MSA MEDICAL SERVICES ADMINISTRATION

Bulletin

Michigan Department of Community Health

Distribution: Ambulance 03-03
Hospital 03-07
Medicaid Health Plans 03-06

Issued: August 1, 2003

Subject: Policy Clarifications/Revisions

Effective: October 1, 2003

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

Effective for services rendered on and after 10/01/2003, the Department of Community Health (DCH) is implementing changes in coverage and reimbursement policies and claim submission requirements for Ambulance Providers. These changes will align DCH requirements with those of other major health care providers, State of Michigan regulations regarding scope of responsibility for Emergency Medical Technicians (EMTs), and the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The following changes will be effective for dates of service on and after 10/01/2003:

- In Ambulance Chapter III, Section 3, Page 3, the phrase **"the establishment of a peripheral intravenous (IV) line"** is deleted from the definition of Basic Life Support (BLS). This terminology does not agree with the State of Michigan's definition of what a Basic Level EMT is qualified to perform.
- In Ambulance Chapter III, Section 4, Page 3, the phrase **"Modifier AS must be reported and"** is deleted from the directions for filing a claim for out-of-state transports. Modifier **AS** is not a HIPAA-acceptable modifier.
- In Chapter IV, Section 6, Page 1, subsection Ambulance, reference to Origin and Destination Modifiers, modifier **"M Hospital emergency room"** is deleted from the table and the example is changed to **"e.g., RH for a transport from the residence to the hospital".** The Origin/Destination Modifier **"M Hospital emergency room"** is no longer valid as it is not a HIPAA-acceptable Origin/Destination Modifier. Providers are instructed to use the origin/destination modifier **"H Hospital"** instead of "M". The HCFA 1500/837P-Chapter IV (Billing and Reimbursement) last issued in MSA 02-08 will be revised at a later date to include this change.

A revised list of the combinations of Origin and Destination Modifiers covered by Medicaid follows.

DD	EE	GE	HE	IE	JE	NE	PE	RG	SH
DE	EG	GH	HH	IH	JG	NG	PH	RH	SX
DG	EH	GI	HI	II	JH	NH	PI	RI	
DH	EI	GJ	HJ	IJ	JJ	NI	PN	RJ	
DI	EJ	GN	HN	IN	JN	NJ	PP	RP	
DJ	EN	GP	HP	IP	JP	NN	PR	RX	
DN	EP	GR	HR	IR	JR	NP	PX		
DP	ER	GX	HX	IX	JX	NR			
DR	EX					NX			
DX									

Manual Maintenance

Insert the attached manual pages in Chapter III of your manual and discard the obsolete pages.

Retain this bulletin for future reference.

Questions

Any questions regarding this bulletin should be directed to Provider Inquiry, Department of Community Health, P.O. Box 30731, Lansing, Michigan 48909-8231 or e-mail 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.

Approval

Paul Reinhart
Deputy Director for
Medical Services Administration

AIR AMBULANCE:

FIXED WING AIR AMBULANCE SERVICES:

Fixed wing air ambulance providers must be licensed by the Michigan Department of Consumer and Industry Services and be properly enrolled with the Michigan Department of Community Health. Providers must indicate on the application for enrollment that they are requesting fixed wing air ambulance status. Fixed wing providers are to submit a copy of their license as an Aircraft Transport Operation which shows their aircraft registered as an Aircraft Transport Vehicle. Since all equipment standards must equate to current Basic Life Support (BLS) or Advanced Life Support (ALS) criteria as appropriate for the transported patient, providers must also submit a copy of their Commission on Accreditation of Air Medical Services (CAAMS) accreditation or an affidavit of substantial CAAMS accreditation compliance to document the provider's fixed wing aircraft as suitable for air ambulance transport. The Medicaid provider enrollment file will then reflect enrollment in the Program as a fixed wing air ambulance provider.

Prior Authorization:

All air ambulance transport provided by fixed wing aircraft must first be prior authorized. For details regarding prior authorization or for out of state services, providers should refer to the Out of State Non-Borderland Transports sub-section of Section 4.

Ambulance transport in a fixed wing aircraft is a covered service if the following requirements are met:

- The transport, including ancillary services (e.g., flight nurse), is ordered by a physician,
- The written physician order is maintained in the beneficiary's file,
- Transport by a ground vehicle would endanger the beneficiary's life due to time and distance from the hospital,
- Necessary care and medical services for the beneficiary's condition cannot be provided by the local facility, and
- Transport is for medical or surgical procedures only and not for diagnostic purposes.

