

Health and Recovery Services Administration (HRSA)



Ambulance and Involuntary Treatment Act (ITA) Transportation

Billing Instructions

[Chapter 388-546 WAC]

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About this publication

These billing instructions are designed to help ambulance providers and their staff understand Health and Recovery Services Administration (HRSA) regulations and requirements necessary for reporting accurate and complete claim information.

This publication reflects revisions to chapter 388-546 WAC adopted in August 2004. This publication supersedes and/or incorporates all previous Ambulance Billing Instructions and related numbered memoranda, and Involuntary Treatment Act Transportation Billing Instructions and related numbered memoranda. The list of superseded and/or incorporated memoranda includes:

02-95 MAA, 03-50 MAA, 03-53 MAA, 03-82 MAA, and 04-54 MAA.

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Important Contacts

A provider may use HRSA's toll-free lines for questions regarding its programs; however, HRSA's response is based solely on the information provided to the [HRSA] representative at the time of the call or inquiry, and in no way exempts a provider from following the rules and regulations that govern HRSA's programs. [WAC 388-502-0020(2)].

Where do I call for information on becoming a DSHS provider, submitting a change of address or ownership, or to ask questions about the status of a provider application?

Call Provider Enrollment toll-free at:
866.545.0544

Where do I send my claims?

Internet Billing (Electronic Claims Submission):

WinASAP
<http://www.acs-gcro.com/>
Select *Medicaid*, then *Washington State*

All other HIPAA transactions
<https://wamedweb.acs-inc.com/>

To use HIPAA Transactions and/or WinASAP 2003, enroll with ACS EDI Gateway at 800.833.2051.

Hard Copy Claims:
Division of Program Support
PO Box 9248
Olympia WA 98507-9248

How do I obtain copies of billing instructions or numbered memoranda?

To view and download, visit HRSA on the web at:

<http://hrsa.dshs.wa.gov/>
Select *Billing Instructions/Numbered Memoranda*

How do I obtain DSHS forms?

To download DSHS forms, visit:

<http://www1.dshs.wa.gov/msa/forms/eforms.html>

How do I obtain a limitation extension?

Fax a request to HRSA – Division of Medical Management: 360.586.1471

How do I obtain an Exception to Rule?

Fax a request to HRSA – Division of Medical Management: 360.586.1471

Or fax the Ambulance Transportation Program Manager: 360.753.9152

**Where can I look/call if I have questions
regarding...**

**Policy, payments, denials, or general
questions regarding claims processing
or HRSA Managed Care?**

Provider Relations Unit
800.562.6188
<http://maa.dshs.wa.gov/provrel>

**Private insurance or third-party
liability, other than HRSA Managed
Care?**

Coordination of Benefits Section
800.562.6136

Electronic Billing?

Electronic Media Claims Help Desk
360.725.1267

**Client Access Issues, Brokered
Transportation, Client Complaints,
Healthy Options Enrollment,
Disenrollment, Exemptions?**

Medical Assistance Customer Service
Center (MACSC) (Clients Only)
800.562.3022

**Provider Information on Nonemergency
Brokered Transportation?**

<http://maa.dshs.wa.gov/Transportation/index.html>

**Eligibility for Children's Medical,
Healthy Options and Basic Health
Plus?**

Medical Eligibility Determination
Services (MEDS)
800.204.6429

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**Ambulance and
ITA Transportation**

Definitions & Abbreviations

This section defines terms and abbreviations (includes acronyms) used in these billing instructions.

Note: Please see page xii of this section for definitions specific to Involuntary Treatment Act (ITA) Transportation and the DSHS Mental Health Division.

Accept Assignment – A process in which a provider agrees to accept Medicare’s payment as payment in full, except for specific deductible and coinsurance amounts required of the patient.

Advanced Life Support (ALS) - The level of care that calls for invasive emergency medical services requiring advanced medical treatment skills. [WAC 388-546-0001]

Advanced Life Support Assessment – An assessment performed by an ALS crew as part of an emergency response that was necessary because the client’s reported condition at the time of dispatch was such that only an ALS crew was qualified to perform the assessment. An ALS assessment does not necessarily result in a determination that the client requires an ALS level of service. [WAC 388-546-0001]

Advanced Life Support Intervention – A procedure that is beyond the scope of care of an emergency medical technician (EMT). [WAC 388-546-0001]

Aid Vehicle – A vehicle used to carry aid equipment and individuals trained in first aid or medical procedures. [WAC 388-546-0001]

Air Ambulance – A helicopter or airplane designed and used to provide transportation for the ill and injured, and to provide personnel, facilities, and equipment to treat clients before and during transportation. Air ambulance is considered an ALS service. [WAC 388-546-0001]

Ambulance - A ground or air vehicle designed and used to provide transportation for the ill and injured; and to provide personnel, facilities, and equipment to treat clients before and during transportation; and licensed per RCW 18.73.140. [WAC 388-546-0001]

Approved Medical Program Director - A person who is:

- Licensed to practice medicine and surgery pursuant to chapter 18.71 RCW or osteopathic medicine and surgery pursuant to chapter 18.57 RCW;
- Qualified and knowledgeable in the administration and management of emergency care and services; and
- So certified by the department of health for a county, group of counties, or cities with populations over four hundred thousand in coordination with the recommendations of the local medical community and local emergency medical services and trauma care council. [Refer to RCW 18.71.205(4)]

cities). [Refer to WAC 388-546-0001]

Authorization – HRSA official approval for action taken for, or on behalf of, an eligible Medical Assistance client. This approval is only valid if the client is eligible on the date of service.

Authorization number – A nine-digit number assigned by HRSA that identifies individual requests for services or equipment. The same authorization number is used throughout the history of the request, whether it is approved, pending, or denied.

Base Rate - HRSA's minimum payment amount per covered trip, which includes allowances for emergency medical personnel and their services, the costs of standing orders, reusable supplies and equipment, hardware, stretchers, oxygen and oxygen administration, intravenous supplies and IV administration, disposable supplies, normal waiting time, and the normal overhead costs of doing business. The base rate excludes mileage. [Refer to WAC 388-546-0001]

Note: For air ambulances, the base rate is the lift-off fee.

Basic Life Support (BLS) - The level of care that justifies ambulance transportation but requires only basic medical treatment skills. It does not include the need for or delivery of invasive medical procedures/services. [WAC 388-546-0001]

Bed-confined – The client is unable to perform all of the following actions:

- Get up from bed without assistance;
- Ambulate; and
- Sit in a chair or wheelchair.

[WAC 388-546-0001]

Bordering City Hospital – A licensed hospital in a designated bordering city (see WAC 388-501-0175 for a list of bordering

By Report (BR) – A method of payment in which HRSA determines the amount it will pay for a service that is covered but does not have an established maximum allowable fee. Providers must submit a report describing the nature, extent, time, effort, and/or equipment necessary to deliver the service. [WAC 388-546-0001]

Chart – A summary of medical records on the individual patient.

Client - An applicant for, or recipient of, DSHS medical care programs.

Code of Federal Regulations (CFR) - Rules adopted by the federal government.

Community Services Office (CSO) - An office of the department that administers social and health services at the community level. [WAC 388-500-0005]

Core Provider Agreement - The basic contract between HRSA and providers serving HRSA clients. The provider agreement outlines and defines terms of participation in Medical Assistance.

Department - The state Department of Social and Health Services (DSHS). [WAC 388-500-0005]

Destination – see “point of destination”.

Emergency Medical Condition– A medical condition that manifests itself by acute symptoms of sufficient severity so that the absence of immediate medical attention could reasonably be expected to result in:

- Placing the patient’s health in serious jeopardy;
- Serious impairment to bodily functions; or
- Serious dysfunction of any bodily organ or part. [WAC 388-531-0050]

Emergency Medical Service - Medical treatment and care which may be rendered at the scene of any medical emergency or while transporting any client in an ambulance to an appropriate medical facility, including ambulance transportation between medical facilities. [WAC 388-546-0001]

Emergency Medical Transportation – Ambulance transportation during which a client receives needed emergency medical services en route to an appropriate medical facility. [WAC 388-546-0001]

Explanation of Benefits (EOB) - A coded message on the Medical Assistance Remittance and Status Report that gives detailed information about a claim associated with that report.

Ground Ambulance - A ground vehicle, including a water ambulance, designed and used to transport the ill and injured and to provide personnel, facilities, and equipment to treat clients before and during transportation. [WAC 388-546-0001]

Health and Recovery Services Administration (HRSA) - The administration within DSHS authorized by the secretary to administer the acute care portion of Title XIX Medicaid, Title XXI State Children's Health Insurance Program (SCHIP), Title XVI Supplemental Security Income for the Aged, Blind, and Disabled (SSI), and the state-funded medical care programs, with the exception of certain nonmedical services for persons with chronic disabilities.

Hospital – An institution licensed as a hospital by the Department of Health. [WAC 388-500-0005]

Interfacility Transport – Medical transportation of a client between recognized medical treatment facilities, requested by a licensed health care provider.

Involuntary Treatment Act (ITA) – See chapter 71.05 RCW and chapter 388-865 WAC for adults. See chapter 71.34 RCW and chapter 388-865 WAC for minors.

Invasive Procedure – A medical intervention that intrudes on the client's person or breaks the skin barrier. [WAC 388-546-0001]

Lift-off fee - Either of the two base rates HRSA pays to air ambulance providers for transporting a client. HRSA establishes separate lift-off fees for helicopters and airplanes. [WAC 388-546-0001]

Loaded Mileage – The number of miles the client is transported in the ambulance vehicle. [WAC 388-546-0001]

Managed Care – A comprehensive system of medical and health care delivery including preventive, primary, specialty, and ancillary health services. These services are provided either through a managed care organization (MCO) or primary care case management (PCCM) provider [WAC 388-538-050]

Maximum Allowable Fee - The maximum dollar amount that HRSA will reimburse a provider for specific services, supplies, or equipment.

Medicaid - The state and federally funded aid program that covers the Categorically Needy (CNP) and Medically Needy (MNP) programs.

Medical Control – The medical authority upon whom an ambulance provider relies to coordinate prehospital emergency services, triage, and trauma center assignment/destination for the patient being transported. The medical control is designated in the trauma care plan by the approved medical program director of the region in which the service is provided. [WAC 388-531-0050]

Medical Identification (ID) card – The document that identifies a client's eligibility for a medical program. This card was formerly known as the medical assistance identification (MAID) card or medical coupon.

Medically Necessary - A term for describing requested service which is reasonably calculated to prevent, diagnose, correct, cure, alleviate or prevent worsening of conditions in the client that endanger life, or cause suffering or pain, or result in an illness or infirmity, or threaten to cause or aggravate a handicap, or cause physical deformity or malfunction. There is no other equally effective, more conservative or substantially less costly course of treatment available or suitable for the client requesting the service. For the purpose of this section, "course of treatment" may include mere observation or, where appropriate, no treatment at all. [WAC 388-500-0005]

Medicare - The federal government health insurance program for certain aged or disabled clients under Titles II and XVIII of the Social Security Act. Medicare has two parts:

"Part A" covers the Medicare inpatient hospital, post-hospital skilled nursing facility care, home health services, and hospice care.

"Part B" is the supplementary medical insurance benefit (SMIB) covering the Medicare doctor's services, outpatient

Ambulance and ITA Transportation

hospital care, outpatient physical therapy and speech pathology services, home health care, and other health services and supplies not covered under Part A of Medicare. [WAC 388-500-0005]

Nonemergency Ambulance Transportation –

The use of a ground ambulance to transport a client who may be confined to a stretcher but typically does not require the provision of emergency medical services en route, or the use of an air ambulance when prior authorized by HRSA. Nonemergency ambulance transportation is usually scheduled or prearranged. See also “Prone or Supine Transportation” and “Scheduled Transportation”. [WAC 388-546-0001]

Paramedic - A person who:

- Has successfully completed an emergency medical technician course as described in chapter 18.73 RCW;
- Is trained under the supervision of an approved medical program director to:
 - ✓ Carry out all phases of advanced cardiac life support;
 - ✓ Administer drugs under written or oral authorization of an approved licensed physician;
 - ✓ Administer intravenous solutions under written or oral authorization of an approved licensed physician; and
 - ✓ Perform endotracheal airway management and other authorized aids to ventilation; and
- Has been examined and certified as a physician’s trained mobile intensive care paramedic by the University of Washington, School of Medicine or the Department of Health.

Patient Identification Code (PIC) - An alphanumeric code assigned to each HRSA client that consists of the client’s:

- a) First and middle initials (or a dash (-) must be entered if the middle initial is not indicated).
- b) Six-digit birthdate, consisting of numerals only (MMDDYY).
- c) First five letters of the last name (and spaces if the name is fewer than five letters).
- d) Alpha or numeric character (tiebreaker).

