# Ambulance

July 20, 2021


"Working to protect, preserve and promote the health and safety of the people of Michigan by listening, communicating and educating our providers, in order to effectively resolve issues and enable providers to find solutions within our industry. We are committed to establishing customer trust and value by providing a quality experience the first time, every time."

-Provider Relations

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MDHHS Michigan Department of Health & Human Services

# Glossary & Common Terms

List of common acronyms & terms used for Ambulance billing



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Michigan Department of Health & Human Services

# Glossary and Common Terms

| | |
|---|---|
| **ALS** | Advanced Life Support |
| **Advanced Life Support Intervention** | A procedure in accordance with state and local laws that is required to be performed by minimum level EMT-S, AEMT, or Paramedic. |
| **AEMT** | Advanced Emergency Medical Technician: An individual licensed by the State of Michigan to provide BLS services. |
| **ALS Assessment** | An assessment performed by an ALS crew (minimum level EMT-S, AEMT, or Paramedic) as part of an emergency response that was necessary because the patient's reported condition at the time of dispatch was such that only an ALS crew was qualified to perform the assessment to determine whether the patient's condition requires an ALS level of care. The completion of an ALS assessment does not necessarily result in a determination that the patient requires an ALS intervention. |
| **Ambulance** | A motor vehicle or aircraft that is primarily used or designated as available to provide transportation and basic life support or advanced life support. |
| **Base Rate** | A payment rate associated with the level of service provided. Included in the base rate is oxygen, equipment and supplies essential to the provision of services, and accompanying personnel. |

# Glossary and Common Terms

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|---|---|
| **BLS** | Basic Life Support |
| **CMS** | Centers for Medicare and Medicaid Services |
| **Continuous or Round Trip** | An ambulance service in which the patient is transported to the hospital, the physician deems it medically necessary for the ambulance to wait, and the beneficiary is then transported to a more appropriate facility for care or back to the place of origin. |
| **EMT-S** | Emergency Medical Technician Specialist: An individual licensed by the State of Michigan to provide limited ALS services. |
| **Fixed Wing Air Ambulance** | An aircraft, such as an airplane, that is licensed as a fixed wing air ambulance and such ancillary services as may be medically necessary. |
| **Loaded Mileage** | The number of miles for which the Medicaid beneficiary is transported in the ambulance vehicle. |
| **Medically Necessary Transport** | An ambulance transport which is required because no other effective and less costly mode of transportation can be used due to the patient's medical condition. |
| **Neonatal Transport Team** | A team of experienced, specialized, multidisciplinary health care providers (established and defined by a health care facility) who are trained for, and immediately available to respond to, calls for high risk neonatal transports. |

# Glossary and Common Terms

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|---|---|
| **Neonate** | An infant less than four weeks old. |
| **Neonate Return Transfer** | An ambulance transport that returns a stabilized neonate from a Level III or Level IV NICU back to the Level I Well Born Nursery or Level II Special Care Nursery from which the neonate was originally transferred. |
| **Paramedic** | An individual licensed by the State of Michigan to provide ALS services. |
| **Rotary Wing Air Ambulance** | An aircraft, such as a helicopter, that is licensed as a rotary wing air ambulance and such ancillary services as may be medically necessary. |
| **Transfer** | The movement of a beneficiary from one health care facility to another in a licensed ground or air ambulance because a medically necessary service was not available at the primary location. |
| **U&C Base Rate** | Usual and Customary base rate |
| **Waiting Time** | When an ambulance provider waits at a hospital while a beneficiary is being stabilized, with the intent of continuing transport to a more appropriate hospital for care, or back to the beneficiary's point of origin. |

# Ambulance Overview

- Policy Review
- Medical Necessity
- Base Rate
- Documentation Requirements
- Prior Authorization
- Direct Data Entry (DDE)
- Ambulance Services

## Policy Review

Medicaid Provider Manual, Ambulance Chapter section 1 General Information & 1.3 Ambulance Services

- The Michigan Department of Health and Human Services (MDHHS), which administers the Medicaid Program, reimburses for ambulance services as medically necessary and appropriate, regardless of whether there is a corresponding medical claim on the date of service, when:
  - Medical/surgical or psychiatric emergencies exist; or
  - No other effective and less costly mode of transportation for medical treatment can be used because of the beneficiary's medical condition.
- MDHHS recognizes different levels of medical services provided by qualified ambulance staff according to the standards established by law and regulation through Michigan Public Act 368 of 1978 as amended. The standards established for each level of service are detailed in the Base Rate subsection of the Ambulance Chapter of the Michigan Medicaid Provider Manual.



