MICHIGAN DEPARTMENT OF HEALTH AND HUMAN SERVICES

NOTICE OF PROPOSED POLICY

Public Act 280 of 1939, as amended, and consultation guidelines for Medicaid policy provide an opportunity to review proposed changes in Medicaid policies and procedures.

Please review the policy summary and the attached materials that describe the specific changes being proposed. Let us know why you support the change or oppose the change.

Submit your comments to the analyst by the due date specified. Your comments must be received by the due date to be considered for the final policy bulletin.

Thank you for participating in the consultation process.

Jackie Prokop

Director, Program Policy Division
Bureau of Medicaid Policy, Operations, and Actuarial Services

Project Number:	1906-Ambulance	**Comments Due:**	April 30, 2019	**Proposed Effective Date:**	July 1, 2019

Mail Comments to: Lida Momeni
Bureau of Medicaid Policy, Operations, and Actuarial Services
Medical Services Administration
P.O. Box 30479
Lansing, Michigan 48909-7979

Telephone Number: 517-284-1215 **Fax Number:** 517-241-8969
E-mail Address: Momenil@michigan.gov

Policy Subject: Medical Necessity of Ambulance Transports, Documentation Requirements, Mileage, Interfacility Transfers, and Non-covered Services

Affected Programs: Medicaid, Healthy Michigan Plan, MIChild, Children's Special Health Care Services (CSHCS)

Distribution: Ambulance Providers, Hospitals, Nursing Facilities

Policy Summary: This policy clarifies medical necessity and documentation requirements for Medicaid Fee-for-Service (FFS) ambulance transports. Additionally, this policy expands on ambulance mileage reimbursement, the documentation and ordering of interfacility transfers, and non-covered services.

Purpose: The Michigan Department of Health and Human Services (MDHHS) Office of Inspector General identifies and recoups ambulance transports without medical necessity and inadequate or missing documentation. The policy's emphasis on the importance of medical necessity and documentation should reduce the frequency of this issue. Cases of inappropriate interfacility transfers are also being subject to review and recoupment. This policy will provide guidance on when it is appropriate to transfer between hospitals. The policy will also clarify ambulance mileage reimbursement as it was not the intent of MDHHS to reimburse mileage for denied ambulance transports, as well as clarify additional non-covered services.

Proposed Policy Draft

Michigan Department of Health and Human Services
Medical Services Administration

Distribution: Ambulance Providers, Hospitals, Nursing Facilities

Issued: June 1, 2019 (Proposed)

Subject: Medical Necessity of Ambulance Transports, Documentation Requirements, Mileage, Interfacility Transfers, and Non-covered Services

Effective: July 1, 2019 (Proposed)

Programs Affected: Medicaid, Healthy Michigan Plan, MIChild, Children's Special Health Care Services (CSHCS)

This policy applies to Medicaid Fee-for-Service (FFS). Medicaid Health Plans (MHP) and Integrated Care Organizations (ICOs) must provide the full range of covered services described in this policy at a minimum and may choose to provide services over and above those specified. For beneficiaries enrolled in an MHP or ICO, the provider must check with the beneficiary's health plan for prior authorization requirements.

The purpose of this bulletin is to inform ambulance providers of changes to Medicaid FFS ambulance policy. Refer to the Michigan Department of Health and Human Services (MDHHS) Medicaid Provider Manual for information regarding Medicaid FFS ambulance policy. The Medicaid Provider Manual is available on the MDHHS website at www.michigan.gov/medicaidproviders >> Policy, Letters & Forms.

Medical Necessity of Ambulance Transports

Medical necessity is established when the beneficiary's condition is such that use of any other method of transportation is contraindicated. In cases where a mode of transportation other than an ambulance could be used without endangering the beneficiary's health, no payment may be made for ambulance services regardless of whether such other transportation is available.

Documentation Requirements

Ambulance providers must maintain documentation of the medical necessity and appropriateness of service in the beneficiary's file. This documentation may be used to assess whether the transport meets medical necessity, eligibility, coverage, benefit category, and any other criteria necessary for payment. Documentation must be sufficiently detailed to allow

reconstruction of what transpired for each service billed. (Refer to the Medicaid Provider Manual, General Information for Providers Chapter for information on documentation.) The level of service and assessment findings must be fully documented. An ambulance provider must document the medical necessity and clinical significance of an Advanced Life Support (ALS) Assessment in the beneficiary's file. The ambulance service must meet all program coverage criteria for payment to be made.

Mileage

Ambulance mileage reimbursement is a covered Medicaid benefit when a transport occurs and has been reimbursed. Transports that are denied for any reason, including lack of emergency criteria, will also be denied for the mileage reimbursement.

Interfacility Transfers

Hospital transfers to the nearest hospital that has the necessary service may be covered when the beneficiary has been stabilized at the first hospital but needs a higher level of care available only at the second hospital. Examples of medically necessary transfers include, but are not limited to, services not available at the first facility such as rehabilitation, a burn unit, ventilator assistance, or other specialized care. The ambulance provider must maintain documentation that clearly describes what service(s) is not available at the first facility.

The ordering provider may be held responsible if a medically unnecessary ambulance transport is ordered. The ordering provider may be subject to corrective action related to these services, including recoupment of funds. The ambulance provider may be subject to corrective action, including the recoupment of funds, if it submits a claim for a medically necessary non-emergency ambulance transport without record of a written order (e.g., physician certification statement). Additionally, any instances in which the ordering provider fails to document all required information necessary for a written order may be subject to recoupment of funds. (Refer to the Ambulance chapter of the Medicaid Provider Manual for information on non-emergency ambulance transport.) Transport from a hospital capable of treating the beneficiary to another hospital for the convenience or preference of the ordering provider, beneficiary or beneficiary's family is not a covered benefit.

Non-covered Services

Ambulance providers cannot be directly reimbursed for the following:

- Transportation to services that are not Medicaid-covered; or
- Transportation to a mental health facility if no other appropriate ambulance criteria is met. (For information on coverage requirements, refer to the Ambulance chapter of the Medicaid Provider Manual, Covered Services section.)