Physician - A doctor of medicine, osteopathy, or podiatry who is legally authorized to perform the functions of the profession by the state in which the services are performed. [WAC 388-500-0005]

Physician Certification Statement (PCS) –

A statement or form signed by a client’s attending physician, Advanced Registered Nurse Practitioner, hospital discharge planner, or other authorized personnel certifying that the client’s use of nonemergency ground ambulance services is medically necessary. This statement must specify the frequency and/or duration of the client’s need for nonemergency ambulance services. The maximum length of time a PCS is valid is three months.

Point of Destination – A facility generally equipped to provide the needed medical or nursing care for the injury, illness, symptoms, or complaint involved. [WAC 388-546-0001]

Point of Pick-up – The location of the client at the time he or she is placed on board the ambulance or transport vehicle. [WAC 388-546-0001]

Prone or Supine Transportation –

Transporting a client confined to a stretcher or gurney, with or without emergency medical services provided en route.

[WAC 388-546-0001]

Provider or Provider of Service - An institution, agency, or person:

- Who has a signed agreement with the department to furnish medical care, goods, and/or services to clients; and
- Is eligible to receive payment from the department. [WAC 388-500-0005]

Psychiatric Indigent Inpatient (PII)

Program – A state-funded, limited casualty (LCP) program specifically for mental health clients identified in need of inpatient psychiatric care by the Regional Support Network (RSN). (See page xii for a definition of Regional Support Network.) [WAC 388-865-0217(1)]

Record – Dated reports supporting claims submitted to the Health and Recovery Services Administration (HRSA) for medical services provided in a physician's office, inpatient hospital, outpatient hospital, emergency room, nursing facility, client's home, or other place of service. Records of services must be in chronological order by the practitioner who provided the service.

Remittance and Status Report (RA) - A report produced by HRSA's claims processing system (known as the Medicaid Management Information System or MMIS) that provides detailed information concerning submitted claims and other financial transactions.

Revised Code of Washington (RCW) - Washington State laws.

Scheduled Transportation – Prearranged transportation for an eligible client, typically in a vehicle other than an ambulance, with no emergency medical services being required or provided en route to or from a covered medical service. The transportation is usually arranged and/or provided by HRSA-contracted transportation brokers. [WAC 388-546-0001]

Specialty Care Transport (SCT) –

Interfacility transportation of a critically injured or ill client by a ground ambulance vehicle, including medically necessary supplies and services, at a level of service beyond the scope of the paramedic. [WAC 388-546-0001]

Standing Order – An order remaining in effect indefinitely until canceled or modified by an approved medical program director (regional trauma system) or the ambulance provider's medical control.

Third Party - Any entity that is or may be liable to pay all or part of the medical cost of care of a medical program client. [WAC 388-500-0005]

Title XIX - The portion of the federal Social Security Act that authorizes grants to states for medical assistance programs. Title XIX is also called Medicaid. [WAC 388-500-0005]

Transportation Broker – A person or organization contracted by HRSA to arrange, coordinate and manage the provision of necessary but nonemergency transportation services for eligible clients to and from covered medical services. [WAC 388-546-0005]

Trauma – A major single- or multi-system injury requiring immediate medical or surgical intervention or treatment to prevent death or permanent disability.

Trip – Transportation one-way from the point of pick-up to the point of destination by an authorized transportation provider.
[WAC 388-546-0001]

Usual and Customary Fee - The maximum rate that may be billed to the Department for a certain service or equipment. This rate may not exceed:

- The usual and customary charge to the general public for the same service(s); or
- If the general public is not served, the rate normally offered to other contractors for the same service(s).

Waiting time - Time spent waiting for the client or some necessary thing or event (e.g., ferry and ferry crossing) to occur in order to complete the ambulance transport.

Washington Administrative Code (WAC) - Codified rules of the state of Washington.

Definitions Related to Involuntary Treatment Act (ITA) Transportation

Note: These definitions are related to Involuntary Treatment Act (ITA) Transportation and the DSHS Mental Health Division.

Commitment – A determination by a court that a person should be detained for a period of either evaluation or treatment, or both, in an inpatient or less restrictive setting.

Consumer – A person who has applied for, is eligible for, or who has received mental health services. For a child under the age of thirteen, or for a child age thirteen or older whose parents or legal guardians are involved in the treatment plan, the definition of consumer includes parents or legal guardians. [WAC 388-865-0150]

County-Designated Mental Health Professional (CDMHP) – A mental health professional designated by one or more counties to perform the functions of a CDMHP described in the Involuntary Treatment Act (ITA), chapters 71.05 RCW (adults) and 71.34 RCW (minors). A CDMHP, following ITA guidelines, detains an individual and assesses that individual's level of need for transportation according to established statewide procedures. Following the assessment, the CDMHP has the individual transported by local police, sheriff, or ambulance.

Detention – The lawful confinement of a person under the provisions of chapter 71.05 RCW or chapter 71.34 RCW.

Evaluation and Treatment Facility – A public or private facility or unit that is certified by the department to provide emergency, inpatient, residential, or outpatient mental health evaluation and treatment services to persons suffering from a mental disorder.

Gravely Disabled – A condition in which a person, as a result of a mental disorder:

- Is in danger of serious physical harm resulting from a failure to provide for his or her essential human needs of health or safety; or
 - Manifests severe deterioration in routine functioning evidenced by repeated and escalating loss of cognitive or volitional control over his or her actions and is not receiving such care as is essential for his or her health or safety.
- [RCW 71.05.020(14)]

Mental Health Division (MHD) – The Department of Social and Health Services (DSHS) has designated the Mental Health Division as the state mental health authority to administer the state and Medicaid funded mental health program authorized by chapters 71.05, 71.24, and 71.34 RCW. [Refer to WAC 388-865-0150]

Outpatient Mental Health Services - An array of mental health services provided to mental health consumers who meet medical necessity criteria. Outpatient mental health services are provided in the consumer's community through the Regional Support Network.

Regional Support Network (RSN) - A single or multiple county authority operating as prepaid health plans through which the Mental Health Division contracts community services (outpatient and acute care inpatient) for the public mental health system. Visit the Mental Health Division website for a list of RSNs at:

[http://www1.dshs.wa.gov/mentalhealth/rsnm
ap.shtml](http://www1.dshs.wa.gov/mentalhealth/rsnm
ap.shtml)

About the Program

HRSA's Ambulance Transportation Program

[Refer to WAC 388-546-0100]

The ambulance transportation program is a medical transportation service. It is part of an overall plan to provide medically necessary emergency transportation to and from the provider of HRSA covered services that is closest and most appropriate to meet the client's medical need.

HRSA covers the following types of ambulance transportation:

- Air Ambulance – emergency medical transportation by air;
- Ground Ambulance – transportation by ground or water ambulance that is either:
 - ✓ Emergency medical transportation; or
 - ✓ Transportation to HRSA-covered medical services requiring that the client:
 - Be transported by stretcher or gurney for medical or safety reasons¹; or
 - Have medical attention from trained medical personnel available en route.

Medical Necessity for Ambulance Transportation

[Refer to WAC 388-546-0200]

Transportation that is provided by ambulance providers and billed to HRSA must be medically necessary. The medical necessity for this type of transportation must be documented in the client's file.

HRSA covers a client's transportation in an ambulance only if the client cannot be safely or legally transported any other way. If a client can safely travel by car, van, taxi, or other means, the ambulance transport is not medically necessary and the ambulance level of service is not covered by HRSA¹.

¹ RCW 18.73.180 requires HRSA to provide transportation by ground ambulance vehicle whenever the client's medical condition requires that the client be transported in the prone or supine position. The law does not prescribe how HRSA should reimburse providers for nonemergency ambulance transportation services.

Standards for Emergency Transportation

In Washington State, the following are determined by certified Emergency Medical Services (EMS) and trauma personnel, in conjunction with their regional “medical control”:

- The type of emergency transportation;
- The mode of emergency transportation;
- The urgency of transport; and
- The destination decision.

These decisions are based on professional judgment in consultation with emergency room physicians, as well as industry standards. These standards are outlined in the following documents:

- *State of Washington Pre-hospital Trauma Triage Procedures* brochure (available from the Department of Health web site: <http://www.doh.wa.gov/hsqa/emstrauma/download/ttt.pdf>);
- Triage plans developed and implemented by the regional EMS and trauma care councils; and
- Client care procedures and protocols developed by the regional councils.

Scheduled or “Brokered” Nonemergency Medical Transportation

Most of the transportation HRSA provides for its clients is nonemergency medical transportation. With few exceptions, nonemergency medical transportation is provided through contracted local transportation brokers who subcontract with providers utilizing vehicles other than ambulances.

HRSA’s contract transportation brokers are listed on HRSA’s website at <http://maa.dshs.wa.gov/Transportation/index.html> and in HRSA’s *General Information Booklet* (found on HRSA’s web site at: <http://maa.dshs.wa.gov/> Select the *Billing Instructions/Numbered Memoranda* link).

Client Eligibility

Who is eligible for HRSA-paid ambulance services?

[Refer to WAC 388-546-0150]

Clients presenting Medical Identification (ID) cards with the following medical program identifiers are eligible for Ambulance Transportation services with few limitations:

| Medical Program Identifier | Medical Program Description |
|----------------------------|--|
| CNP * | Categorically Needy Program |
| LCP - MNP | Limited Casualty Program - Medically Needy Program |

Note: *A Medical ID card with a “CNP” identifier does not automatically mean the client is eligible for a particular ambulance service. See chart, below.

Washington and Bordering Cities Only

[WAC 388-546-0150(1)]

Clients presenting Medical ID cards with the following identifiers are eligible **for ambulance services within Washington State or designated bordering cities only**:

| Medical Program Identifier | Medical Program Description |
|---|---|
| CNP GA-X | General Assistance-Expedited Medical |
| CNP – Emergency Medical Only | Categorically Needy Program – Emergency Medical Only (including Alien Emergency Medical) |
| CNP SCHIP | State Children’s Health Insurance Program when the client is not enrolled in a managed care plan. |
| GA-U No Out of State Care | General Assistance-Unemployable |
| Detox Only | Detox |
| General Assistance – No Out of State Care | ADATSA |
| LCP-MNP – Emergency Medical Only | Limited Casualty Program – Medically Needy Program – Emergency Medical Only (including Alien Emergency Medical) |

Who is not eligible for HRSA-paid ambulance services?

Clients presenting Medical ID cards with the following identifiers are **not** eligible for HRSA-paid Ambulance Transportation services:

| Medical Program Identifier | Medical Program Description |
|---|--|
| Family Planning Only | Family Planning |
| QMB-Medicare Only | Qualified Medicare Beneficiary-Medicare Only (HRSA pays only the Medicare premiums and coinsurance costs for these clients.) |
| MIP Emergency Hospital Only No Out of State Care | PII - Psychiatric Indigent Inpatient (Mental Health Division program) |

Jail inmates and persons living in a correctional facility are not eligible for HRSA ambulance coverage [Refer to WAC 388-546-0150 (6)].

Note: Although clients in the programs listed above are not eligible for ambulance services under normal circumstances, HRSA reimburses providers who transport these clients in-state under the Involuntary Treatment Act (ITA). ITA clients are not eligible for any out-of-state transportation services or ambulance services to or from bordering cities. (See Section I – *Involuntary Treatment Act (ITA) Transportation* for more information on ITA.)

Are clients enrolled in an HRSA managed care plan eligible to receive ambulance transportation services?

Yes! Clients whose Medical ID cards have an HMO identifier in the HMO column are enrolled in an HRSA managed care plan. Ambulance transportation services are covered under HRSA's managed care plans, subject to each plan's coverage and limitations. Services include, but are not limited to:

- Basic Life Support;
- Advanced Life Support; and
- Other required transportation costs, such as tolls and fares.

In addition, HRSA's managed care plans cover nonemergency ambulance services for clients if the client must be carried on a stretcher or may require medical attention en route [refer to RCW 18.73.180].

Please contact the client's managed care plan to become familiar with their prior authorization and billing procedures. See <http://maa.dshs.wa.gov/healthyoptions> for a listing of HRSA's managed care plans by county.

Clients covered by a Primary Care Case Manager (PCCM) are eligible for ambulance services that are emergency medical services, or are approved by their PCCM in accordance with HRSA requirements. The PCCM's name and phone number is located in the bottom right-hand corner of the client's Medical ID card.

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Provider Responsibilities

General Requirements for Ambulance Providers

[Refer to WAC 388-546-0300]

Licensing

- Ambulances must be licensed, operated, and equipped according to applicable federal, state, and local statutes, ordinances, and regulations; and
- All required licenses must be current and kept up to date.

Note: HRSA requires any out-of-state ground ambulance provider who is transporting HRSA clients within the state of Washington to comply with RCW 18.73.180 regarding stretcher transportation. [Refer to WAC 388-546-0800 (4)]

Staffing/Training

- Ambulances must be staffed and operated by appropriately trained and certified personnel. Personnel who provide any invasive procedure/emergency medical services for a client during an ambulance trip must be properly trained and authorized; and
- Ambulance providers must be in good standing to participate in HRSA's Ambulance Transportation Program. Ambulance providers cannot be on Medicare's or any state Medicaid agency's sanctioned (disapproved) list.