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# Medical Necessity

Medicaid Provider Manual
Ambulance Chapter,
Section 1.4 Medical
Necessity

## Determination

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.

## Emergency Medical Necessity

The medical care personnel in attendance, including the Emergency Medical Technician (EMT) at the scene of an emergency, determine medical necessity and appropriateness of service within the scope of accepted medical practice and Medicaid guidelines.

## Non-Emergency Medical Necessity

The beneficiary's attending physician must order all non-emergency, medically necessary ambulance transportation.

# Base Rate

Medicaid Provider Manual, Ambulance Chapter, Section 2.2 Base Rate

Ambulance Fee Schedule

The ambulance provider may bill one base rate procedure code:

- Advanced Life Support 1 (ALS 1) Non-emergency;
- ALS 1 Emergency;
- Advanced Life Support 2 (ALS 2);
- Basic Life Support (BLS) Non-emergency;
- BLS Emergency;
- Neonatal Emergency Transport;
- Rotary Wing Air Ambulance; or
- Fixed Wing Air Ambulance Transport.

Reimbursement for the base rate covers all services rendered except mileage that may be billed separately.

# Documentation Requirements

## Level of Service

- The level of service and assessment findings must be fully documented. An ambulance provider must document the medical necessity and clinical significance of an ALS assessment in the beneficiary's file.

## Documentation

- Ambulance providers must maintain documentation of the medical necessity and appropriateness of service in the beneficiary's file regardless of the level of service provided.

## Coverage

- The ambulance service must meet all program coverage criteria for payment to be made.
- Documentation must be sufficiently detailed to allow reconstruction of what transpired for each service billed.



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# Prior Authorization

Medicaid Provider Manual, Ambulance Chapter, Section 1.9 Prior Authorization

Ambulance: Prior Authorization Tip

For services requiring Prior Authorization (PA), the ambulance provider must request authorization from the MDHHS Program Review Division (PRD). The request must include the following information:

- Beneficiary's name and Medicaid ID number
- Diagnosis
- Point of pick-up and destination
- Services(s) to be provided
- Explanation as to why the ambulance transportation is medically necessary
- Explanation as to why the beneficiary cannot be transported by other means
- Name, address, and National Provider Identifier (NPI) of the ambulance provider
- PA requestor's name

Additional information regarding requesting Prior Authorization in CHAMPS can be found through the Medicaid Provider website www.Michigan.gov/MedicaidProviders.



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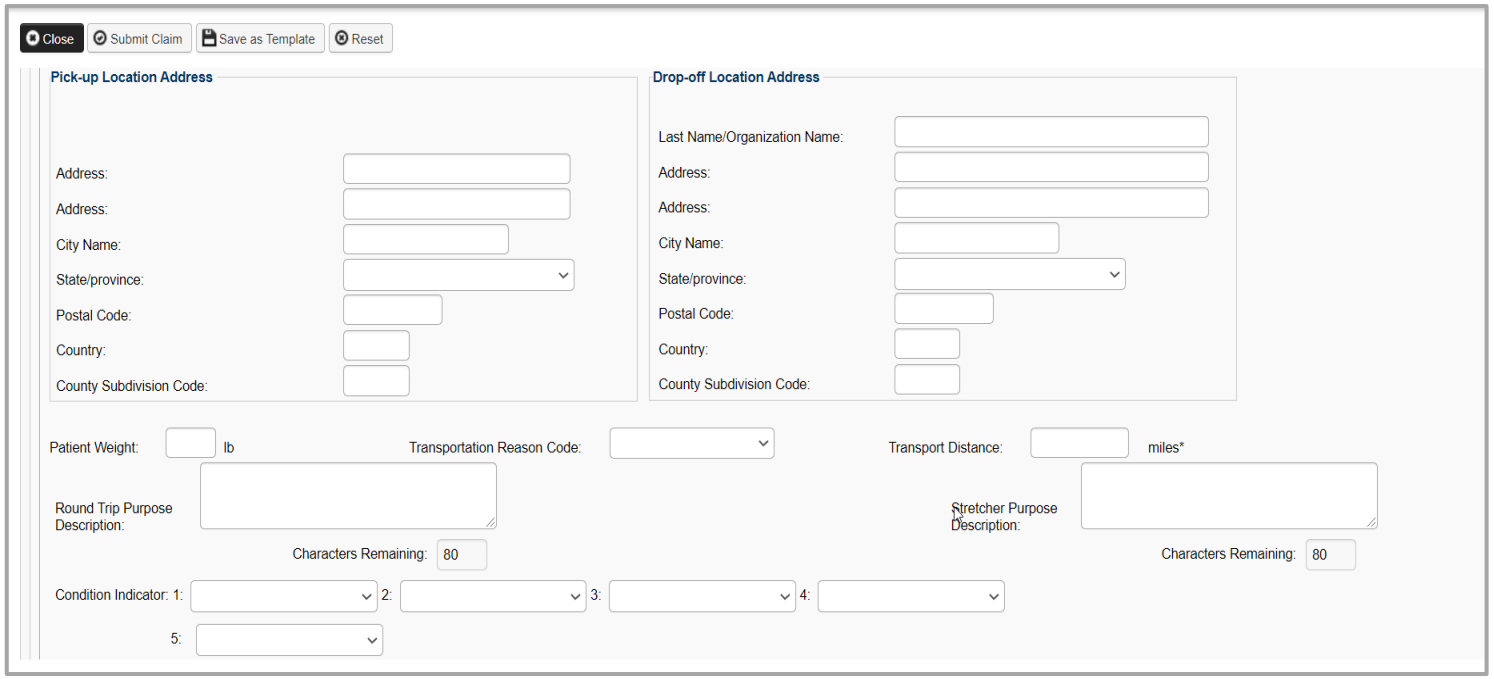
# Direct Data Entry (DDE)

