

**Bulletin Number:** MSA 15-48

**Distribution:** Ambulance Providers, Hospitals, Medicaid Health Plans

**Issued:** December 1, 2015

**Subject:** Medicaid Ambulance Policy Revisions

**Effective:** January 1, 2016

**Programs Affected:** Medicaid, Healthy Michigan Plan, Children's Special Health Care Services

The purpose of this bulletin is to clarify and amend Michigan Medicaid, Children's Special Health Care Services and Healthy Michigan Plan ambulance policy pertaining to Advanced Life Support (ALS) and base rate services, non-emergent air ambulance transports and neonatal emergency transports. This policy is effective for dates of service on and after December 1, 2015, and applies to Medicaid Fee-for Service. For beneficiaries enrolled in a Medicaid Health Plan (MHP), providers should contact the MHP for policy and coverage information.

## **I. Advanced Life Support & Base Rate Services**

The determination to respond emergently with either an ALS or Basic Life Support (BLS) ambulance vehicle is dependent upon local 911 or equivalent service dispatch protocol. When a dispatch was inconsistent with this standard of protocol, or when no protocol was used, the beneficiary's condition at the time of ambulance arrival determines the appropriate level of reimbursement. Even if a local government or medical control authority requires an ALS-level response to all calls, the base rate billed must reflect the level of service rendered and not the vehicle in which the beneficiary was transported. 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.

**A.** The following reflects the updated Advanced Life Support, Level 2 (ALS2) subsection of the Ambulance Chapter within the Medicaid Provider Manual:

ALS2 is defined as the transportation by ground ambulance vehicle and the provision of medically necessary supplies and services, including an ALS assessment, and one of the following:

- 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.

- B. The following terms and definitions are being amended or added to the Common Terms subsection of the Ambulance Chapter:

**1. Advanced Life Support Assessment**

An assessment performed by an ALS crew (minimum level emergency medical technician-specialist [EMT-S], advanced emergency medical technician [AEMT], or paramedic) as part of an emergency response that was necessary because the beneficiary'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 beneficiary'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.

**2. Advanced Life Support Intervention**

A procedure in accordance with state and local laws that is required to be performed by an emergency medical technician-specialist (EMT-S), AEMT, or paramedic.

**3. Base Rate**

A payment rate associated with the level of service provided. Included in the base rate are oxygen, equipment and supplies essential to the provision of services, and accompanying personnel.

**4. Emergency Medical Technician (EMT)**

An individual licensed by the state of Michigan to provide BLS services.

**5. Emergency Medical Technician Specialist (EMT-S)**

An individual licensed by the state of Michigan to provide limited ALS services.

**6. 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.

**7. Paramedic**

An individual licensed by the State of Michigan to provide ALS services.

**8. 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.

**9. Waiting Time**

The time 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.

## **II. 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.

Transportation and mileage provided and billed by fixed wing air ambulance providers that meet the requirements listed in the Ambulance Chapter of the Medicaid Provider Manual, Emergency Section, do not require prior authorization (PA) or an order by the beneficiary's attending physician. Hospital-to-hospital emergent transfers performed by either a helicopter or fixed-wing air ambulance require clinical documentation (i.e. the History and Physical [H & P] report) from the beneficiary's attending physician stating the reason ground transportation was not appropriate. All air ambulance transports that are of a non-emergent nature, regardless of if they're performed by either a helicopter or fixed-wing, will continue to require PA and an order by the beneficiary's attending physician.

## **III. Neonatal Emergency Transports**

Medicaid ambulance policy pertaining to neonatal emergency ambulance transportation is being updated and modernized. The following reflects the updated Neonatal subsection of the Ambulance Chapter:

Coverage of neonatal transport includes the neonatal base rate, loaded mileage, and waiting time. The cost of the transfer isolette use is included in the neonatal base rate.

The intensive care transport of critically ill neonates to a Level III or Level IV Neonatal Intensive Care Unit (NICU) as approved and designated by Certificate of Need (CON) review standards, is covered. A neonatal transport team must accompany the neonate. The neonatal transport team has primary responsibility for the neonate and the hospital is reimbursed for these services. The designated ambulance provider may bill the neonatal base rate and mileage for the transport.

A neonate return transfer from a NICU to a Level I Well Newborn Nursery or a Level II Special Care Nursery as approved and designated by CON review standards, after the neonate's condition is stabilized, is covered if the transportation is ordered by the neonate's attending physician. A physician's order indicating the medical necessity of the return trip must be retained in the beneficiary's file as detailed in the Ambulance Services subsection of this chapter.

**A.** The following terms and definitions are also being added to the Common Terms subsection of the Ambulance Chapter:

### **1. Neonate**

An infant less than four weeks old.

### **2. 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.

### **3. 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.

## Manual Maintenance

Retain this bulletin until the information is incorporated into the Michigan Medicaid Provider Manual.

## Questions

Any questions regarding this bulletin should be directed to Provider Inquiry, Department of Health and Human Services, P.O. Box 30731, Lansing, Michigan 48909-8231, or e-mail at [ProviderSupport@michigan.gov](mailto:ProviderSupport@michigan.gov). When you submit an e-mail be sure to include your name, affiliation, and phone number so you may be contacted if necessary. Providers may phone toll-free 1-800-292-2550.

## Approved

A handwritten signature in black ink that reads "Chris Priest". The signature is written in a cursive style with a long horizontal stroke at the end.

Chris Priest, Director  
Medical Services Administration