Record Keeping

- HRSA requires providers of ambulance services to document medical justification for transportation and related services billed to HRSA. Documentation in the provider's client record must include adequate descriptions of the severity and complexity of the client's condition (including the circumstances that made the conditions acute and emergent) at the time of transportation. HRSA may review the client record to ensure HRSA's criteria were met.
- HRSA requires providers to document why an ambulance was the only appropriate and effective means of transportation that did not endanger the client's health. Please ensure that proper documentation is included in the client's file.

- Providers must make charts and records available to DSHS, its authorized contractors, and the US Department of Health and Human Services, upon their request. Providers must keep charts and records **for at least six years from the date of service** or more if required by federal or state law or regulation.

What records must be kept?

[Refer to WAC 388-502-0020, WAC 388-546-0300, and WAC 388-546-0700 (3)]

The transportation provider must keep sufficient documentation to justify decisions about destination and type of transport for each client. The documentation must be legible, accurate, and complete. It must include, but is not limited to, the following information:

- Date(s) and time of service;
- Transported client's name and date of birth;
- Name(s) and title of person(s) performing service(s);
- Medical justification for each transport (e.g., suspected heart attack);
- Pertinent medical history;
- Pertinent findings on examination (e.g., will require medical attention en route);
- All medications and/or equipment/supplies provided;
- Description of treatment/medical intervention(s) (when applicable);
- Specific location of pick-up and destination and any additional or non-scheduled destinations (e.g., intermediate stop at physician's office to stabilize client). Origin information must include the facility's full name and address, including state. Destination information must include the facility's full name and address, including state;
- Beginning and ending mileage readings (ground ambulance) for the trip. Use statute miles for air ambulance; and
- If air transportation is necessary to bypass the Washington State ferry system, this must be clearly documented, including the reasons why the ferry was inadequate in any particular case.

Any documentation or chart must be authenticated by the person who gave the order, provided the care, or performed the observation, examination, assessment, treatment or other service to which the entry pertains.

Ambulance and ITA Transportation

Documentation must show that clients are being triaged in a manner that ensures prompt access to appropriate care (i.e., to a facility best able to provide the level of care appropriate to a client's injuries and/or medical needs). The ambulance provider's Medical Control must consider the following in directing the client's transport to a treatment facility:

- The availability of special regional resources such as:
 - ✓ Trauma centers;
 - ✓ Burn centers; and
 - ✓ Toxicology treatment centers;
- The presence of regional health care networks;
- The existence of physician to physician relationships; and
- The availability of care at the destination hospital.

Quality of Care Audits and Reviews

- HRSA expects providers to provide high quality care. HRSA conducts reviews and/or audits to monitor and enforce quality standards.
- HRSA conducts prepayment and/or postpayment reviews of providers. Based on national and local medical policies, HRSA selects providers demonstrating aberrant billing patterns for these reviews. HRSA conducts these postpayment reviews using the national and local policies effective when claims were processed. Based on these policies, HRSA requests refunds for any services that were not medically necessary.
- HRSA may conduct an on-site review of any ambulance facility. See WAC 388-501-0130, Administrative Controls, for additional information on audits conducted by HRSA staff.

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Coverage

The HRSA ambulance program is a medical transportation service.

What ambulance transportation services are covered?

HRSA covers the following ambulance transportation:

- Ground ambulance when the eligible client:
 - ✓ Has a medical need for the transportation;
 - ✓ Needs medical attention to be available during the trip; or
 - ✓ Must be transported by stretcher or gurney (See RCW 18.73.180).
- Air ambulance when justified under the conditions specified by HRSA in these billing instructions (in accordance with chapter 388-546 WAC) or when HRSA determines that air ambulance service is less costly than ground ambulance service in a particular case. In the latter case, HRSA must prior authorize the air ambulance transportation.

When are ambulance transportation services covered?

[Refer to WAC 388-546-0200]

HRSA pays for ambulance transportation to and from covered medical services when the transportation is:

- Within the scope of an eligible client's medical care program;
- Medically necessary based on the client's condition at the time of the ambulance trip and as documented in the client's record;
- Appropriate to the client's actual medical need; and
- To one of the following destinations:
 - ✓ The nearest appropriate HRSA-contracted medical provider of HRSA-covered services; or
 - ✓ The designated trauma facility as identified in the emergency medical services and trauma regional patient care procedures manual.

What happens if there is third-party coverage for the ambulance transportation services?

Providers must bill a client's primary health insurance before billing HRSA.

If Medicare or another third party is the client's primary health insurer and that primary insurer denies coverage of an ambulance trip due to a lack of medical necessity, HRSA requires the provider when billing HRSA for that trip to:

- Report the third party determination on the claim; and
- Submit documentation showing that the trip meets the medical necessity criteria of HRSA.

HRSA will determine whether the ambulance trip was medically necessary based on the documentation provided.

If the third party insurer pays for the ambulance transportation, HRSA pays for coinsurance and deductibles only, up to HRSA's maximum allowable amount.

Ambulance Coverage During Inpatient Hospital Stays

[Refer to WAC 388-546-0425]

In certain situations, such as during inpatient stays, ambulance transport is included in the bundled payment to the hospital or other facility. In such cases, the ambulance provider may not bill HRSA or HRSA's client for the transport. The hospital is responsible for the reimbursement of the ambulance transport.

1. Transports to and from Other Diagnostic or Treatment Facilities

HRSA does not cover ambulance transportation services under fee-for-service when a client remains as an inpatient client in a hospital and the transportation to and/or from another facility is for diagnostic or treatment services (e.g., MRI scanning, kidney dialysis). Transportation of an inpatient client for such services is the responsibility of the hospital, whether HRSA pays the hospital under the diagnosis-related group (DRG) or ratio of costs-to-charges (RCC) method.

2. Hospital-to-Hospital Transfers

HRSA does not cover hospital-to-hospital transfers of clients under fee-for-service when ambulance transportation is requested solely to:

- ✓ Accommodate a physician's or other health care provider's preference for facilities;
- ✓ Move the client closer to family or home (i.e., for personal convenience); or
- ✓ Meet insurance requirements or hospital/insurance agreements.

a. Transfer to a Higher Level of Care

HRSA covers ambulance transportation through fee-for-service for a client being transferred from one hospital to another when the transferring or discharging hospital has inadequate facilities to provide the necessary medical services required by the client. HRSA covers air ambulance transportation for hospital transfers **only** if the use of slower transportation such as ground ambulance would endanger the client's life or health.

The reason for transferring a client from one hospital to another, as well as the need for air ambulance transport, if applicable, must be clearly documented in the client's hospital chart and in the ambulance trip report.

b. Transfer to a Lower Level of Care

HRSA does not cover ambulance transportation through fee-for-service for a client being transferred from a hospital providing a higher level of care to a hospital providing a lower level of care, except as allowed below.

HRSA considers requests for fee-for-service ambulance transportation of a client from an intervening hospital to the discharging hospital under the provisions of WAC 388-501-0160, Exception to Rule. HRSA evaluates such transfer requests based on clinical considerations and cost-effectiveness. HRSA approves transfer requests that are in the state's best interests. In this type of transfer (from a higher level to a lower level of care), fee-for-service payment is made only when the transport is prior authorized by HRSA.

The reason for transferring a client from a hospital to another medical facility must be clearly documented in the client's hospital chart and in the ambulance trip record. See Section E for further information on requesting Exception to Rule.

Nonemergency Ambulance Coverage

[Refer to WAC 388-546-0800, 388-546-1000, and 388-546-1500]

Nonemergency Ground Ambulance

- HRSA covers nonemergency ground ambulance transportation under the following conditions:
 - ✓ The client is bed-confined and must be transported by stretcher or gurney (in the prone or supine position) for medical or safety reasons. Justification for stretcher or gurney must be documented in the client's record; or
 - ✓ The client's medical condition requires that he or she have basic ambulance level medical attention available during transportation, regardless of bed confinement.
- HRSA requires ambulance providers to thoroughly document the circumstances requiring nonemergency ground ambulance transportation using the Physician Certification Statement - PCS. (See Section E – *Authorization Requirements*).

Nonemergency Air Ambulance

- HRSA covers nonemergency air ambulance transportation only when the transport is prior authorized by HRSA and all of the following conditions are met:
 - ✓ The client is eligible for ambulance transportation coverage;
 - ✓ The client's destination is an acute care hospital or approved rehabilitation facility; and
 - ✓ The client's physical or medical condition is such that travel by any other means endangers the client's health; or
 - ✓ Air ambulance is less costly than ground ambulance under the circumstances.
- HRSA requires providers to thoroughly document the circumstances requiring a nonemergency air ambulance transport. The medical justification must be submitted to HRSA prior to transport and must be documented in the client's medical record and ambulance trip report. Documentation must include adequate descriptions of the severity and complexity of the client's condition at the time of transportation.

Out-of-State Ambulance Coverage

[Refer to WAC 388-546-0800]

- HRSA covers emergency transportation provided to HRSA's eligible fee-for service clients who are out-of-state at the time of service (see *Section B - Client Eligibility* for exceptions). HRSA requires out-of-state ambulance providers who provide covered medical services to eligible HRSA clients and want to be reimbursed by HRSA for their services to:
 - ✓ Meet the licensing requirements of the ambulance provider's home state; and
 - ✓ Complete and sign an HRSA Core Provider Agreement.

- HRSA does not cover out-of-state ambulance transportation for a fee-for service client when:
 - ✓ The client's medical eligibility program covers medical services within Washington State and/or designated bordering cities only.
 - ✓ The ambulance transport is taking the client to an out-of-state treatment facility for a medical service, treatment, or procedure that is available from a facility within Washington state or in a designated bordering city; or
 - ✓ The transport was not an emergency transport and was not prior authorized by HRSA.

Out-of-Country Ambulance Coverage

[Refer to WAC 388-546-0900]

HRSA covers ambulance transportation for eligible fee-for-service clients traveling outside of the US and US territories, subject to the provisions and limitations of Chapter 388-546 WAC.

Note: See Section H – *Out-of-State Services*, for information about transportation to or from out-of-state treatment facilities – coordination of benefits.

Noncovered Ambulance Services

[Refer to WAC 388-546-0250]

HRSA does not cover ambulance services when the transportation is:

- ✓ Not medically necessary based on the client's condition at the time of service (for exceptions, see page D.4);
- ✓ Refused by the client (see exception for ITA clients on page I.1);
- ✓ For a client who is deceased at the time the ambulance arrives at the scene;
- ✓ For a client who dies after the ambulance arrives at the scene but prior to transport and the ambulance crew provided minimal to no medical interventions/supplies at the scene;
- ✓ Requested for the convenience of the client or the client's family
- ✓ More expensive than bringing the necessary medical service(s) to the client's location in nonemergency situations;
- ✓ To transfer a client from a medical facility to the client's residence (except when the residence is a nursing facility);
- ✓ Requested solely because a client has no other means of transportation;
- ✓ Provided by other than licensed ambulance providers (e.g., wheelchair vans, cabulance, stretcher cars); or
- ✓ Not to the nearest appropriate medical facility.

HRSA evaluates requests for services that are listed as noncovered in this section under the provisions of WAC 388-501-0160. See Section E, *Authorization Requirements*, for further information on requesting an Exception to Rule. For ambulance services that are otherwise covered under this section but are subject to one or more limitations or other restrictions, HRSA evaluates, on a case-by-case basis, requests to exceed the specified limits or restrictions in accordance with WAC 388-501-0165.

Note: An ambulance provider may bill a client for noncovered services as described in this section if the requirements of WAC 388-502-0160 are met.

Noncovered Ambulance Transport Destinations

Home

HRSA does not cover ambulance transports to a client's home, except when the client's home is a nursing facility and the client needs to be transported in a prone or supine position. Claims submitted for transports from the hospital, skilled nursing facility, nursing home, or hospice should reflect the reason(s) why the client could not have gone home by any other means without endangering his/her health. **Ambulance transports in such cases must be prior authorized by HRSA.** HRSA evaluates these types of requests on a case-by-case basis.

Hospital (Nonemergency Transfers)

As a rule, HRSA does not cover nonemergency hospital-to-hospital ambulance transports. Examples of nonemergency transports HRSA does not cover include:

- ✓ Doctor's preference (e.g., the client's primary physician practices at receiving hospital);
- ✓ Client's preference (e.g., to be closer to home or family);
- ✓ Evaluation and treatment of a client at another facility when inpatient status is maintained at originating hospital;
- ✓ Back door to front door transports within the same hospital complex; and
- ✓ Transports to meet insurance requirements or hospital/insurance agreements.

In general, for HRSA to pay for a hospital-to-hospital ambulance transport, the client must have been discharged from the first hospital. HRSA does not pay separately for transporting inpatients to and from another facility for diagnostic or therapeutic services without being discharged from the first hospital.