- When submitting a claim in CHAMPS DDE and reporting the transport information, it should be reported within the Ambulance Information section. Click the plus sign and the screen will open.
- The ambulance information reported should match the provider's run report within the beneficiary's file.

[CHAMPS DDE for Professional Claims]

[CHAMPS DDE for Institutional Claims]


*Screenshot references Professional DDE Claim



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# Ambulance Services

- CMS/ Medicare Covered Ambulance Services

- CMS Ambulance Transportation Locations
- CMS Air Ambulance Transportation

## Ground Ambulance Transport

- When all other program requirements for coverage are met, ground ambulance transports are covered only to and from these destinations:
  - Hospitals
  - Beneficiaries' homes
  - CAHs
  - Dialysis facilities for End-Stage Renal Disease (ESRD) beneficiaries who require dialysis
  - Physicians' offices only when:
    - The transport is en route to a Medicare-covered destination
    - The ambulance stops because of the beneficiary's dire need for professional attention and
    - Immediately thereafter, the ambulance continues to the covered destination
  - SNFs and
  - From an SNF to the nearest supplier of medically necessary services not available at the SNF where the beneficiary is a resident and not in a covered Part A stay, including the return trip

## Air Ambulance Transport

- When all other program requirements for coverage are met, air ambulance transports are covered only to an acute care hospital. Air ambulance transports to these destinations are not covered:
  - Nursing Facilities
  - Physicians' offices and
  - Beneficiaries' homes

# Covered and Excluded Services

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- Advanced Life Support: ALS1 and ALS2
- Basic Life Support (BLS)
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- Special Situations
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- Ambulance Coverage Exclusions



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# Air Ambulance

Medicaid Provider Manual, Ambulance Chapter, Section 2.1 Air Ambulance

- Medicaid reimburses air ambulance services only when a beneficiary requires medical or surgical (not diagnostic) procedures, and their condition requires rapid transportation to a treatment facility. One of the following requirements must be met:
  - Great distance or obstacles preclude such delivery to the most appropriate facility; or,
  - The beneficiary is inaccessible by either ground or water ambulance.
- Hospital-to-hospital emergent transfers performed by either a rotary wing or fixed-wing air ambulance require clinical documentation (i.e., the History and Physical [H & P] report) from the beneficiary's attending physician validating the need for the air, rather than ground, transportation.



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# Advanced Life Support: ALS1

Non-Emergency ALS1 includes an ALS assessment or the furnishing of at least one ALS intervention within the context of a non-emergency response.

Ambulance providers must secure a physician's written order indicating the medical necessity of the elevated level of transport and retain it in their files.

Emergency ALS1 is the transportation by ground ambulance and the provision of ALS1 services within the context of an emergency response.

The furnishing of an ALS assessment, without a medically necessary ALS intervention, is sufficient to bill the ALS base rate if the beneficiary's condition at the time of dispatch indicated an ALS level of service was required.

