MSA Bulletin

MEDICAL SERVICES ADMINISTRATION

Michigan Department of Community Health

Distribution: Ambulance 01-03
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Issued: April 1, 2001

Subject: Uniform Billing Project for Ambulance Providers

Effective: August 1, 2001

Programs Affected: Medicaid, Children's Special Health Care Services, State Medical Program

Effective for services rendered on or after August 1, 2001, the Department of Community Health (DCH) is implementing changes in coverage and reimbursement policies, and claim submission requirements for Ambulance Providers. These changes will help align DCH requirements with those of other major health insurers and are a step toward HIPAA (Health Insurance Portability and Accountability Act of 1996) compliance.

This bulletin contains information about specific changes being implemented for Ambulance Providers. You should also refer to Medicaid Bulletin MSA 01-01 (revised Chapter IV) issued January 1, 2001, for additional information regarding claims completion requirements. Copies of all draft and final policy bulletins, the electronic claim transaction set, and other information related to changes being made are available on the DCH website at www.mdch.state.mi.us, click on Medical Services Administration, Information for Medicaid Providers.

The following changes will be implemented August 1, 2001:

- Claims will be submitted on either the HCFA 1500 paper claim or the National Electronic Data Interchange Transaction Set Health Care Claim: Professional 837 (ASC X12N 837, version 3051) electronic format.
- Origin and Destination Modifiers:

  Providers must utilize the HCPCS Level II modifiers (as updated annually) or the following Level III modifier to report Origin and Destination which are required for any claim line for mileage. Failure to report a valid origin and destination modifier combination will result in the claim being rejected.

  - M Emergency Room (outpatient)

The following list contains the combinations of Origin and Destination modifiers covered by Medicaid.

DD	EE	GE	HE	IE	JE	MD	NE	PE	RH	SM
DE	EG	GH	HH	II	JG	ME	NG	PI	RI	SX
DG	EH	GI	HI	IJ	JJ	MH	NH	PM	RM	
DH	EI	GJ	HJ	IN	JN	MI	NI	PN	RP	
DI	EJ	GN	HN	IJ	JM	MM	NJ	PP	RX	
DJ	EN	GM	HM	IP	JP	MN	NM	PR		
DN	EM	GP	HP	IR	JR	MR	NN	PX		
DM	EP	GR	HR	IX	JX	MX	NP			
DP	ER	GX	HX				NR			
DR	EX						NX			
DX										

- Modifiers:

  Providers may report the following modifiers as appropriate when billing for ambulance services:

  - CPT Modifiers
    - 22 Unusual procedural services: when the service(s) provided is greater than that usually required for the listed procedure, it may be identified by adding modifier "22" to the usual procedure number. A report may also be appropriate.
  - Level II Modifiers
    - QL "Patient pronounced dead after ambulance called" (Information only)
    - QM "Ambulance service provider under arrangement by a provider of services" (Information only)
    - QN "Ambulance service provided directly by a provider of services" (Information only)
  - Level III Modifiers
    - YZ "Multiple recipients per transport"
      The YZ modifier must be entered in field 43J or 43K of the HCFA 1500 claim form on the mileage code line.
    - AS "Out of state transports"
      When seeking reimbursement for out of state transports, providers must report modifier AS in field 43J or 43K of the HCFA 1500 on the mileage code line and the prior authorization number must be entered on the claim, except in the case of emergency transports"

- WA "Transportation by means other than an ambulance are contraindicated because of one of the following:

  - Patient was immobile because of fracture or possibility of fracture.
  - Patient had to be restrained.
  - Patient sustained severe hemorrhage.
  - Patient could only be moved by stretcher.
  - Patient was bed-confined before and after the ambulance trip." May be reported. (Information only)

- WB "Transportation in an emergency situation as a result of an accident, injury, or acute illness". (Information only)

- WZ "Patient had to be moved because individual facility was inadequate." (Information only)

- Diagnosis Coding:

  Providers must enter the appropriate diagnosis code on all ambulance claims using the International Classification of Diseases, Ninth Edition, Clinical Modification (ICD-9-CM). Providers are to report the most specific diagnosis code available that identifies the reason for the service. If a four (4) digit code is more specific than a corresponding three (3) digit code, use the four digit code. Likewise, if a five (5) digit code is the most specific appropriate code, report it.

For reimbursement, a claim for emergency ambulance transport must be coded with both an emergency procedure code and an appropriate ICD-9-CM diagnosis code whenever the service results in transport to an emergency department, or assessment and treatment/stabilization determines that no further transport is necessary. Claims for emergency transports without this information will be rejected.

Documentation supporting the emergency diagnosis code must be retained in the ambulance provider's records for audit purposes.

- Place of Service Code:

  - The new HCPCS ambulance place of service codes will be:
    - 41 ambulance - land
    - 42 ambulance - air or water

  - Place of service 9 will no longer be valid for ambulance

INTERCEPTS
In situations where a BLS vehicle intercepts with an ALS vehicle, each provider may bill for the appropriate base rate and for the loaded mileage (if any) they provided.

REMINDER

The DCH implemented its 2001 HCPCS code updates effective for dates of service on and after 04-01-01. The following clarifies billing instructions for services previously identified by the Level III codes that were end-dated effective 03-31-01.

Y9951 Ambulance service, waiting time, 15 minute increments
Is replaced by A0420 Ambulance waiting time, (ALS or BLS), one half (1/2) hour increments. "Report 1 unit for every 30-minute increment. Waiting time is covered only if there is waiting time with the loaded round trip or the segmented one way loaded trip. No reimbursement is made for the first one-half hour since this would be the normal load/unload time. The first half hour should not be included in the number of units billed The maximum number of hours allowed for waiting time is 4 hours. If more than 4 hours of waiting time is involved, request Individual Consideration and provide documentation."

Y9953 Ambulance service, limited advanced life support run, base rate, one-way
Is replaced by HCPCS code A0426 Ambulance service, ALS, non-emergency transportation level 1 (ALS1) or A0427 Ambulance service, ALS, emergency transportation level 1 (ALS1)

Y9954 Ambulance service, neonatal incubator usage
The cost of the isolette is new included in neonatal transportation base rate. (Procedure Code A0225)

Y9955 Air ambulance, mileage transportation
Is replaced by HCPCS code A0436 Rotary wing air mileage, per statute mile

Manual Maintenance

Retain this bulletin for future reference.

Questions

Any questions regarding this bulletin should be directed to: Provider Inquiry, Medical Services Administration, P.O. Box 30479, Lansing, Michigan 48909-7979, or e-mail at ProgramSupport@state.mi.us. Providers may phone toll free 1-800-292-2550.

Approved

James K. Havemen, Jr.
Director

Robert M. Smedes
Deputy Director for
Medical Services Administration