Noncovered Ambulance Transport Destinations (*Cont'd*)

24-Hour walk-in clinics, Urgent Care Centers, Free Standing Outpatient Facilities, and Physician's Office

An Emergency Department is defined as an organized hospital-based facility that is open 24 hours a day. HRSA considers 24-hour walk-in clinics and Urgent Care Centers as physician-based or physician-directed clinics. Like physician offices, they are not acceptable destinations for ambulance coverage, except under the following circumstances:

- ✓ When the ambulance stops at one of these entities in order to stabilize the client or because of a client's dire need for professional attention, **and immediately thereafter, the ambulance continues en route to the hospital**; or
- ✓ When a nursing facility resident is transported roundtrip for specialized services to the nearest hospital or non-hospital treatment facility (e.g., clinic, therapy center, or physician's office) to obtain necessary diagnostic and/or therapeutic services (such as CT scan or radiation therapy) **not available** at the institution where the client is an inpatient. However, this benefit is subject to all existing coverage requirements and is limited to those cases where the transportation of the client is less costly than bringing the service to the client.

HRSA does not cover ambulance transports to a physician's office for evaluation and management services **in the absence of any specialized services** (i.e., tests or procedures that could not be brought to the client).

HRSA does not cover ambulance services if the client is transported from home or a nursing home to the hospital outpatient department or other treatment/diagnostic facility for treatment that could have been performed in the client's home or nursing home.

“Treat But No Transport” Service Calls

- ✓ HRSA’s Ambulance Program is a transportation service. HRSA does not pay for services under the Ambulance Transportation Program if no transport takes place, except as provided in WAC 388-546-0500(2).
- ✓ HRSA does not pay providers if no transport occurs because the client dies:
 - Before the ambulance arrives at the scene; or
 - After the ambulance arrives at the scene, but before medical intervention is provided.
- ✓ When an ambulance provider provides medical services to a client at the scene, but the client dies before transport is made, HRSA pays the provider the **appropriate base rate**, commensurate with the level of service provided. Providers must document in their files what medical interventions were provided to the client by the ambulance crew at the scene before the client died. [WAC 388-546-0500 (2)]
- ✓ An ALS assessment is not sufficient to trigger payment to the provider unless transport takes place.
- ✓ “Treat but no transport” calls are **noncovered services**, except as provided in WAC 388-546-0500 (2).

Ambulance & ITA Transportation Coverage Table

Air Ambulance

HRSA considers all air transports to be ALS. This is taken into consideration in the rates. There is no separate reimbursement for equipment and supplies such as incubators, dressings, or oxygen tanks. The base rate (lift-off fee) includes these costs.

Note: The need for air ambulance transport must be clearly documented in the ambulance provider's records.

| Procedure Code | Modifier | Brief Description | EPA/PA | Policy/ Comments |
|------------------|----------|--|--------|--|
| Base Rate | | | | |
| A0430 | | Ambulance service, conventional air services, transport, one way (fixed wing) | | Per client transported. |
| A0431 | | Ambulance service, conventional air services, transport, one way (rotary wing) | | Per client transported. |
| Mileage | | | | |
| A0435 | | Fixed wing air mileage, per statute mile | | One way, per flight, equally divided by the number of clients transported. |
| A0436 | | Rotary wing air mileage, per statute mile | | One way, per flight, equally divided by the number of clients transported. |

HRSA conducts post-pay reviews. HRSA may determine that ground ambulance transport would have been sufficient, based on information available at the time of service. If this happens, HRSA pays the rate for ALS ground service, unless the provider can justify the use of air ambulance.

Ground Ambulance

Modifiers are required on all codes. See Modifiers, page F.4, for descriptions.

| Procedure Code | Modifier | Brief Description | EPA/PA | Policy/ Comments |
|------------------------------------|----------|--|--------|---|
| Basic Life Support (BLS) | | | | |
| A0428 | | Ambulance service, basic life support, non-emergency transport (BLS) | | Origin and destination modifiers required. For each additional client, use modifier GM in addition to the origin and destination modifiers. |
| A0429 | | Ambulance service, basic life support, emergency transport (BLS-emergency) | | Origin and destination modifiers required. For each additional client, use modifier GM in addition to the origin and destination modifiers. |
| Advanced Life Support (ALS) | | | | |
| A0426 | | Ambulance service, advanced life support non-emergency transport, level 1 (ALS 1). | | Origin and destination modifiers required. For each additional client, use modifier GM in addition to the origin and destination modifiers. |
| A0427 | | Ambulance service, advanced life support, emergency transport, level 1 (ALS 1 emergency) | | Origin and destination modifiers required. For each additional client, use modifier GM in addition to the origin and destination modifiers. |
| A0433 | | Advanced life support, level 2 (ALS 2). | | Origin and destination modifiers required. For each additional client, use modifier GM in addition to the origin and destination modifiers. |

**Ambulance and
ITA Transportation**

| Procedure Code | Modifier | Brief Description | EPA/PA | Policy/ Comments |
|---|-----------------|---|---------------|--|
| A0434 | | Specialty care transport (SCT) | | Origin and destination modifiers required. For each additional client, use modifier GM in addition to the origin and destination modifiers. |
| Mileage | | | | |
| A0425 | | Ground mileage, per statute mile. | | Origin and destination modifiers required. |
| Other Services | | | | |
| A0170 | | Transportation ancillary: parking fees, tolls, other | | Invoice required. Origin and destination modifiers required. |
| A0424 | | Extra ambulance attendant, ground (ALS or BLS) or air (fixed or rotary winged); (requires medical review) | | <p>Pertinent documentation to evaluate medical appropriateness should be included when this code is reported. Origin and destination modifiers required.</p> <p>Justification required:</p> <ul style="list-style-type: none"> ✓ The client weighs 300 pounds or more; or ✓ Client is violent or difficult to move safely; or ✓ More than one client is being transported, and each requires medical attention and/or close monitoring. |
| Note: HRSA pays for an extra attendant in ground ambulance transports only. No payment is made for an extra attendant in air ambulance transports. | | | | |
| T2006 | | Ambulance response and treatment, no transport. | | Code not payable. Used for data collection purposes only. |

Involuntary Treatment Act (ITA) Transportation

| Procedure Code | Modifier | Brief Description | EPA/PA | Policy/ Comments |
|----------------|----------|--|--------|--|
| S0215 | | Nonemergency transportation; mileage, per mile. | | Rate per consumer. Use this same code to bill for emergency non-ambulance ITA transportation. |
| T2001 | | Non-emergency transportation; patient attendant/ escort. | | Requires justification: ✓ The client weighs 300 pounds or more; or ✓ Client is violent or difficult to move safely and must be restrained; or ✓ More than one client is being transported, and each requires medical attention and/or close monitoring. |

- The mileage rate is only for those miles that the involuntarily detained consumer is on-board the vehicle (loaded mileage). MHD does not allow any additional charges beyond the rate per mile allowance, except for the extra attendant when specified conditions are met.
- MHD reimburses for transportation services at a provider's usual and customary rate or the above maximum allowable per mile, whichever is less, for each eligible involuntarily detained consumer.
- MHD payment is payment in full. MHD allows no additional charge to the involuntarily detained consumer.

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Authorization Requirements

Ambulance transportation usage in emergency situations does not require prior authorization.

Ambulance usage in nonemergency situations requires authorization:

- ✓ Hospital transfers to a lower level facility – may be ground or air;
- ✓ Air ambulance to or from out-of-state treatment facilities;
- ✓ Prone or supine transportation (ground only).

Out-of-State Transportation [WAC 388-546-0800]

Ambulance providers who provide medical transportation that takes a client out-of-state or that brings a client into Washington State from an out-of-state location must obtain HRSA's prior authorization. Fax request and justification to HRSA: 360.586.1471.

Under no circumstances are such transports covered for clients under the Involuntary Treatment Act (ITA).

Nonemergency Ground Ambulance Transportation

HRSA requires ambulance providers to thoroughly document the circumstances requiring nonemergency ground ambulance transportation using the Physician Certification Statement (PCS).

Physician Certification Statement (PCS)

- For nonemergency, scheduled ambulance services that are repetitive in nature, the ambulance provider must obtain a written physician certification statement (PCS) from the client's attending physician certifying that the ambulance services are medically necessary. The PCS must specify the expected duration of treatment or span of dates during which the client requires repetitive nonemergency ambulance services. The PCS must be dated no earlier than 60 days before the first date of service. A PCS for repetitive, nonemergency ambulance services is valid for 60 days as long as the client's medical condition does not improve. Kidney dialysis clients may receive nonemergency ground ambulance transportation to and from outpatient kidney dialysis services for up to 3 months per authorization span.

Ambulance and ITA Transportation

- For nonemergency ambulance services that are either unscheduled or scheduled on a nonrepetitive basis, the ambulance provider must obtain from the client's attending physician a signed PCS within 48 hours after the transport. The PCS must certify that the ambulance services are medically necessary.

- If the ambulance provider is not able to obtain a signed PCS from the attending physician, a signed certificate of medical necessity form must be obtained from a qualified provider who is employed by the client's attending physician or by the hospital or facility where the client is being treated and who has personal knowledge of the client's medical condition at the time the ambulance service was furnished. In lieu of the attending physician, one of the following may sign the certification form:
 - ✓ A physician assistant;
 - ✓ A nurse practitioner;
 - ✓ A registered nurse;
 - ✓ A clinical nurse specialist; or
 - ✓ A hospital discharge planner.

The signed certificate must be obtained from the alternate provider no later than 21 calendar days from the date of service.

- If, after 21 days, the ambulance provider is unable to obtain the signed PCS from the attending physician or alternate provider for nonemergency ambulance services that are either unscheduled or scheduled on a nonrepetitive basis, the ambulance provider may submit a claim to HRSA, as long as the provider is able to show acceptable documentation of the attempts to obtain the PCS.

- In addition to the signed certification statement of medical necessity, all other program criteria must be met in order for HRSA to pay for the service.

Exception to Rule

Many transports from a higher level of care to a lower level of care involve the return of infants from Neonatal Intensive Care Units to community hospital special care nurseries. HRSA does not pay for these transports.

To request an Exception to Rule (see WAC 388-501-0160) to transfer a newborn to its home community hospital, the transferring hospital must submit to HRSA the following information:

- ✓ Newborn's name and date of birth;
- ✓ Newborn's diagnosis and prognosis;
- ✓ Length of stay (to date) at transferring hospital;
- ✓ Name and address of receiving hospital;
- ✓ Number of days that the newborn is expected to stay at the receiving hospital prior to discharge;
- ✓ Parental travel distance between the client's home and the special care nursery;
- ✓ Extenuating social circumstances; and
- ✓ Contact names and numbers at the transferring and receiving hospitals.

If HRSA approves the ETR request, the transferring hospital must give the ambulance provider copies of authorization documentation pertinent to the transport.

Fax requests for Exception to Rule to:

HRSA - Division of Medical Management

360.586.1471

or

HRSA's Ambulance Transportation Program Manager

360.753.9152

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Reimbursement

Ambulance Transports Included in Bundled Payment to Other Providers

In certain situations, ambulance transportation may be medically necessary, but it does not qualify for separate payment by HRSA. This occurs when the ambulance transport is included in bundled payments to hospitals or other providers.

Example: A client who is a registered inpatient of one hospital is transported to another facility for a diagnostic service (e.g., a CAT scan, etc.) and is given a return transport to the first hospital. HRSA's hospital contracts state that: "transportation services subsequent to admission and prior to discharge which are necessary to provide inpatient services under this contract are part of inpatient services." Payment for such inpatient transport is included within the hospital's payment. In such a case, HRSA does not reimburse the ambulance provider separately, and the ambulance provider may not bill HRSA's client for the transport.

The hospital in which the client is a registered inpatient is responsible for the reimbursement of the ambulance transport.

What is included in the base rate?

The base rate includes:

- ✓ Emergency medical services;
- ✓ Costs of standing orders;
- ✓ Attendants;
- ✓ Reusable supplies and equipment;
- ✓ Hardware;
- ✓ Stretchers;
- ✓ Disposable supplies;
- ✓ Normal waiting time; and
- ✓ Normal overhead costs of doing business.
- ✓ Oxygen and oxygen administration; and
- ✓ Extra attendant in specific circumstances (see page F.7).

For air ambulance, the base rate is the lift-off fee.

What is not included in the base rate?

The base rate does not include mileage. For ground ambulance, the base rate also excludes the cost of an extra attendant, ferry and bridge tolls.

General Limitations on Payment for Ambulance Services

[Refer to WAC 388-546-0400]

- HRSA pays providers the lesser of the provider's usual and customary charge or the maximum allowable rate established by HRSA. HRSA's fee schedule payment for ambulance services includes a base rate or lift-off fee plus mileage.
- HRSA does not pay providers under fee-for-service for ambulance services provided to a client who is enrolled in an HRSA managed care plan. Payment in such cases is the responsibility of the prepaid managed care plan.
- HRSA does not pay providers for mileage incurred traveling to the point of pick-up or any other distances traveled when the client is not on board the ambulance. HRSA pays for loaded mileage only.
 - ✓ HRSA pays ground ambulance providers for the actual mileage incurred for covered trips by paying from the client's point of pick-up to the point of destination.
 - ✓ HRSA pays air ambulance providers for the statute miles incurred for covered trips by paying from the client's point of pick-up to the point of destination.
- HRSA does not pay for ambulance services if:
 - ✓ The client is not transported;
 - ✓ The client is transported but not to an appropriate treatment facility; or
 - ✓ The client dies before the ambulance trip begins (see the single exception for ground ambulance providers on page F.8).