NOTE: Any ground ambulance transportation ordered to and from the airport must be billed by the ambulance company in the normal manner.

HELICOPTER AIR AMBULANCES:

Helicopter air ambulance providers must be licensed by the Michigan Department of Consumer and Industry Services and be properly enrolled with the Michigan Department of Community Health. Providers must indicate on the application for enrollment that they are requesting helicopter air ambulance status. Providers are to submit a copy of their license with their enrollment application. The Medicaid provider enrollment file will then reflect enrollment in the Program as a helicopter air ambulance provider.

Helicopter air ambulance services are covered by the Program **only** under the following circumstances:

- Time and distance in a ground ambulance would be a hazard to the life of the patient,
- The reason for the service is that the necessary care and services for the beneficiary's needs are not available at the local hospital, and
- The transfer is for medical or surgical therapy, not for diagnosis only.

Refer to Ambulance Services in Section 1 for documentation requirements for emergency and medically necessary services.

Coverage of helicopter air ambulance services includes the helicopter base rate, mileage, and waiting time.

Base Rate: Reimbursement for the helicopter air ambulance base rate includes oxygen, equipment and supplies essential for the provision of services and accompanying personnel.

Mileage: Mileage may only be billed for loaded air miles.

Waiting time: Waiting time which exceeds 30 minutes is reimbursable as detailed in the Waiting Time sub-section of this section.

BASE RATE:

The ambulance provider should bill one base rate procedure code [e.g., Basic Life Support Non-Emergency (BLS), Basic Life Support Emergency (BLS), Advanced Life Support 1 Non-Emergency (ALS1), Advanced Life Support 1 Emergency (ALS1), Advanced Life Support 2 (ALS2), Neonatal Emergency Transport, Helicopter Air Ambulance, or Fixed Wing Air Ambulance Transport]. The base rate must reflect the level of service rendered, not the type of vehicle in which the beneficiary was transported, except in those localities where local ordinance requires ALS as the minimum standard of service. Ambulance providers in these localities may bill the ALS rate which most closely fits the services rendered for all emergency transports, regardless of the level of service rendered. For transfers in these localities, the base rate billed must reflect the level of service rendered, not the type of vehicle in which the beneficiary was transferred.

If an ambulance provider has only ALS vehicles, but operates in a locality where both BLS and ALS are available, the base rate billed must reflect the level of service rendered rather than the type of vehicle used.

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

When treatment is rendered and no other care or transport is necessary, the ambulance provider may bill the base rate procedure code for the level of service performed but **not** for mileage. See Special Situations in Section 4 for instructions regarding intercept situations.

ADVANCED LIFE SUPPORT (ALS):

Ambulance operations and ambulance staff must be licensed to render ALS services by the Michigan Department of Consumer and Industry Services (MDCIS) and properly enrolled with the Michigan Department of Community Health (MDCH). MDCH recognizes two levels: ALS1 and ALS2.

ADVANCED LIFE SUPPORT 1 (ALS1) NON-EMERGENCY:

When medically necessary, the ALS1 base rate may be billed when an advanced life support provider (minimum level of EMT-Intermediate or Paramedic) renders an assessment or furnishes one or more ALS interventions or in those localities where ALS has been mandated as the minimum level of service.

ADVANCED LIFE SUPPORT 1 (ALS1) EMERGENCY:

When medically necessary and ALS1 services, as specified above, are provided in the context of an emergency response.

ADVANCED LIFE SUPPORT 2 (ALS2):

When medically necessary, the ALS2 base rate may be billed when an advanced life support provider (minimum level of EMT-Intermediate or Paramedic) renders an assessment and the administration of at least three (3) different medications or furnishes one or more of the following ALS procedures:

- Manual defibrillation/cardioversion
- Endotracheal intubation
- Central venous line
- Cardiac pacing
- Chest decompression
- Surgical airway
- Intraosseous line

Reimbursement for the ALS base rates includes those services listed under Basic Life Support (BLS).

Reimbursement is also the same whether special services were or were not performed.

