transportation (NEAT) is transportation provided to a Medicaid enrollee to and/or from a Medicaid~~provider of medical services for a~~ covered ~~medical~~ service or VAB when no other means of transportation is available and the enrollee is unable to ride in any other type of vehicle due to medical reasons. The nature of the trip is not an emergency, but the enrollee requires the use of an ambulance.

Refer to the *Non-Emergency Medical Transportation* section of this Manual for additional transportation requirements that apply to both NEMT and NEAT.

Coverage Requirements

The enrollee's treating physician, a registered nurse, the director of nursing at a nursing facility, a nurse practitioner, a physician assistant, or a clinical nurse specialist must certify on the Certification of Ambulance Transportation (CAT) that the transport is medically necessary and describe the medical condition which necessitates ambulance services. The certifying authority shall complete the date range on the CAT, which shall be no more than 180 days. A single CAT should be utilized by the MCO for all of the enrollee's transports within the specified date range. The MCO may not require a new CAT from the certifying authority for the same enrollee during this date range.

NEAT must be scheduled by the enrollee or a medical facility through the MCO or the ambulance provider.

- If transportation is scheduled *through the MCO*, the MCO shall verify, prior to scheduling, enrollee eligibility, that the originating or destination address belongs to a medical facility, and that a completed Certification of Ambulance Transportation form is received for the date of service. Once the trip has been

dispatched to an ambulance provider and completed, the ambulance provider shall be reimbursed upon submission of the clean claim for the transport.

- If transportation is scheduled *through the ambulance provider*, the MCO shall require the ambulance provider to verify enrollee eligibility, that the originating or destination address belongs to a medical facility, and that a completed Certification of Ambulance Transportation form is received for the date of service. The MCO shall reimburse the ambulance provider only if a completed Certification of Ambulance Transportation form is submitted with the clean claim or is on file with the MCO or its transportation broker prior to reimbursement.

Mileage must be reimbursed in accordance with the type of service indicated by the licensed medical professional on the Certification of Ambulance Transportation.

The Certification of Ambulance Transportation form is located at www.lamedicaid.com [link]~~[link]~~.

Nursing Facility Ambulance Transportation

Nursing facilities are required to provide medically necessary transportation services for Medicaid enrollees residing in their facilities. Any nursing facility enrollee needing non-emergency, non-ambulance transportation services are the financial responsibility of the nursing facility. NEAT services provided to a nursing facility enrollee must include the Certification of Ambulance Transportation to be reimbursable by the MCO; otherwise, the nursing facility shall be responsible for reimbursement for such services.

Air Ambulance

Air ambulances may be used for emergency and non-emergency ambulance transportation when medically necessary. Licensure by the LDH Bureau of Emergency Medical Services is also required. Licensure for air ambulance services is governed by La. R.S. 40:1135.8. Rotor winged (helicopters) and fixed winged emergency aircraft must be certified by BHSF in order to receive Medicaid reimbursement. Fixed wing transports must be prior approved by the MCO.

All air ambulance services must comply with state laws and regulations governing the personnel certifications of the emergency medical technicians, registered nurses, respiratory care technicians, physicians, and pilots as administered by the appropriate agency of competent jurisdiction.

The MCO shall cover air ambulance services only if:

- Speedy admission of the enrollee is essential and the point of pick-up of the enrollee is inaccessible by a land vehicle; or
- Great distances or other obstacles are involved in getting the enrollee to the nearest hospital with appropriate services.

If both land and air ambulance transport are necessary during the same trip, the MCO shall reimburse each type of provider separately according to regulations for that type of provider.

Ambulance Memberships

The MCO shall prohibit ambulance companies that are enrolled in Medicaid from soliciting Medicaid enrollees for membership fees for a subscription plan. Solicitation of such fees is a violation of Section 1916 of the Social

Security Act and regulations at 42 C.F.R. §§ 447.15 and 447.56. If such membership fees are collected, the Medicaid enrollee must be refunded in full, or the ambulance provider will be terminated from the program.

It is not a violation of the regulations when a Medicaid-enrolled ambulance company accepts membership fees if the Medicaid enrollee voluntarily subscribes to the plan.

If a Medicaid-enrolled ambulance company's subscription plan operates as an insurance policy, and the Medicaid enrollee pays the fee, the fee is treated as an insurance premium and is not in violation of Medicaid regulations.

Return Trips and Transfers

Return Trips

When an enrollee is transported to a hospital by ambulance on an emergency basis and is not admitted, the hospital shall request an NEMT return trip with the MCO unless the enrollee meets the medical necessity requirements for NEAT.