Ambulance and ITA Transportation

- For clients in the Categorically Needy/Qualified Medicare Beneficiary (CN/QMB) and Medically Needy/Qualified Medicare Beneficiary (MN/QMB) programs, HRSA's payment is as follows:
 - ✓ If Medicare covers the service, HRSA will pay the lesser of:
 - The full coinsurance and deductible amounts due, based upon Medicaid's allowed amount; or
 - HRSA's maximum allowable for that service minus the amount paid by Medicare.
 - ✓ If Medicare does not cover or denies the ambulance services that HRSA covers, HRSA pays at HRSA's maximum allowable; **except** HRSA does not pay for clients on the QMB-only program.

Qualified Trauma Cases

[Refer to WAC 388-546-3000]

HRSA does not pay ambulance providers an additional amount (supplemental payment from the Trauma Care Fund) for transports involving qualified trauma cases. Ambulance providers may apply to the Department of Health for an annual participation grant for pre-hospital verified trauma services.

Reimbursement for Out-of-State Transportation

[Refer to WAC 388-546-0800]

Except in cases involving scheduled transports with negotiated rates, HRSA pays for out-of-state ambulance transportation at the lower of:

- ✓ The provider's billed amount; or
- ✓ The rate established by HRSA.

Ambulance providers must have a current, signed Core Provider Agreement on file with HRSA to receive payment.

HRSA pays ambulance providers the agreed upon amount for each medically necessary interstate ambulance trip that has HRSA's prior authorization. The provider is responsible for ensuring that all necessary services associated with the transport are available and provided to the client. In transports involving negotiated rates, the provider is responsible for the costs of all services included in the contractual amount. The contractual amount for an air ambulance transport may include ground ambulance fees at the point of pick-up and the point of destination.

Note: Under no circumstances are out-of-state transports covered for ITA clients.

Reasons for Recoupment of Payment

Ambulance operators must comply with all HRSA published rules and billing instructions. HRSA will recoup reimbursements made to providers if, among other reasons, it finds providers to be out of compliance with HRSA rules and billing instructions. A paid claim does not mean the item or service is a covered benefit.

Modifiers [Refer to WAC 388-546-0600]

The following origin and destination modifiers are single-digit modifiers used in combination. The first digit indicates the transport's place of origin. The destination is indicated by the second digit. You must enter these modifiers in field 24D on the HCFA-1500 claim form.

Providers must use a combination of **two digits** to identify origin and destination (e.g., A0428 NH, A0425 NH). Providers must use the appropriate modifiers for all services related to the same trip for the same client (Refer to WAC 388-546-0600).

Note: Complete addresses for origin and destination must be kept in the client's file and available for review.

Origin/Destination Modifiers

- D** Diagnostic or therapeutic site other than "P" or "H" when used as origin codes
- E** Residential, domiciliary, custodial facility
- G** Hospital-based dialysis facility (hospital or hospital-related)
- H** Hospital
- I** Site of transfer (e.g., airport or helicopter pad) between types of ambulance
- J** Non-hospital based dialysis facility
- N** Skilled nursing facility (SNF)
- P** Physician's office (includes HMO non-hospital facility, clinic, etc.)
- R** Residence
- S** Scene of accident or acute event
- X** (Destination code only) Intermediate stop at physician's office on the way to hospital

Other Modifiers

- QL** Use if services are provided but client dies prior to transport.
- GM** Use in addition to the 2-digit destination modifier for each additional client per transport

Reimbursement Specific to Ground Ambulance

[Refer to WAC 388-546-0450]

Levels of Transporting Service [Refer to WAC 388-546-0450(1)]

HRSA pays for two levels of service for ground ambulance transportation: Basic Life Support (BLS) and Advanced Life Support (ALS).

- A **BLS** ambulance trip is one in which the client requires and receives basic services at the scene and/or en route from the scene of the acute and emergency illness or injury to a hospital or other appropriate treatment facility. Examples of basic medical services are:
 - ✓ Controlling bleeding;
 - ✓ Splinting fracture(s);
 - ✓ Treating for shock; and
 - ✓ Performing cardiopulmonary resuscitation (CPR).

- An **ALS** trip is one in which the client requires and receives more complex services at the scene and/or en route from the scene of the acute and emergency illness or injury to a hospital. To qualify for payment at the ALS level, certified paramedics or other ALS-qualified personnel on-board must provide the advanced medical services in a properly equipped vehicle. Examples of complex medical services or ALS procedures are:
 - ✓ Administration of medication by intravenous push/bolus or by continuous infusion;
 - ✓ Airway intubation;
 - ✓ Cardiac pacing;
 - ✓ Chemical restraint;
 - ✓ Chest decompression;
 - ✓ Creation of surgical airway;
 - ✓ Initiation of intravenous therapy;
 - ✓ Manual defibrillation/cardioversion;
 - ✓ Placement of central venous line; and
 - ✓ Placement of intraosseous line.

Base Rate [WAC 388-546-0450(2)(3)]

- HRSA's base rate includes:
 - ✓ Necessary personnel and services;
 - ✓ Oxygen and oxygen administration;
 - ✓ Intravenous supplies and IV administration;
 - ✓ Reusable supplies;
 - ✓ Disposable supplies;
 - ✓ Required equipment;
 - ✓ Waiting time; and
 - ✓ Other overhead costs.

 - Local ordinances or standing orders that require all ambulance vehicles be ALS-equipped do not qualify a trip for HRSA payment at the ALS level of service unless ALS services were provided.

 - A ground ambulance trip is classified and paid at a BLS level, even if certified paramedics or ALS-qualified personnel are on board the ambulance, if no ALS-type interventions were provided en route. The base rate billed for each transport must reflect the level of care and types of medical interventions by trained and certified personnel on-board. HRSA classifies a ground ambulance transport as BLS even with paramedics or ALS-qualified personnel on board if no ALS-type interventions are provided en route. Medical necessity, **not the level of personnel on board an ambulance**, dictates which level (BLS or ALS) of ground ambulance service is billed to HRSA.
- For example:** A client with an IV is transported from the hospital to a nursing facility. Hospital staff set up and started the IV administration. The ambulance personnel provided no other interventions except to monitor the client during the transport. This transport qualifies only for the BLS base rate.
- An ALS assessment does not qualify as an ALS transport if no ALS-type interventions were provided to the client en route to the treatment facility.

 - Providers may bill for ALS return pickup or second ALS transport **only** when all of the conditions for an ALS transport are met (i.e., when ambulance personnel **perform** ALS-level interventions). Otherwise, the BLS base rate applies.

Note: HRSA does not pay separately for chargeable items/services that are provided to the client based on standing orders.

- HRSA includes professional services performed by a registered nurse (RN) or a physician in the base rate reimbursement. **HRSA makes NO separate payment for professional services.** (See Specialty Care Transport on page F.9.)

Mileage [WAC 388-546-0450(2)-(5)]

- HRSA pays ground ambulance providers the same mileage rate for ALS and BLS transports.
- Providers may bill HRSA only for mileage incurred from the client's *point of pickup* to the *nearest appropriate destination*. A fraction of a mile may be rounded up to the next whole number.

Note: HRSA pays for mileage when the client is transported to and from medical services within the local community only, unless necessary medical care is not available locally. To be reimbursed for extra mileage, the provider must fully document in the client's record the circumstances that make medical care outside of the client's local community necessary.

- HRSA pays for extra mileage only with sufficient justification. The justification must be documented in the client's record and the ambulance trip report. Acceptable reasons for extra mileage include, but are not limited to the following:
 - ✓ A hospital was on "divert" status and not accepting patients; or
 - ✓ A construction site caused a detour, or had to be avoided to save time.

Extra Attendant [WAC 388-546-0450(7)]

In most situations, the base rate includes personnel charges. Therefore, an extra attendant is not paid separately. However, in the following situations, an additional payment for an extra attendant may be allowed when the justification for those services is documented in the client's file.

Justification for an extra attendant would be:

- ✓ The client weighs 300 pounds or more; or
- ✓ Client is violent or difficult to move safely; or
- ✓ The client is being transported for Involuntary Treatment Act (ITA) purposes and the client must be restrained during the trip; or
- ✓ More than one client is being transported, and each requires medical attention and/or close monitoring.

When billing HRSA, the provider must send justification/documentation of the unusual

circumstances that warranted the need for an extra attendant.

For example: A suspected heart attack client in most cases would not be viewed as unusual or require an extra attendant. If the suspected heart attack client is extremely obese or mentally disturbed, an extra attendant may be warranted, provided documentation clearly indicates the **need** for such services.

Ferry and Bridge Tolls [WAC 388-546-0450(8)]

HRSA pays ambulance providers “by report” (see *Definitions* section) for ferry and bridge tolls incurred when transporting HRSA clients. To be paid, providers must document the toll(s) by attaching the receipt(s) for the toll(s) to the claim.

Waiting Time

There is no separate payment for waiting time. The cost of additional waiting time has been rolled into the ground ambulance base rates.

Special Circumstances

- ***Multiple Providers Responding*** [WAC 388-546-0450(6)]

When multiple ambulance providers respond to an emergency call, HRSA pays only the ambulance provider that actually furnishes the transportation.

- ***Multiple Clients, Same Transport*** [WAC 388-546-0500(1)]

When more than one client is transported in the same ground ambulance at the same time, the provider must bill HRSA:

- ✓ At a reduced base rate for the additional client (use modifier GM in addition to the 2-digit origin/destination modifier when billing for the second client); and
- ✓ No mileage charge for the additional client.

- ***Death of a Client*** [WAC 388-546-0500(2)]

HRSA pays an ambulance provider at the appropriate base rate (BLS or ALS) if no transportation takes place because the client died at the scene of the illness or injury but the ambulance crew provided medical interventions/supplies to the client at the scene prior to the client's death. See page F.5 for examples of medical interventions/supplies associated with each base rate.

The intervention/supplies must be documented in the client's record. No mileage charge is allowed with the base rate when the client dies at the scene of the illness or injury after medical interventions/supplies are provided but before transport takes place.

- ***BLS-ALS Combined Response*** [WAC 388-546-0500(3)]

In situations where a BLS entity provides the transport of the client and an ALS entity provides a service that meets HRSA's fee schedule definition of an ALS intervention, the transporting BLS provider may bill HRSA the ALS rate for the transport, provided a written reimbursement agreement between the BLS and ALS entities exists.

The BLS provider must give HRSA a copy of its agreement with the ALS entity upon request. If there is no written agreement between the BLS and ALS entities, HRSA will pay only for the BLS level of service for the combined response.

- ***Residents/Nonresidents*** [Refer to WAC 388-546-0500(4)]

In areas that distinguish between residents and nonresidents, a provider must bill HRSA the same rate for ambulance services provided to an HRSA client in that particular jurisdiction as would be billed by that provider to members of the general public of comparable status in the same jurisdiction.

- ***Specialty Care Transport*** [Refer to WAC 388-546-0425(6)]

Specialty care transport (SCT) is hospital-to-hospital transportation by ground ambulance of a critically injured or ill client, at a level of service beyond the scope of a paramedic. HRSA pays an ambulance provider the advanced life support (ALS) rate for an SCT-level transport provided:

- ✓ The criteria for covered hospital transfers under fee-for-service are met; and
- ✓ There is a written reimbursement agreement between the ambulance provider and SCT personnel. The ambulance provider must give HRSA a copy of the agreement upon request. If there is no written reimbursement agreement between the ambulance provider and SCT personnel, HRSA pays the provider at the basic life support (BLS) rate.

- ***Nonemergency Ground Ambulance Transportation***
[Refer to WAC 388-546-1000]

HRSA pays for nonemergency ground ambulance transportation at the BLS ambulance level of service when the conditions in WAC 388-546-1000 (1) and (2) are met.

Ground ambulance providers may choose to enter into contracts with HRSA's transportation brokers to provide nonemergency transportation at a negotiated payment rate. Any such subcontracted rate may not exceed the costs HRSA would incur under WAC 388-546-1000 (1).

- ***“Treat But No Transport” Tracking Code (T2006)***

This code is not payable, but HRSA is asking providers to keep track of the frequency and type of situations in which they respond to emergency calls without a resulting transport. HRSA will use the data collected in developing program policy.

Reimbursement Specific to Air Ambulance

[WAC 388-546-0700]

Air Ambulance

HRSA considers all air ambulance transports as ALS. Payment is based on lift-off and mileage.