BASIC LIFE SUPPORT (BLS):

Ambulance operations and ambulance staff must be licensed to render BLS services by the Michigan Department of Consumer and Industry Services and properly enrolled with the Michigan Department of Community Health. Medicaid coverage of the BLS base rate includes transportation and medical services which an Emergency Medical Technician is routinely trained to provide (e.g., the provision of oxygen, and resuscitation). Reimbursement for accompanying personnel, suctioning, delivery/labor, emergency first aid, emergency/night call services, oxygen, and resuscitation is included in the BLS base rate. BLS also includes equipment and supplies essential to the provision of such services (e.g., splints, backboards, obstetrical kits).

BLS NON-EMERGENCY:

When medically necessary, the BLS base rate may be billed when a BLS or ALS provider renders basic life support services as defined above.

BLS EMERGENCY:

When medically necessary, the BLS emergency transport base rate may be billed when a BLS or ALS provider renders basic life support services as defined above.

DRUGS AND SOLUTIONS:

Drugs, intravenous solutions and needles, and hypodermic needles and syringes carried in ambulances require replacement by a cooperating hospital pharmacy and under the supervision of a licensed pharmacist, as detailed in Public Act 368 of 1978, as amended. Reimbursement will be made only to the hospital for these items.

EMERGENCY:

Claims may be made to the Program for emergency transports which meet the criteria specified in the definitions of BLS Emergency, ALS1 Emergency and ALS2 transports in this section.

Claims for emergency ambulance transports 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.

MILEAGE:

Mileage is a benefit of the Program :

- Only when a transport occurs.
- Only when the beneficiary is in the vehicle (Loaded mileage only).
- When billed with the appropriate origin and destination modifier combination.
  - Refer to Chapter IV for list of origin and destination modifiers.
  - Modifier 22 is not an appropriate origin and destination modifier.

When billing for mileage greater than 100 miles, enter the origin and destination addresses in the Remarks.

Note: A charge may be made for the loaded mileage only.

NEONATAL:

Coverage of neonatal transport includes neonatal base rate, loaded mileage, transfer isolette, and waiting time.

The intensive care transport of critically ill neonates (i.e., newborns) to approved, designated neonatal intensive care units (regional centers) is covered, providing the designated carrier is approved by the regional center to which the provider renders service.

A hospital medical team must accompany the newborn on the newborn run for ambulance services to be reimbursed by the Medicaid Program. The hospital team usually consists of a physician, nurse, and respiratory therapist. The primary care of the newborn is the hospital team's responsibility, and reimbursement of these services is made to the hospital. The designated ambulance provider bills **the neonatal base rate and mileage for the transport**.

A return trip of a newborn from a regional center to a community hospital (after the newborn's condition is stabilized) is covered. 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 in Section 1.

The cost of the isolette use is included in the neonatal base rate.

Waiting time which exceeds 30 minutes is reimbursable and must be billed as detailed in the WAITING TIME sub-section of this section.

NON-EMERGENCY:

A claim may be made to the Program for medically necessary non-emergency transport **only** when it is provided in a licensed BLS or ALS vehicle. Ambulance providers must obtain appropriate documentation of the medical necessity of the transport (a copy of the physician's written order or signed certification statement from the attending physician) and retain it in their files. **NOTE:** A copy of the physician's order for non-emergency ambulance transport in the patient's chart is acceptable documentation. A physician may write a single prescription for non-emergency ambulance transport of a beneficiary with a chronic condition to a planned treatment that will cover up to one month of treatment. The prescription must contain information that would indicate the type of transport necessary, why other means of transport could not be used, frequency of needed transport, origin, destination, diagnosis, and medical necessity. For all other non-emergency transport, a separate physician's order is required for each individual transport.

If the ambulance provider is unable to obtain the required written documentation of medical necessity within 21 days following the date of service, the ambulance provider must document a minimum of two (2) attempts to obtain the physician's order/documentation of medical necessity. Acceptable documentation must include a signed return receipt from the U.S. Postal Service, or other similar delivery service, as well as a copy of the request itself. Such a return receipt will serve as proof that the ambulance provider attempted to obtain the required documentation of medical necessity from the attending physician.

Non-emergency transport in a Medi-Van or other wheelchair-equipped vehicle is not a covered service for ambulance providers. However, Medicaid beneficiaries or transportation providers may receive reimbursement for this type of transport directly from their Family Independence Agency (FIA) caseworker or if the beneficiary is an enrollee in a health plan, the health plan may provide or reimburse for this service.