# Advanced Life Support: ALS2

Medicaid Provider Manual, Ambulance Chapter, Section 2.3.C Advanced Life Support Level 2 (ALS2)

- ALS2 is defined as the transportation by ground ambulance vehicle, and the provision of medically necessary supplies and services, including an ALS assessment, and:
  - At least three separate administrations of one or more medications by intravenous push/bolus or by continuous infusions (excluding crystalloid fluids); or
  - One or more of the following ALS2 procedures:
    - Manual defibrillation/cardioversion
    - Endotracheal intubation, or the monitoring and maintenance of an endotracheal tube that was previously inserted prior to the transport
    - Central venous line
    - Cardiac pacing
    - Chest decompression
    - Surgical airway
    - Intraosseous line
    - Reimbursement for the ALS base rates includes those services listed under BLS and is the same whether or not special services were performed.

# Basic Life Support (BLS)

Medicaid Provider Manual,
Ambulance Chapter, Section 2.4
Basic Life Support

- Medicaid coverage of the BLS base rate includes transportation and medical services that an EMT is routinely trained to provide. (e.g., the provision of oxygen and resuscitation).
- Non-emergency BLS is defined as the transportation by ground ambulance within the context of a non-emergency response. The BLS service must be provided by either a BLS or an ALS licensed provider. Ambulance providers must secure a physician's written order indicating the medical necessity of the transport and retain it in their files.
- Emergency BLS is defined as the transportation by ground ambulance and when either a BLS or an ALS licensed provider renders BLS services as defined above within the context of an emergency response.

# Emergency / Non-Emergency

Medicaid Provider Manual, Ambulance Chapter, Section 2.6 Emergency and 2.9 Non-Emergency

Emergent Provider Transport Tip

Non-Emergency Provider Transport Tip

- Claims for emergency ambulance transports must be coded with both an emergency procedure code and an appropriate ICD diagnosis code whenever the service results in transport to a hospital, or assessment and treatment/stabilization determines that no further transport is necessary. Claims for emergency transports without this information will be rejected.
  - To assure appropriate coverage and reimbursement for emergency ambulance services, MDHHS maintains an Ambulance Emergency Transports Diagnosis Code Database.
  - A claim may be made to MDHHS for a scheduled, medically necessary non-emergency ambulance transport only when the beneficiary's attending physician orders the transportation and provides, to the ambulance provider, a written order (e.g., physician certification statement) certifying the medical necessity of the transport.
  - A separate physician's order is required for each individual round trip transport, unless a beneficiary has a chronic medical condition that requires planned treatment. For chronic conditions, a physician may order non-emergency transportation for a maximum time period of up to 60 days in a single order. The physician's order for ongoing treatment must state the frequency of the transport and the type of ongoing treatment necessary.
  - The written order must include specific information outlined in the Non-Emergency section of the Provider Manual

# Mileage

## Ambulance mileage is only reimbursable when the transport has been reimbursed.

Appropriate origin and destination modifier combinations must be utilized.

When billing for mileage greater than 100 miles, enter the origin and destination addresses in the remark section on the claim.

Transports that are denied for any reason, including lack of emergency criteria, will also be denied for the mileage reimbursement.



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# Special Situations

Medicaid Provider Manual, Ambulance Chapter, Section 3 Special Situations

- Nursing Facilities
  - Ambulance Provider may only bill MDHHS directly when a resident requires Physician-ordered medically necessary non-emergency ambulance transportation.
  - Provider must maintain the written order as documentation of medical necessity.
- Multiple Beneficiaries per Transport
  - When more than one eligible beneficiary is transported at the same time, the only acceptable duplication of charges is half the base rate.
  - Separate claims must be submitted for each beneficiary.
  - Appropriate modifier (GM) must be reported on service line for the transport for the second or subsequent patient being transported. Do not report for the first patient.
- Continuous or Round-Trip Transports
  - Transports are one run.
  - Base rate code for the highest level of service performed during transport should be billed on one claim line.
  - Loaded mileage is also billed on one claim line, with the total number of whole (loaded) miles indicated as the quantity.



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# Special Situations

Medicaid Provider Manual, Ambulance Chapter, Section 3 Special Situations

- Multiple Transports per Beneficiary
  - If more than two ambulance transports are needed for the same beneficiary on the same date of service, the third transport will require PA. When additional transports of an emergent nature are necessary, ambulance providers can secure PA after the transport has been rendered.
- Out of State Transport
  - Out of State Transport requires a PA unless it is an emergent transport.
    - Provider must bill with approved emergency diagnosis code and ensure the emergent indicator on the line is selected as Yes (Y).
- Pronouncement of Death
  - Reimbursement depends upon when the beneficiary's death occurs by an individual legally authorized to pronounce death:
    - Prior to the time the ambulance is called: no payment is made
    - After the ambulance is called, either before or after the ambulance arrives at the scene: payment for an ambulance trip is made at the BLS rate but no mileage is paid
    - On arrival to the receiving hospital after getting medically necessary care during the ambulance transport from the scene to the receiving facility: payment is made at the medically necessary level of service furnished.