What is covered? [WAC 388-546-0700]

HRSA pays for air ambulance services when all of the following apply:

- ✓ The necessary medical treatment is not available locally or the client's point of pick-up is not accessible by ground;
- ✓ The vehicle and crew meet the provider requirements on pages C.1 and D.4.
- ✓ The client's destination is an acute care hospital; and
- ✓ The client's physical/medical condition requires immediate and rapid ambulance transportation that cannot be provided by ground ambulance; or
- ✓ The client's physical or mental condition is such that traveling on a commercial flight is not safe.

- ***Lift-off***

HRSA pays providers for one lift-off fee per client, per trip.

- ***Mileage*** [WAC 388-546-0700(4)]

Air mileage is based on loaded miles flown, as expressed in statute miles.

HRSA pays for extra air mileage with sufficient justification except in cases involving scheduled air transports with negotiated rates. The reason for the added mileage must be documented in the client's record and the ambulance trip report. Acceptable reasons include, but are not limited to:

- ✓ Having to avoid a "no fly zone"; or
- ✓ Being forced to land at an alternate destination due to severe weather.

Special Circumstances

- ***Multiple Clients*** [WAC 388-546-0700(5)]

HRSA pays a lift-off fee for each client when two or more clients are transported on a single air ambulance trip. In such a case, the provider must divide equally the total air mileage by the number of clients transported and bill HRSA for the mileage portion attributable to each eligible client.

- ***Multiple Lift-offs*** [WAC 388-546-0700(6)]

If a client's transportation requires use of more than one ambulance to complete the trip to the hospital or other approved facility, HRSA limits its payment as follows:

- ✓ If air ambulance is used and the trip involves more than one lift-off, HRSA pays only one air ambulance transport for the same client one way. If the transport involves both helicopter and airplane, the lift-off fee and mileage payment will be based on the mode of air transport used for the greater distance traveled.
- ✓ If both air and ground ambulances are used, HRSA pays one lift-off fee and total air miles to the air ambulance provider, and the applicable base rate and ground mileage to each ground ambulance provider involved in the trip, except when ground ambulance fees are included in the negotiated trip payment as provided on page D.4.

If multiple transports are made on the same day for the same client, every lift-off is a separate trip, except when the lift-off is part of a one-way trip involving multiple legs of travel (see above). Records must reflect why multiple trips have occurred on the same day.

- ***Transports by Private Organizations*** [WAC 388-546-0700(7)]

HRSA does not pay private organizations for volunteer medical air ambulance transportation services, unless the organization has HRSA's prior authorization for the transportation services and fees. If authorized, HRSA's payment is based on the actual cost to provide the service or at HRSA's established rates, whichever is lower.

HRSA does not pay separately for items or services that HRSA includes in the established rate(s).

- ***Medical Necessity Not Clearly Established***

If HRSA determines, upon review, that an air ambulance trip was not:

- ✓ Medically necessary, HRSA may deny or recoup its payment and/or limit payment based on HRSA's established rate for a ground ambulance trip provided ground ambulance transportation was medically necessary; or
- ✓ To the nearest available and appropriate hospital, HRSA may deny or recoup its payment and/or limit its maximum payment for the trip based on the nearest available and appropriate facility.

If the client is transported by air ambulance, but HRSA determines that ground ambulance would have sufficed, HRSA bases payment on the amount payable for ground transport, if less costly. Also, as with ground ambulance, if the transport was medically necessary, but the client could have been treated at a nearer hospital, the air transport payment is limited to the rate from the point of pickup to the closer hospital.

- ***Nonemergency Transports Require Prior Authorization***

Providers must have prior authorization from HRSA for any nonemergency air transportation, whether by air ambulance or other mode of air transportation. Nonemergency air transportation includes scheduled transports to or from out-of-state treatment facilities.

HRSA uses commercial airline companies (i.e., HRSA does not authorize air ambulance transports) whenever the client's medical condition permits the client to be transported by nonmedical and/or scheduled carriers.

- ***Cancelled Trips***

HRSA does not pay for air ambulance services if no air ambulance transportation is provided. HRSA does not pay for cancelled transports.

Note: See Section H – *Out-of-State Services* for air ambulance services to out-of-state treatment.

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Fee Schedule

Air Ambulance

HRSA considers all air transports to be Advanced Life Support (ALS). This is taken into consideration in the rates. There is no separate reimbursement for equipment and supplies such as incubators, dressings, or oxygen tanks. The base rate (lift-off fee) includes these costs.

Note: The need for air ambulance transport must be clearly documented in the ambulance provider's records.

Base Rate

| Procedure Code | Description | Maximum Allowable Fee 7/1/06 |
|----------------|--|------------------------------|
| A0430 | Ambulance service, conventional air services, transport, one way (fixed wing) Per client transported. | \$910.81 |
| A0431 | Ambulance service, conventional air services, transport, one way (rotary wing) Per client transported. | 804.45 |

Mileage

| Procedure Code | Description | Maximum Allowable Fee 7/1/05 |
|----------------|--|------------------------------|
| A0435 | Fixed wing air mileage, per statute mile One way, per flight, equally divided by the number of clients transported. | \$5.50/ air mile |
| A0436 | Rotary wing air mileage, per statute mile One way, per flight, equally divided by the number of clients transported. | 13.31/ air mile |

HRSA conducts post-pay reviews. HRSA may determine that ground ambulance transport would have been sufficient, based on information available at the time of service. If this happens, HRSA pays the rate for ALS ground service, unless the provider can justify the use of air ambulance.

Ground Ambulance

Modifiers are required on all codes. See Modifiers, page F.4, for descriptions.

Basic Life Support (BLS)

| Procedure Code | Description | Maximum Allowable Fee 7/1/05 |
|----------------|--|------------------------------|
| A0428 | Ambulance service, basic life support, non-emergency transport (BLS) Origin and destination modifiers required. For each additional client, use modifier GM in addition to the origin and destination modifiers. | \$115.34 |
| A0429 | Ambulance service, basic life support, emergency transport (BLS-emergency) Origin and destination modifiers required. For each additional client, use modifier GM in addition to the origin and destination modifiers. | 115.34 |

Advanced Life Support (ALS)

| Procedure Code | Description | Maximum Allowable Fee 7/1/05 |
|----------------|--|------------------------------|
| A0426 | Ambulance service, advanced life support non-emergency transport, level 1 (ALS 1) Origin and destination modifiers required. For each additional client, use modifier GM in addition to the origin and destination modifiers. | \$168.43 |
| A0427 | Ambulance service, advanced life support, emergency transport, level 1 (ALS 1 emergency) Origin and destination modifiers required. For each additional client, use modifier GM in addition to the origin and destination modifiers. | 168.43 |
| A0433 | Advanced life support, level 2 (ALS 2) Origin and destination modifiers required. For each additional client, use modifier GM in addition to the origin and destination modifiers. | 168.43 |
| A0434 | Specialty care transport (SCT) Origin and destination modifiers required. For each additional client, use modifier GM in addition to the origin and destination modifiers. | 168.43 |

Ground Ambulance (cont'd)

Mileage

| Procedure Code | Description | Maximum Allowable Fee 7/1/06 |
|----------------|---|---------------------------------|
| A0425 | Ground mileage, per statute mile Origin and destination modifiers required. | \$5.08/ mile |

Other Services

| Procedure Code | Description | Maximum Allowable Fee 7/1/05 |
|----------------|---|---------------------------------|
| A0170 | Transportation ancillary: parking fees, tolls, other Invoice required. Origin and destination modifiers required. | By Report |
| A0424 | Extra ambulance attendant, ground (ALS or BLS) or air (fixed or rotary winged); (requires medical review) Pertinent documentation to evaluate medical appropriateness should be included when this code is reported. Origin and destination modifiers required. Justification required: <ul style="list-style-type: none"> ✓ The client weighs 300 pounds or more; or ✓ Client is violent or difficult to move safely; or ✓ More than one client is being transported, and each requires medical attention and/or close monitoring. <p>Note: HRSA pays for an extra attendant in ground ambulance transports only. No payment is made for an extra attendant in air ambulance transports.</p> | \$23.18 |
| A0998 | Ambulance response and treatment, no transport Code not payable. Used for data collection purposes only. | # |

= Non-covered

Involuntary Treatment Act (ITA) Transportation

| Procedure Code | Description | Maximum Allowable Fee 07/01/07 |
|----------------|---|-----------------------------------|
| S0215 | Non-emergency transportation; mileage, per mile Rate per consumer. Use this same code to bill for emergency non-ambulance ITA transportation. | \$5.08/mile |
| T2001 | Non-emergency transportation; patient attendant/ escort Requires justification: <ul style="list-style-type: none"> ✓ The client weighs 300 pounds or more; or ✓ Client is violent or difficult to move safely and must be restrained; or ✓ More than one client is being transported, and each requires medical attention and/or close monitoring. | 23.18/trip |

- The mileage rate is only for those miles that the involuntarily detained consumer is on-board the vehicle (loaded mileage). MHD does not allow any additional charges beyond the rate per mile allowance, except for the extra attendant when specified conditions are met.
- MHD reimburses for transportation services at a provider's usual and customary rate or the above maximum allowable per mile, whichever is less, for each eligible involuntarily detained consumer.
- MHD payment is payment in full. MHD allows no additional charge to the involuntarily detained consumer.

Out-of-State Services

Transportation to or from Out-of-State Treatment Facilities – Coordination of Benefits [Refer to WAC 388-546-2500]

HRSA does not pay for a client's transportation to or from an out-of-state treatment facility when the medical service, treatment, or procedure sought by the client is available from an in-state facility or in a designated bordering city, whether or not the client has other insurance coverage.

For clients who are otherwise eligible for out-of-state coverage (see the Client Eligibility section), but have other third-party insurance, HRSA does not pay for transportation to or from out-of-state treatment facilities when the client's primary insurance:

- ✓ Denies the client's request for medical services out-of-state for lack of medical necessity; or
- ✓ Denies the client's request for transportation for lack of medical necessity.

For clients who are otherwise eligible for out-of-state coverage, but have other third-party insurance, HRSA does not consider requests for transportation to or from out-of-state treatment facilities unless the client has tried **all** of the following:

- ✓ Requested coverage of the benefit from his/her primary insurer and been denied; **and**
- ✓ Appealed the denial of coverage by the primary insurer; **and**
- ✓ Exhausted his/her administrative remedies through the primary insurer.

If HRSA authorizes transportation to or from an out-of-state treatment facility for a client with other third-party insurance, HRSA's liability is limited to the cost of the least costly means of transportation that does not jeopardize the client's health, as determined by HRSA in consultation with the client's referring physician.

For clients eligible for out-of-state coverage but have other third-party insurance, HRSA considers requests for transportation to or from out-of-state treatment facilities as an Exception to Rule (see WAC 388-501-0160).

Note: Under no circumstances are out-of-state transports covered for ITA clients.

Air Ambulance Services to Out-of-State Treatment Facilities

- HRSA approves out-of-state transportation only when medical services in an out-of-state treatment facility have been prior authorized by HRSA. The client's medical provider (hospital or attending physician) must submit a written request for prior authorization of the out-of-state treatment to:

Division of Medical Management
360.725.1555 (phone)
360.586.1471 (fax)

- HRSA considers the following criteria when reviewing a request for out-of-state services:
 - ✓ There is no equally effective, less costly alternative available in Washington State and/or in designated bordering cities; and
 - ✓ The service/treatment is not experimental.
- If HRSA authorizes the out-of-state treatment, and the client needs air ambulance services, the referring provider must request authorization for air ambulance transport. The request for an air ambulance may be made at the same time as the request for out-of-state treatment, but the requests are evaluated separately by HRSA.
- If HRSA authorizes the air ambulance transport for the out-of-state treatment, call the Ambulance Program Manager at 360.725.1835 to arrange for the air ambulance transport.
- Air ambulance transports in these cases are reimbursed at negotiated rates. HRSA payment is payment-in-full (see note on page H.3).
- HRSA uses commercial airline companies when the client's medical condition allows the client to travel on a commercial flight.

Air Ambulance Services from Out-of-State to In-State Treatment Facilities

- HRSA considers transports from out-of-state to in-state facilities on a case-by-case basis. The client's medical provider (hospital or attending physician) must submit a written request for prior authorization of the in-state treatment to:

Division of Medical Management
360.725.1555 (phone)
360.586.1471 (fax)

Ambulance and ITA Transportation

After authorization is received from HRSA for the transport to an in-state treatment facility, call the Ambulance Transportation Program Manager at 360.725.1835 to arrange for air ambulance transport, if air ambulance services are required.

- HRSA uses commercial airline companies whenever the client's medical condition allows.

Note: HRSA pays air ambulance providers the contractually agreed upon rate for each medically necessary, interstate air ambulance trip HRSA prior authorizes. Therefore, providers should maintain close contact with the discharging and/or receiving facilities to ensure proper coordination of the client transfer process. HRSA makes no additional payment to the air ambulance provider when the transport is rescheduled or re-routed.

Example: When flying to another state to pick up a client, an air ambulance provider should maintain contact with the facility providing medical services to the client in case the client has a setback and is not medically stable for transport. This will help ensure that the provider does not reach the facility only to have to leave without the client and return later for pickup, thus being reimbursed for only one trip when two were made.