NOTE: MDCH will pay on a fee-for-service basis for health plan enrollees only if the non-emergency transport was medically necessary and was for Community Mental Health Services Program (CMHSP) related services. When submitting claims, providers are to enter in the Remarks section that the ambulance transport was to receive CMHSP services.

UNLISTED AMBULANCE SERVICE:

If a service is rendered which is not included in the coverages defined under the existing procedure codes, the ambulance provider may bill the procedure under the "Unlisted Ambulance Service" procedure code. The claim will pend for manual review to determine whether the service is reimbursable under Program guidelines.

NOTE:
1. Items included in the base rate are not separately reimbursable.
2. If no transport was provided, refer to the base rate billing instructions.
3. The Remarks section, or an attachment to the claim, must include a complete description of the service.

WAITING TIME:

Waiting time is reimbursable after the first 30 minutes when a physician deems it medically necessary for the ambulance provider to wait at a hospital while the patient is being stabilized, with the intent of continuing the **beneficiary's** transport to a more appropriate hospital for care or back to the point of origin.

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. Providers should refer to Chapter IV for instructions regarding requesting Individual Consideration.

The appropriate number of time units must be reflected in the Quantity box. One time unit represents each 30 minutes of waiting time **after the first 30 minutes** (e.g., total waiting time of 1 hour, 30 minutes = 2 time units),

The usual and customary charge must be entered.

The Remarks section, or attachment to the claim, must include the following documentation:

1. Total length of waiting time **including** the first 30 minutes,
2. The physician's name who ordered the wait, and
3. The reason for the wait.

WATER AMBULANCE:

Water ambulance services are a benefit of the program. Non-emergency ambulance services provided by marine craft must be prior authorized. Refer to the Prior Authorization instructions in Chapter I for details on the Prior Authorization process.

Emergency ambulance services provided by marine craft do not require prior authorization.

Claims are to be submitted to:

Michigan Department of Community Health
Miscellaneous Transaction Unit
P.O. Box 30239
Lansing, MI 48909

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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 they provided (if any).

BRIDGE TOLL:

Bridge toll charges are reimbursable to the ambulance provider. Coverage includes both loaded and return trip charges.

Billing Instructions:

- The Unlisted Ambulance Service Code must be used.
- All toll charges must be combined on one claim line.
- The Remarks section must contain the bridge or tunnel name and the number of times used.

CONTINUOUS OR ROUND TRIP TRANSPORT:

This type of transport is considered to be **one** run.

The base rate code for the highest level of service performed during transport is billed on one claim line.

The loaded mileage is billed on one claim line with the total number of whole (loaded) miles indicated in the quantity item.

The Waiting Time sub-section in Section 3 should be referred to in cases where waiting time exceeds 30 minutes.

LTC NURSING FACILITIES:

Routine, non-emergency medical transportation provided for LTC nursing facility residents in a van or other non-emergency vehicle is included in the facility's per diem rate or is billed separately by the facility. This includes transportation for medical appointments, dialysis, therapies or other treatments not available in the facility but located in the county or in the normal service delivery area. When non-emergency transportation by ambulance is ordered by a LTC nursing facility resident's personal physician, due to the need for a stretcher or other emergency equipment, the ambulance provider may bill the Program directly. The ambulance provider must maintain the physician's written order as documentation of medical necessity. If the non-emergency ambulance transport is not ordered by the resident's personal physician, arrangements for payment must be between the facility and the ambulance provider, and cannot be charged to the resident, the resident's family, or used to offset the patient pay amount. This cost may not be claimed as a routine cost on Michigan's Medicaid cost report. The cost of non-emergency ambulance transports not ordered by the resident's physician must be identified and removed on Worksheet 1-B by the LTC nursing facility.

For direct reimbursement by the Medicaid Program to an enrolled ambulance provider for services provided to a LTC nursing facility resident who is a Medicaid beneficiary, refer to the Ambulance Quick Reference Guide (Section 5) of this chapter.

MULTIPLE ARRIVALS:

When multiple units respond to a call for services, only the entity which actually provides services for the beneficiary may bill and be paid. The entity which rendered service/care would bill for all services furnished.

MULTIPLE BENEFICIARIES PER TRANSPORT:

When more than one eligible beneficiary is transported at the same time, the only acceptable duplication of charges is half of the base rate.