Transfers

An ambulance transfer is the transport of an enrollee by ambulance from one hospital to another. The MCO shall only cover ambulance transfers when it is medically necessary for the enrollee to be transported by ambulance. The enrollee must be transported to the most appropriate hospital that can meet ~~his or her~~their needs.

If the physician makes the decision that the level of care required by the enrollee cannot be provided by the hospital, and the enrollee has to be transported by the provider to another hospital, the MCO shall reimburse the transportation provider for both transfers once clean claims are submitted for the transfers.

Claims and Encounters

Claims Filing

Ambulance providers shall submit claims using the CMS 1500 Health Insurance Claim Form (paper) or the 837P (electronic).

Ambulance providers shall submit claims for ambulance transportation to the MCO.

Claims shall be submitted within 365 days of the date of service.

Medicaid and Medicare Part B

Services for Medicare Part B enrollees should be billed to the Medicare carrier on the Medicare claim form. Medicare will make payment and cross the claim over to the MCO for Title XIX payment.

Medicaid will not make payment on any claim denied by Medicare as not being medically necessary. Qualified Medicare Beneficiary (QMB) claims are included in this policy.

For trips that are not covered by Medicare but are covered by Medicaid, payment will not be made unless the claim is filed with the Medicare EOB attached stating the reason for denial by Medicare.

For claims that fail to cross over electronically, a hard-copy claim may be filed up to six months after the date of the Medicare EOB, provided that the claim was filed with Medicare within a year of the date of service.

Medicaid does a cost comparison of cross-over claims to determine if Medicare paid more than Medicaid for the claim. If this occurs and Medicare has paid more than Medicaid reimburses for the service, the claim will be "zero" paid and the ambulance provider will be considered paid in full. No balance may be collected from the enrollee.

Ambulance Transportation Modifiers

When billing for procedure codes A0425-A0429 and A0433-A0434 for ambulance transportation services, the MCO shall require the provider to also enter a valid 2-digit modifier at the end of the associated 5-digit procedure code. Different modifiers may be used for the same procedure code. Spaces will not be recognized as a valid modifier for those procedures requiring a modifier. ~~The following table identifies the valid modifiers.~~

The following table identifies the valid modifiers.

Modifier	Description
DD	Trip from DX/Therapeutic Site to another DX/Therapeutic Site
DE	Trip from DX/Therapeutic Site to Residential, Domiciliary, Custodial Facility
DH	Trip from DX/Therapeutic Site to Hospital
DI	Diagnostic-Therapeutic Site/Transfer Airport Heli Pad
DP	Trip from DX/Therapeutic Site to Physician's Office
DR	Trip from DX/Therapeutic Site to Home
DX	Trip from DX/Therapeutic Site to MD to Hospital
ED	Trip from an RDC or Nursing home to DX/Therapeutic Site
EH	Trip from an RDC or Nursing home to Hospital
EG	Trip from an RDC or Nursing home to Dialysis Facility (Hospital based)
EI	Residential Domicile Custody Facility/Transfer Airport Heli Pad
EJ	Trip from an RDC or Nursing home to Dialysis Facility (non-Hospital based)
EN	Trip from an RDC or Nursing home to SNF
EP	Trip from an RDC or Nursing home to Physician's Office
ER	Trip from an RDC or Nursing home to Physician's Office
EX	Trip from RDC to MD to Hospital
GE	Trip from HB Dialysis Facility to an RDC or Nursing Home
GG	Trip from HB Dialysis Facility to Dialysis Facility (Hospital Based)
GH	Trip from HB Dialysis Facility to Hospital
GI	HB Dialysis Facility/Transfer Airport Heli Pad
GJ	Trip from HB Dialysis Facility to Dialysis Facility (non-Hospital Based)
GN	Trip from HB Dialysis Facility to SNF
GP	Trip from HB Dialysis Facility to Physician's Office
GR	Trip from HB Dialysis Facility to Patient's Residence
GX	Trip from HB Dialysis Facility to MD to Hospital
HD	Trip from Hospital to DX/Therapeutic Site
HE	Trip from Hospital to an RDC or Nursing Home
HG	Trip from Hospital to Dialysis Facility (Hospital Based)
HH	Trip from One Hospital to Another Hospital