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Involuntary Treatment Act (ITA) Transportation

Transportation under the Involuntary Treatment Act (ITA)

The Involuntary Treatment Act (ITA), Chapter 71.05 RCW (adults) and Chapter 71.34 RCW (minors), provides for the involuntary detention of individuals who are assessed by a County-Designated Mental Health Professional (CDMHP) as being:

- A danger to themselves;
- A danger to others; or
- Gravely disabled.

Note: Please see list of ITA Transportation definitions on page xii.

The CDMHP follows statewide protocol for the ITA transportation process. The CDMHP is authorized to approve the level of transportation needed. When the CDMHP detains an individual, the CDMHP assesses the level of need for transportation. As a result of this assessment, the CDMHP follows established statewide procedures and chooses an appropriate method of transportation from one of the following:

The local police or sheriff

The CDMHP contacts local law enforcement to request transport for involuntarily detained consumers who need a high security/safety level of supervision; or

Ambulance

The CDMHP contacts an ambulance provider to request transport for involuntarily detained consumers when:

- The police department will not transport; or
- The involuntarily detained consumer is medically fragile.

When ITA ambulance services are provided, ambulance providers must bill HRSA using the procedures outlined in this document to receive reimbursement.

ITA Transportation Client Eligibility - Verification of Eligible Involuntarily Detained Consumers

- All ITA transportation claims must have attached the ITA Patient Claim Information form, DSHS 13-628 (visit the DSHS Forms website at <http://www1.dshs.wa.gov/msa/forms/eforms.html>) to ensure that the billing is for services to a consumer involuntarily detained under chapter 71.05 RCW or chapter 71.34 RCW. This verification can take place at the time of service or after services have been provided and must show the following:
 - ✓ Date of initial ITA detention;
 - ✓ Date of 72-hour hearing;
 - ✓ Date of conversion to voluntary consumer status (if appropriate);
 - ✓ Date of release or transfer.
- After verification that the individual is involuntarily detained, the provider of service sends the 1500 Claim Form with the DSHS 13-628 attached to:

Health and Recovery Services Administration
Division of Program Support
P.O. Box 9245
Olympia, WA 98504-9245

Note: The ITA applies to all citizens within the borders of the state of Washington. An involuntarily-detained consumer does not have to be Medicaid eligible. The department will pay the ITA transportation costs for any consumer that a CDMHP determines is in need of ITA services. This includes the groups of clients identified on page B.2 as not normally eligible for HRSA-paid ambulance services.

Under no circumstances will the department pay for transportation costs to or from out-of-state or bordering cities for clients under ITA.

Please visit the DSHS Mental Health Division's website for a list of RSNs that you may contact regarding ITA services: <http://www1.dshs.wa.gov/mentalhealth/rsnmap.shtml>

- HRSA receives and processes claims, but **all** claims are funded through the Mental Health Division (MHD).

When are transportation services covered under ITA?

- The Mental Health Division (MHD) covers transportation for ITA consumers when provided **from**:
 - ✓ The site of the initial detention;
 - ✓ A court hearing; or
 - ✓ A hospital or an evaluation and treatment facility.

- MHD covers transportation for ITA consumers when provided **to**:
 - ✓ A hospital or an evaluation and treatment facility;
 - ✓ A less restrictive alternative setting (except home); or
 - ✓ A court hearing.

What transportation services are not payable under ITA?

MHD does not reimburse providers for non-ITA transportation (e.g., for **voluntary** mental health consumers or those who need transportation to and from outpatient mental health services). For information regarding non-ITA transportation, please refer to the following HRSA publications:

- For emergency and nonemergency ambulance transportation, refer to the *Table of Contents* of these billing instructions; and
- For all other nonemergency or scheduled transportation, refer to HRSA's Brokered Transportation program and HRSA's *General Information Booklet*.

HRSA's contract transportation brokers are listed on HRSA's website at <http://maa.dshs.wa.gov/Transportation/index.html>

HRSA's *General Information Booklet* is found on HRSA's web site at: <http://maa.dshs.wa.gov> (Select the *Billing Instructions/Numbered Memoranda* link.)

Note: See *Important Contacts* section for ordering information.

Driver and Vehicle Requirements for Non-Ambulance ITA Providers

Vehicle Standards and Maintenance

- Vehicles and equipment must be maintained in good working order and may be inspected by DSHS staff on request. The following equipment must be installed on each vehicle transporting physically restricted consumers:
 - ✓ The vehicle must be equipped so consumers are unable to interfere with the driver's operation of the vehicle;
 - ✓ Door(s) adjacent to a consumer must be secured from being opened from the inside of the vehicle when the consumer is not accompanied by an escort person other than the driver;
 - ✓ American Red Cross first aid box or equivalent;
 - ✓ Fire extinguisher;
 - ✓ Flares, or other warning devices;
 - ✓ Flashlight; and
 - ✓ Traction devices or tire chains when required by the Department of Transportation.

Driver Requirements

Each designated organization must include the following criteria in its driver selection process:

- Verify that the driver has a valid state driver's license;
- Verify that the driver has not had any major moving traffic violations for the past three years and has not been involved in any at-fault accidents within the past two years; and
- Verify that the driver is physically capable of safely handling consumers and capable of safely driving the vehicles. It is recommended that verification of these abilities be in the form of a written medical statement, or, if not available, some other form of credible verification.

Driver Training

Drivers must be completely familiar with their job and be able to use all accessory equipment in a safe manner. A driver-training program includes:

- First aid training including current cardio-pulmonary resuscitation (CPR) certification; and
- The operation and use of all equipment associated with the job.

Billing

What is the time limit for billing? [Refer to WAC 388-502-0150]

HRSA has two timeliness standards for: 1) initial claims; and 2) resubmitted claims.

- **Initial Claims**

- ✓ HRSA requires providers to obtain an ICN for an **initial claim** within 365 days from any of the following:
 - The date the provider furnishes the service to the eligible client;
 - The date a final fair hearing decision is entered that impacts the particular claim;
 - The date a court orders HRSA to cover the service(s) provided; or
 - The date DSHS certifies a client eligible under delayed² certification criteria.
- ✓ HRSA may grant exceptions to the 365 day time limit for **initial claims** when billing delays are caused by either of the following:
 - DSHS certification of a client for a retroactive³ period; or
 - The provider proves to HRSA's satisfaction that there are extenuating circumstances.

2 **Delayed Certification** - According to WAC 388-500-0005, delayed certification means department approval of a person's eligibility for a covered service made after the established application processing time limits. If, due to delayed certification, the client becomes eligible for a covered service that has already been provided, **the provider must not bill**, demand, collect, or accept payment from the client or anyone on the client's behalf for the service; and **must promptly refund** the total payment received from the client or anyone acting on the client's behalf and then bill HRSA for the service.

Eligibility Established After Date of Service but Within the Same Month - If the client becomes eligible for a covered service that has already been provided because the client applied to the department for medical services later in the same month the service was provided (and is made eligible from the first day of the month), **the provider must not bill**, demand, collect, or accept payment from the client or anyone acting on the client's behalf for the service; and **must promptly refund** the total payment received from the client or anyone acting on the client's behalf and then bill HRSA for the service.

3 **Retroactive Certification** - According to WAC 388-500-0005, retroactive period means the three calendar months before the month of application (month in which client applied). If, due to retroactive certification, the client becomes eligible for a covered service that has already been provided, **the provider must not bill**, demand, collect, or accept payment from the client or anyone acting on the client's behalf for any unpaid charges for the service; **and may refund** any payment already received from the client or anyone acting on the client's behalf, and after refunding the payment, the provider may bill HRSA for the service.

- **Resubmitted Claims**

Providers may **resubmit, modify, or adjust** any timely initial claim, **except** prescription drug claims, for a period of 36 months from the date of service. (Prescription drug claims must be resubmitted, modified, or adjusted within 15 months from the date of service.)

Note: HRSA does not accept any claim for resubmission, modification, or adjustment after the time periods listed above.

- The time periods do not apply to overpayments that the provider must refund to DSHS. After the allotted time periods, a provider may not refund overpayments to HRSA by claim adjustment. The provider must refund overpayments to HRSA by a negotiable financial instrument such as a bank check.
- The provider, or any agent of the provider, must not bill a client or a client's estate when:
 - ✓ The provider fails to meet these listed requirements; and
 - ✓ HRSA does not pay the claim.

What fee should I bill HRSA for eligible clients?

Bill HRSA your usual and customary charge.

When can I bill a Medical Assistance client?

Please refer to WAC 388-502-0160 or HRSA's *General Information Booklet* for information on billing the client.

How do I bill for services provided to PCCM clients?

When billing for services provided to clients with a Primary Care Case Manager (PCCM):

- Enter the referring physician or PCCM name in field 17 on the HCFA-1500 claim form; and
- Enter the seven-digit identification number of the PCCM who referred the client for the service(s). If the client is enrolled with a PCCM and the PCCM referral number is not in field 17a when you bill HRSA, the claim will be denied.

How do I bill for mileage?

- Bill mileage only from the client's point of pick-up to the point of destination.
- If an air ambulance transports more than one client on a single trip, HRSA will pay the lift-off rate for each client. If more than one client is served with a single transport, document each pick-up point, destination, number of air miles. The miles associated with the trip must be divided equally by the number of clients transported. Modifier GM is required to indicate multiple patients on one ambulance trip.
- For ground ambulance only, if the provider makes a second or third transport for the same client during the same 24-hour period, the client's file must document or the billing must indicate that it is a second or third transport, with appropriate pick-up and destination modifiers.
- For ground ambulance when more than one client is transported on the same trip, no mileage charge is payable for the additional client(s).

How do I bill for clients eligible for Medicare and Medicaid?

If a client is eligible for both Medicare and Medical Assistance, **you must first submit a claim to Medicare and accept assignment within Medicare's time limitations.** HRSA may make an additional payment after Medicare reimburses you.

- If Medicare pays the claim, the provider must bill HRSA within six months of the date Medicare processes the claims.
- If Medicare denies payment of the claim, HRSA requires the provider to meet HRSA's initial 365-day requirement for initial claims.

Medicare Part A

Medicare Part A is a health insurance program for:

- Individuals who are 65 years of age and older;
- Certain individuals with disabilities (under 65 years of age); or
- Individuals with End-Stage Renal Disease (permanent kidney failure requiring dialysis or transplant).

Medicare Part A helps individuals pay for hospital stays, skilled nursing facilities, hospice and some home health care. Check the client's red, white and blue Medicare card for the words "Part A (hospital insurance)" in the lower left corner of the card to determine if they have Medicare Part A coverage. Under Part A, Medicare will pay its allowed charges, minus any deductible and/or coinsurance, when appropriate.

Medicare Part B

Benefits covered under Part B include: **Physician, outpatient hospital services, home health, durable medical equipment, and other medical services and supplies** not covered under Part A.

When the words *"This information is being sent to either a private insurer or Medicaid fiscal agent"* appear on your Medicare remittance notice, it means that your claim has been forwarded to HRSA or a private insurer for deductible and/or coinsurance processing.

If you have received a payment or denial from Medicare, but it does not appear on your HRSA Remittance and Status Report (RA) within 45 days from Medicare's statement date, you should bill HRSA directly.

- If Medicare has made payment, and there is a balance due from HRSA, you must submit a HCFA-1500 claim form (with the "XO" indicator in field 19). Bill only those lines Medicare paid. Do not submit paid lines with denied lines. This could cause a delay in payment.
- If Medicare denies services, but HRSA covers them, you must bill on a HCFA-1500 claim form (without the "XO" indicator in field 19). Bill only those lines Medicare denied. Do not submit denied lines with paid lines. This could cause a delay in payment.

Note: Medicare/Medical Assistance billing claims must be received by HRSA within 6 months of the Medicare EOMB paid date.

Note: A Medicare Remittance Notice or EOMB must be attached to each claim.

Payment Methodology – Part B

- MMIS compares HRSA's allowed amount to Medicare's allowed amount and selects the lesser of the two. (If there is no HRSA allowed amount, HRSA uses Medicare's allowed amount.)
- Medicare's payment is deducted from the amount selected above.

- If there is *no* balance due, the claim is denied because Medicare's payment exceeds HRSA's allowable.
- If there *is* a balance due, payment is made towards the deductible and/or coinsurance up to HRSA's maximum allowable.

HRSA cannot make direct payments to clients to cover the deductible and/or coinsurance amount of Part B Medicare. HRSA *can* pay these costs to the provider on behalf of the client when:

- 1) The provider **accepts** assignment; and
- 2) The total combined reimbursement to the provider from Medicare and Medicaid does not exceed Medicare or Medicaid's allowed amount, whichever is less.

Third-Party Liability

You must bill the insurance carrier(s) indicated on the client's Medical ID card. An insurance carrier's time limit for claim submissions may be different from HRSA's. It is your responsibility to meet the insurance carrier's requirements relating to billing time limits, as well as HRSA's, prior to any payment by HRSA.