# Excluded Services

Medicaid Provider Manual, Ambulance Chapter, Section 4 Ambulance Coverage Exclusions

Excluded Services Provider Tip

Circumstances under which Medicaid does not pay for ambulance transportation include, but are not limited to:

- Services that are not medically necessary
- Services that are included as a part of the base rate
- Services for beneficiaries in a nursing facility (NF) that are reimbursed as part of the facility's per diem or are billed separately by the facility
- Non-ambulance, non-emergency medical transportation that is provided by an MHP
- Non-ambulance, non-emergency medical transportation arranged by either the local MDHHS office or an MDHHS-contracted transportation broker who reimburses the beneficiary or the transportation provider directly
- Transport of inmates to or from a correctional facility

For a complete list of excluded services, please reference the Medicaid Provider Manual, Ambulance Chapter, Section 4: Ambulance Coverage Exclusions



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# Common Denials & Billing Tips

Reason and Remark Code Definitions:

https://x12.org/reference



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# Common Denials

| Claim Adjustment Reason Code (CARC) | Remittance Advice Remark Code (RARC) | What does this mean? | Resolution/ Resource |
|---|---|---|---|
| 206 - National Provider Identifier - missing. | N286 - Missing/incomplete/invalid referring provider primary identifier. | Procedure code requires a referring/ordering provider | https://www.michigan.gov/documents/mdhhs/Internet_Workgroup_-_Provider_Verification_Tool_Guide_Professional_Tips_532686_7.pdf |
| 50 - These are non-covered services because this is not deemed a 'medical necessity' by the payer. | M76 - Missing/incomplete/invalid diagnosis or condition. | Claim billed as an emergency without a Medicaid approved Emergency Diagnosis code | https://www.michigan.gov/documents/Emergency_Ambulance_Transport_Database_88508_7.PDF |
| 24 - Charges are covered under a capitation agreement/managed care plan. | | Beneficiary enrolled in an HMO or clinic plan | https://www.michigan.gov/documents/mdhhs/CHAMPS_Member_700457_7.pdf |
| 22 - Care may be covered by another payor | N598 - Health care policy coverage is primary | Beneficiary has other insurance | https://www.michigan.gov/documents/mdhhs/Inst_Billing_Tip_Other_Insurance_Reporting_Requirements_09_21_2017_601846_7.pdf |

## Billing Tips:

- When billing for ambulance services, appropriate origin and destination modifiers must be included on any service line when billing for mileage. Transport modifiers can be found in the Medicaid Provider Manual, Billing & Reimbursement for Professionals, Section 7.2A Origin and Destination Modifiers
- Procedure code A0998 – Ambulance Response Treatment. This code is to be used when an Ambulance provider responds and treats at the scene and no transport is necessary. Mileage is not reported when this code is billed.

# Coronavirus (COVID-19) Resources

For the most recent information on the vaccine in Michigan:

Michigan.gov/COVIDVaccine



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# Coronavirus (COVID-19) Resources

MDHHS resources to keep providers informed about the Coronavirus (COVID-19) pandemic and the State of Michigan's response.

- Learn about our responses to Coronavirus (COVID-19) and find the latest program guidance. www.michigan.gov/coronavirus >> Resources >> For Health Professionals

- Additional Information:
  - COVID-19 Response Database
  - Telemedicine Database
  - Actions for Caregivers of Older Adults During COVID-19 and supporting Frequently Asked Questions (FAQ) document
  - COVID-19 Response MSA Policy Bulletins

- Questions About COVID-19?
  - Visit our Frequently Asked Questions page
    - Our most commonly answered questions can be found there and are updated often.
  - Call the COVID-19 Hotline at 1-888-535-6136
  - Email COVID19@michigan.gov

Learn about each phase of the MI Safe Start Plan

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# Provider Resources

**MDHHS website:** www.michigan.gov/medicaidproviders

**We continue to update our Provider Resources:**

- CHAMPS Resources
- Listserv Instructions
- Medicaid Provider Training Sessions
- Provider Alerts
- Provider Enrollment Website

**Provider Support:**

ProviderSupport@Michigan.gov

1-800-292-2550

Thank you for participating in the Michigan Medicaid Program