Modifier	Description
HI	Hospital/Transfer Airport Heli Pad
HJ	Trip from Hospital to Dialysis Facility
HN	Trip from Hospital SNF
HP	Trip from Hospital to Physician's Office
HR	Trip from Hospital to Patient's Residence
IH	Transfer Airport Heli Pad/Hospital
JE	Trip from NHB Dialysis Facility to RDC or Nursing Home
JG	Trip from NHB Dialysis Facility to Dialysis Facility (Hospital Based)
JH	Trip from NHB Dialysis Facility to Hospital
JI	NHB Dialysis Facility/Transfer Airport Heli Pad
JN	Trip from NHB Dialysis Facility to SNF
JP	Trip from NHB Dialysis Facility to Physician's Office
JR	Trip from NHB Dialysis Facility to Patient's Residence
JX	Trip from NHB Dialysis Facility to MD to Hospital
ND	Trip from SNF to DX/Therapeutic Site
NE	Trip from SNF to an RDC or Nursing Home
NG	Trip from SNF to Dialysis Facility (Hospital based)
NH	Trip from SNF to Hospital
NI	Skilled Nursing Facility/Transfer Airport Heli Pad
NJ	Trip from SNF to Dialysis Facility (non-Hospital based)
NN	Trip from SNF to SNF
NP	Trip from SNF to Physician's Office
NR	Trip from SNF to Patient's Residence
NX	Trip from SNF to MD to Hospital
PD	Trip from a Physician's Office to DX/Therapeutic Site
PE	Trip from a Physician's Office to an RDC or Nursing Home
PG	Trip from a Physician's Office to Dialysis Facility (Hospital based)
PH	Trip from a Physician's Office to a Hospital
PI	Physician's Office/Transfer Airport Heli Pad
PJ	Trip from a Physician's Office to Dialysis Facility (non-Hospital based)
PN	Ambulance trip from the Physician's Office to Skilled Nursing Facility
PP	Ambulance trip from Physician to Physician's Office
PR	Trip from Physician's Office to Patient's Residence
RD	Trip from the Patient's Residence to DX/Therapeutic Site
RE	Trip from the Patient's Residence to an RDC or Nursing Home
RG	Trip from the Patient's Residence to Dialysis Facility (Hospital based)
RH	Trip from the Patient's Residence to a Hospital
RI	Residence/Transfer Airport Heli Pad
RJ	Trip from the Patient's Residence to Dialysis Facility (non-Hospital based)
RN	Trip from the Patient's Residence to Skilled Nursing Facility
RP	Trip from the Patient's Residence to a Physician's Office
RX	Trip from Patient's Residence to MD to Hospital
SH	Trip from the Scene of an Accident to a Hospital
SI	Accident Scene, Acute Event/Transfer Airport, Heli Pad
TN	Rural Area (for rotary wing emergency air ambulance trips only)

Emergency ambulance claims, that are not treatment-in-place, are only payable with a destination modifier of H, I, or X. Valid treatment-in-place ambulance claim modifiers are identified in the Treatment-in-Place section.

Medicaid Non-Covered Ambulance Modifiers

The MCO shall have edits in place to deny ambulance claims as non-covered services when any of the following modifiers are billed on the claim, in any modifier field.

Modifier	*Description*
GY	An item or service is that statutorily excluded
QL	The patient is pronounced dead after the ambulance is called but before transport.
TQ	Basic life support by a volunteer ambulance provider

Medicare Non-Covered Transportation Modifiers

The MCO shall require the following modifiers to be used when billing for transports that are non-covered services by Medicare. These modifiers may be used ONLY with procedure codes A0425-A0429 and A0433-A0434 to allow the claim to bypass the Medicare edit and process as a Medicaid claim.

Modifier	*Description*
DD	Clinic/Free-standing Facility to Clinic/Free-standing Facility
DE	Clinic/Free-standing Facility to Nursing Home
DP	Clinic/Free-standing Facility to Physician
DR	Clinic/Free-standing Facility to Residence
ED	Nursing Home to Clinic/Free-standing Facility
EP	Nursing Home to Physician *
ER	Nursing Home to Residence
HP	Hospital to Physician
NP	Skilled Nursing Facility to Physician *
PD	Physician to Clinic/Free-standing Facility
PE	Physician to Nursing Home
PN	Physician to Skilled Nursing Facility
PP	Physician to Physician
PR	Physician to Residence
RD	Residence to Clinic/Free-standing Facility
RE	Residence to Nursing Home
RP	Residence to Physician *

* These modifiers will bypass the Medicare edit for non-emergency transports ONLY.

Encounter Submissions

The MCO shall submit encounters in compliance with the contract and the **MCO System Companion Guide**.