Separate claims must be submitted for each beneficiary. The first claim is completed in the usual manner and the base rate billed must reflect the highest level of service performed.

Claims for additional beneficiaries must indicate the usual and customary base rate charge. The appropriate modifier must be reported. Provider should refer to Chapter IV for a list of modifiers. Payment will be made at 50% of Medicaid's reimbursement rate or 50% of the provider's charge, whichever is less.

NOTE: No mileage or waiting time is to be charged for additional beneficiaries. These services are included in the reimbursement of the first claim.

MULTIPLE TRANSPORTS PER BENEFICIARY:

More than one transport per beneficiary on the same date of service is covered when the following conditions apply:

- The beneficiary received a different level of service on each transport (e.g., Advanced Life Support 1 and Basic Life Support), enter the appropriate code for each base rate on the claim.
- The beneficiary received the same level of service on each transport, enter the appropriate code for each base rate on one claim line with the appropriate combined base rate charge. A quantity of one (1) must be reported and individual consideration (Modifier 22) requested.
- Other services duplicated from the multiple transports must be combined and billed on one claim line (e.g., the total loaded mileage is combined and billed on one claim line).
- Other services not duplicated are billed on separate claim lines.
- The Remarks section of the claim, or an attachment to the claim, must detail the following information:
  - Number of transports
  - Originating and terminating locations
  - Ambulance requestor's name(s)
  - Reason for multiple transports on the same day, and
  - Number of times each base rate was provided.
  - If transport is for any reason other than further treatment, the reason for the transport must be provided in addition to the diagnosis

NOTE: Return trips are multiple transports **if** a break in service has occurred, i.e., the ambulance is available to respond to other requests for service.

OUT OF STATE NON-BORDERLAND TRANSPORTS:

Except for emergencies, out of state, non-borderland transports require prior authorization. Refer to the Prior Authorization instructions in Chapter I for details on the Prior Authorization process.

The ambulance provider, home health agency, hospital, LTC nursing facility, physician, or social worker may request this authorization. The ambulance provider must retain documentation of medical necessity (physician's order) in the beneficiary's file to support the need for ambulance transportation. To request authorization, the requestor must submit a letter to the Michigan Department of Community Health. The requestor is responsible for requesting prior authorization before services are rendered.

NOTE: The request must include:

- Point of pickup,
- Beneficiary's name and ID number,
- Diagnosis,
- Service to be provided,
- Destination point,
- Reason why the ambulance transport was medically necessary,
- Reason why the beneficiary cannot be transported by any other means,
- Name and address of the ambulance provider, and
- Requestor's name.

The authorization may be obtained by writing to:

Michigan Department of Community Health
Medical Services Administration
Review and Evaluation Division
P.O. Box 30170
Lansing, Michigan 48909

Or by calling 1-800-622-0276

Based on the authorization request, the Department will approve or disapprove the request. The ambulance provider may render the service upon receipt of verbal approval. A copy of the approval authorization letter will be mailed to the ambulance provider following the verbal authorization. The ambulance provider may not bill the Program until he/she has received the authorization letter. The ambulance provider must keep a copy of the authorization letter in the beneficiary's file. Documentation of medical necessity (physician's order) must also be retained in the beneficiary's file to support the need for ambulance transportation.

NOTE: The requestor must notify the Review and Evaluation Division of any changes to the approved PA (e.g., change in service date or ambulance provider, etc).

When seeking reimbursement for out of state transports, the prior authorization number must be entered on the claim, except in the case of emergency transports.

Claims are to be submitted to:

Michigan Department of Community Health
Miscellaneous Transaction Unit
P.O. Box 30239
Lansing, MI 48909

PRONOUNCEMENT OF DEATH:

There are three (3) rules that apply to ambulance services and the pronouncement of death:

1. If the beneficiary was pronounced dead by an individual who is licensed to pronounce death (coroner/physician) prior to the time that the ambulance is called, no payment will be made.

2. If the beneficiary is pronounced dead after the ambulance is called but before the ambulance arrives at the scene, payment for an ambulance trip will be made at the BLS rate, but no mileage will be paid.

3. If the beneficiary is pronounced dead after being loaded into the ambulance, payment will be made following the usual rules (that is, the same level of payment would be made as if the beneficiary had not died).