You must meet HRSA's 365-day billing time limit even if you have not received notification of action from the insurance carrier. If your claim is denied due to any existing third-party liability, refer to the corresponding HRSA Remittance and Status Report for insurance information appropriate for the date of service.

If you receive an insurance payment and the carrier pays you less than the maximum amount allowed by HRSA, or if you have reason to believe that HRSA may make an additional payment:

- Submit a completed claim form to HRSA;
- Attach the insurance carrier's statement or EOB;
- If rebilling, also attach a copy of the HRSA Remittance and Status Report showing the previous denial; or
- If you are rebilling electronically, list the claim number (ICN) of the previous denial in the Comments field of the Electronic Media Claim (EMC).

Third-party carrier codes are available on HRSA's website at <http://maa.dshs.wa.gov> or by calling the Coordination of Benefits Section at 800.562.6136.

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Completing the 1500 Claim Form

Attention! HRSA now accepts the new 1500 Claim Form.

- **On November 1, 2006**, HRSA began accepting the new 1500 Claim Form (version 08/05).
- **As of April 1, 2007**, HRSA will no longer accept the old HCFA-1500 Claim Form.

Note: HRSA encourages providers to make use of electronic billing options.
For information about electronic billing, refer to the *Important Contacts* section.

Refer to HRSA's current *General Information Booklet* for instructions on completing the 1500 claim form. You may download this booklet from HRSA's website at: <http://maa.dshs.wa.gov/download/Billing%20Instructions%20Web%20Pages/General%20Information.html> or request a paper copy from the Department of Printing (see Important Contacts section).

The following 1500 claim form instructions relate to **Ambulance and ITA Transportation Billing Instructions**. Click the link above to view general 1500 claim form instructions.

For questions regarding claims information, call HRSA toll-free:

800.562.3022

1500 Claim Form Field Descriptions

| Field No. | Name | Field Required | Entry |
|-----------|--------------------|----------------|--|
| 1a. | Insured's I.D. No. | Yes | Enter the HRSA Patient (client) Identification Code (PIC) – an alphanumeric code assigned to each HRSA client - exactly as shown on the client's Medical ID card. This information consists of the client's: a) First and middle initials (a dash [-] <i>must</i> be used if the middle initial is not available). b) Six-digit birthdate, consisting of <i>numerals only</i> (MMDDYY). c) First five letters of the last name. If there are fewer than five letters in the last name, leave spaces for the remainder before adding the tiebreaker. d) An alpha or numeric character (tiebreaker). |

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| Field No. | Name | Field Required | Entry |
|-------------|-------------------------------|-----------------|--|
| | | | <p><i>For example:</i></p> <ol style="list-style-type: none"> 1. Mary C. Johnson's PIC looks like this: MC010667JOHNSB. 2. John Lee's PIC needs two spaces to make up the last name, does not have a middle initial and looks like this: J-100257LEE B. <p>Note: Use the PIC code of either parent if a newborn has not been issued a PIC. Enter a B in <i>field 19</i> to indicate the baby is on a parent's PIC.</p> |
| 19. | Reserved For Local Use | When applicable | <p>Enter indicator B to indicate <i>Baby on Parent's PIC</i>.</p> <p>Medicare/Medicaid Eligible Clients: Also when applicable, enter <i>nonemergent</i> here when you are billing for a nonemergency service provided to a client whose physical condition was such that the use of any other transportation method was inadvisable.</p> <p>ITA Transportation: For ITA transports this is a required field. Enter "ITA".</p> |
| 24B. | Place of Service | Yes | <p>Enter:</p> <p style="margin-left: 40px;">41 Ambulance, land 42 Ambulance, air 99 ITA transport</p> |
| 24C. | Type of Service | No | |
| 24E | Diagnosis Code: | Yes | <p>Ambulance Services: Enter the ICD-9-CM diagnosis code or V68.9. When code V68.9 is used, written justification noting condition requiring level of service is necessary (enter in <i>field 21</i>).</p> |
| | | Yes | <p>ITA Transports: Enter the ICD-9-CM diagnosis code or V40.9.</p> |

How to Obtain DSHS Form 13-628

To download DSHS forms, visit:

<http://www1.dshs.wa.gov/msa/forms/eforms.html>

**Ambulance and
ITA Transportation**

To **have a hard copy sent** to you, visit:
<http://www.prt.wa.gov/> and click on *General Store*.

Completing the 1500 Claim Form for Medicare Part B/Medicaid Crossovers

The 1500 Claim Form (U2) (12-90) (Health Insurance Claim Form) is a universal claim form used by many agencies nationwide; a number of the fields on the form do not apply when billing the Health and Recovery Services Administration (HRSA). Some field titles may not reflect their usage for this claim type. The numbered boxes on the claim form are referred to as fields.

The 1500 Claim Form used for Medicare/Medicaid Benefits Coordination, *cannot* be billed electronically.

General Instructions

- Please use an original, red and white 1500 Claim Form (U2) (12-90) claim form.
- Enter only one (1) procedure code per detail line (field 24A-24K). If you need to bill more than 6 lines per claim, please complete an additional 1500 Claim Form.
- You must enter all information within the space allowed.
- Use upper case (capital letters) for all alpha characters.
- Do not write, print, or staple any attachments in the bar area at the top of the form.

| Field No. | Name | Field Required | Entry |
|-----------|---------------------------|----------------|--|
| 1a. | Insured's I.D. No. | Yes | <p>Enter the HRSA Patient Identification Code (PIC) - an alphanumeric code assigned to each Medical Assistance client - exactly as shown on the Medical ID card. This information consists of the client's:</p> <ul style="list-style-type: none"> a) First and middle initials (a dash [-] <i>must</i> be used if the middle initial is not available). b) Six-digit birthdate, consisting of <i>numerals only</i> (MMDDYY). c) First five letters of the last name. If there are fewer than five letters in the last name, leave spaces for the remainder before adding the tiebreaker. d) An alpha or numeric character (tiebreaker). |

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ITA Transportation**

| Field No. | Name | Field Required | Entry |
|-----------|---|-----------------|---|
| | | | (Continued next page) <i>For example:</i> 1. Mary C. Johnson's PIC looks like this: C010633JOHNSB. 2. John Lee's PIC needs two spaces to make up the last name, does not have a middle initial and looks like this: J-100226LEE B. |
| 2. | Patient's Name | Yes | Enter the last name, first name, and middle initial of the HRSA client (the receiver of the services for which you are billing). |
| 3. | Patient's Birthdate | Yes | Enter the birthdate of the HRSA client. Sex: Check M (male) or F (female). |
| 4. | Insured's Name (Last Name, First Name, Middle Initial) | When applicable | If the client has health insurance through employment or another source (e.g., private insurance, Federal Health Insurance Benefits, CHAMPUS, or CHAMPVA), list the name of the insured here. Enter the name of the insured except when the insured and the client are the same - then the word <i>Same</i> may be entered. |
| 5. | Patient's Address | Yes | Enter the address of the HRSA client who has received the services you are billing for (the person whose name is in <i>field 2</i>). |
| 9. | Other Insured's Name | | Secondary insurance. When applicable, enter the last name, first name, and middle initial of the insured. If the client has insurance secondary to the insurance listed in <i>field 11</i> , enter it here. |
| 9a. | | | Enter the other insured's policy or group number <i>and</i> his/her Social Security Number. |
| 9b. | | | Enter the other insured's date of birth. |
| 9c. | | | Enter the other insured's employer's name or school name. |
| 9d. | | | Enter the insurance plan name or the program name (e.g., the insured's health maintenance organization, or private supplementary insurance). |
| | | | Please note: DSHS, Welfare, Provider Services, Healthy Kids, First Steps, Medicare, Indian Health, PCCM, Healthy Options, PCOP, etc., are inappropriate entries for this field. |

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| Field No. | Name | Field Required | Entry |
|-----------|---|-----------------|---|
| 10. | Is Patient's Condition Related to | Yes | Check <i>yes</i> or <i>no</i> to indicate whether employment, auto accident or other accident involvement applies to one or more of the services described in <i>field 24</i> . Indicate the name of the coverage source in field 10d (L&I, name of insurance company, etc.). |
| 11. | Insured's Policy Group or FECA (Federal Employees Compensation Act) Number | When applicable | Primary insurance. This information applies to the insured person listed in <i>field 4</i> . Enter the insured's policy and/or group number and his/her social security number. The data in this field will indicate that the client has other insurance coverage and HRSA pays as payor of last resort. |
| 11a. | Insured's Date of Birth | When applicable | Primary insurance. Enter the insured's birthdate, if different from <i>field 3</i> . |
| 11b. | Employer's Name or School Name | When applicable | Primary insurance Enter the insured's employer's name or school name. |
| 11c. | Insurance Plan Name or Program Name | When applicable | Primary insurance. Show the insurance plan or program name to identify the primary insurance involved. (<i>Note: This may or may not be associated with a group plan.</i>) |
| 11d. | Is There Another Health Benefit Plan? | Yes | Required if the client has secondary insurance. Indicate <i>yes</i> or <i>no</i> . If yes, you should have completed <i>fields 9a.-d</i> . If the client has insurance, and even if you know the insurance will not cover the service you are billing, you must check <i>yes</i> . If 11d. is left blank, the claim may be processed and denied in error. |
| 19. | Reserved For Local Use | Yes | When Medicare allows services, enter <i>XO</i> to indicate this is a crossover claim. |
| 22. | Medicaid Resubmission | When applicable | If this billing is being resubmitted more than 6 months from Medicare's paid date, enter the Internal Control Number (ICN) that verifies that your claim was originally submitted within the time limit. (The ICN number is the <i>claim number</i> listed on the Remittance and Status Report.) Also enter the three-digit denial Explanation of Benefits (EOB). |
| 24. | | | Enter only 1 procedure code per detail line (fields 24A – 24K). If you need to bill more than 6 lines per claim, please use an additional 1500 Claim Form. |
| 24A. | Date(s) of Service | Yes | Enter the "from" and "to" dates using all six digits for each date. Enter the month, day, and year of service |

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| Field No. | Name | Field Required | Entry |
|-----------|---|----------------|---|
| | | | numerically (e.g., March 4, 2005 = 030405). |
| 24B. | Place of Service | Yes | Enter: 41 Ambulance, land 42 Ambulance, air |
| 24C. | Type of Service | No | |
| 24D. | Procedures, Services or Supplies HCPCS/Modifier | Yes | Coinsurance and Deductible: Enter the total combined and deductible for each service in the space to the right of the modifier on each detail line. |
| 24E. | Diagnosis Code | Yes | Enter the ICD-9-CM diagnosis code or V68.9. When code V68.9 is used, written justification noting condition requiring level of service is necessary (enter in <i>field 21</i>). |
| 24F. | \$ Charges | Yes | Enter the amount you billed Medicare for the service performed. If more than one unit is being billed, the charge shown must be for the total of the units billed. Do not include dollar signs or decimals in this field. Do not add sales tax. |
| 24G. | Days or Units | Yes | Multiple units valid only on Mileage and Waiting Time codes. For all other codes enter a "1". |
| 24K. | Reserved for Local Use | Yes | Use this field to show Medicare's allowed charges. Enter the Medicare's allowed charge on each detail line of the claim (see sample). |
| 26. | Your Patient's Account No. | No | Enter an alphanumeric ID number, for example, a medical record number or patient account number. This number will be printed on your Remittance and Status Report under the heading Patient Account Number. |
| 27. | Accept Assignment | Yes | Check yes . |
| 28. | Total Charge | Yes | Enter the sum of your charges. Do not use dollar signs or decimals in this field. |
| 29. | Amount Paid | Yes | Enter the Medicare Deductible here. Enter the amount as shown on Medicare's Remittance Notice and Explanation of Benefits. If you have more than 6 detail lines to submit, please use multiple HCFA-1500 claim forms (<i>see field 24</i>) and calculate the deductible based on the lines on each form. Do not include coinsurance here. |
| 30. | Balance Due | Yes | Enter the Medicare Total Payment . Enter the amount as shown on Medicare's Remittance Notice or Explanation |

**Ambulance and
ITA Transportation**

| Field No. | Name | Field Required | Entry |
|-----------|---|----------------|---|
| | | | of Benefits. If you have more than 6 detail lines to submit, please use multiple HCFA claim forms (see <i>field 24</i>) and calculate the Medicare payment based on the lines on each form. Do not include coinsurance here. |
| 32. | Name and Address of Facility Where Services Are Rendered | Yes | Enter Medicare Statement Date <i>and</i> any Third-Party Liability Dollar Amount (e.g., auto, employee-sponsored, supplemental insurance) here, if any. If there is insurance payment on the claim, you must also attach the insurance Explanation of Benefits (EOB). Do not include coinsurance here. |
| 33. | Billing Name, Address, Zip Code, and Telephone # | Yes | Enter the provider's <i>Name, Address, and Telephone #</i> on all claim forms. Group: Enter your seven-digit provider number as assigned to you by HRSA. |

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