Washington State Health Care Authority

Washington Apple Health (Medicaid)

Ambulance and ITA Transportation Billing Guide

October 1, 2016

Every effort has been made to ensure this guide's accuracy. If an actual or apparent conflict between this document and an agency rule arises, the agency rules apply.

About this guide*

This publication takes effect October 1, 2016, and supersedes earlier guides to this program.

HCA is committed to providing equal access to our services. If you need an accommodation or require documents in another format, please call 1-800-562-3022. People who have hearing or speech disabilities, please call 711 for relay services.

Washington Apple Health means the public health insurance programs for eligible Washington residents. Washington Apple Health is the name used in Washington State for Medicaid, the children's health insurance program (CHIP), and state-only funded health care programs. Washington Apple Health is administered by the Washington State Health Care Authority.

This guide is designed to help ambulance providers and their staff to understand agency regulations and requirements necessary for reporting accurate and complete claim information for ambulance transportation and transportation under the Involuntary Treatment Act (ITA).

* This publication is a billing instruction.

What has changed?

Subject	Change	Reason for Change
Billing and Claim Forms	Effective October 1, 2016, all claims must be submitted electronically to the agency.	Policy change to improve efficiency in processing claims
Documenting services billed/provided	Trip reports / run sheets are now required as supporting documentation	Program update
Payment for mileage	The agency pays ground mileage to providers for every loaded mile traveled while on ferry. To receive payment, providers must attach the ferry route documentation along with their trip report/run sheet and claim.	Clarification
When does the agency pay for ambulance services provided to qualified Medicare beneficiaries?	If Medicare does not cover or denies an ambulance service that the agency covers, the agency pays for that service, unless the client has QMB-only, SLMB, QI-1, or QDWI eligibility. The agency does not pay for ambulance services for clients in the QMB-only, SLMB, QI-1, or QDWI programs.	Clarification
How do providers complete the UB-04 claim form?	Updated information in blue box.	Clarification

How can I get agency provider documents?

To access provider alerts, go to the agency's provider alerts web page.

To access provider documents, go to the agency's provider billing guides and fee schedules web page.

Copyright disclosure

Current Procedural Terminology (CPT) copyright 2015 American Medical Association (AMA). All rights reserved. CPT is a registered trademark of the American Medical Association.

Fee schedules, relative value units, conversion factors and/or related components are not assigned by the AMA, are not part of CPT, and the AMA is not recommending their use. The AMA does not directly or indirectly practice medicine or dispense medical services. The AMA assumes no liability for data contained or not contained herein.

Table of Contents

Documenting services billed/provided 3
How do providers complete the UB-04 claim form? 3

Important Changes to Apple Health Effective April 1, 2016 10

New MCO enrollment policy – earlier enrollment 10
How does this policy affect providers? 11
Behavioral Health Organization (BHO) 11
Fully Integrated Managed Care (FIMC) 11
Apple Health Core Connections (AHCC) 12
AHCC complex mental health and substance use disorder services 13
Contact Information for Southwest Washington 13

Resources Available 14

Definitions 15

About the Program 19

What is the ambulance transportation program? 19
When does the agency pay for ambulance transportation? 20
What are the guidelines for emergency medical transportation? 20
What about scheduled or "brokered" (nonemergency) medical transportation? 21

Client Eligibility 22

What ambulance services are clients in fee-for-service programs eligible for? 22
How can I verify a patient's eligibility? 22
What ambulance services are clients enrolled in an agency-contracted managed care organization (MCO) eligible for? 23
What ambulance services are clients enrolled in Primary Care Case Management (PCCM) eligible for? 25
What ambulance services are clients under the Involuntary Treatment Act (ITA) eligible for? 25
Who is responsible for payment of ambulance services for incarcerated people? 26

Provider Responsibilities 27

What are the general requirements for ambulance providers? 27
Licensing 27
Staffing/training 27
Verifying client eligibility 27
Billing in a timely manner 27
Documenting services billed/provided 28
Record keeping and retention 29
Reporting material changes in provider status 29
Knowing health care resources in service area 30

Coverage **31**
What ambulance services does the agency cover? 31
When ambulance transportation services are covered? 31
When does the agency pay for nonemergency ground ambulance services? 32
When are ambulance services *not* separately payable? 32
Transporting an inpatient client to and from other diagnostic or treatment facilities 33
When does the agency not pay for ambulance services? 33
What are examples of noncovered ambulance services? 34
"Treat but no transport" service calls 34
ALS assessment only, no transport 35
Back door to front door transports (or vice versa) within the same hospital complex 35
Some nonemergency hospital transfers 35
What ambulance coverage is available for interfacility transfers? 35
Transfer to a higher level of care 35
Transfer to an equivalent or lower level of care 36
Is out-of-state ambulance transportation covered? 37
Is out-of-country ambulance transportation covered? 37
What if a client has third-party coverage for ambulance transportation? 38
Frequently asked questions (FAQ) about ambulance transportation coverage 38
Does the agency pay for ambulance transportation home? 38
Does the agency pay for ambulance transportation to a kidney dialysis center? 39
Does the agency pay for ambulance transportation to a free-standing emergency department? 39
Does the agency pay for nonemergency ambulance transportation to a physician's office? 39
Does the agency pay for ambulance transportation resulting from a 911 or emergency call center request? 40
Does the agency pay for ambulance transportation to an urgent care/24-hour walk-in clinic? 40
Does the agency pay for ambulance transportation based on a patient's expressed preference to be transported by ambulance? 40

Coverage Table **41**
Air ambulance 41
Ground ambulance 42

Authorization **44**
What requires prior authorization (PA)? 44
Who can authorize ambulance services? 44
What form(s) should be used to request PA? 45
When is *Non-Emergency Transfer Request* form, HCA 13-950, required? 45
When is the *Out-of-State Medical Services request* form, HCA 13-787 and companion *General Information for Authorization* form, HCA 13-835, required? 46
When is the *Involuntary Treatment Act (ITA)* form, HCA 14-002 required? 47
When is a physician certification statement (PCS) appropriate to use? 47

Who can sign a PCS? 48
What must a PCS include? 48

Reimbursement 49

What are the general limitations on ambulance payment? 49
What is the importance of origin and destination modifiers? 50
Origin/Destination Modifiers 51
Other Modifiers 52
When does the agency pay for air ambulance services? 53
Payable circumstances for air ambulance services 53
Prior authorization (PA) requirement for nonemergency air ambulance transportation 53
Components of air ambulance payment 54
Special circumstances involving air ambulance transportation 54
When does the agency pay for ground ambulance services? 56
Levels of ground ambulance service 56
Factors affecting ALS or BLS classification 57
Payment for ground ambulance base rate 58
Payment for mileage 58
Payment for extra attendant 59
Payment for ferry and bridge tolls 59
Payment for waiting time 59
Payment in special circumstances involving ground ambulance transportation 60
When does the agency pay for out-of-state emergency ambulance services? 62
When does the agency pay for prior authorized ambulance services to or from and out-of-state facilities? 62
When does the agency pay for ambulance services provided to qualified Medicare beneficiaries? 63
When does the agency pay for ambulance transportation of qualified trauma cases? 63
When does the agency pay for ITA transportation? 64
ITA transportation - general 64
ITA ambulance transportation 64
ITA non-ambulance transportation 64
Where is the ambulance fee schedule? 65

Ambulance Services Provided Out-of-State 66

Does the agency cover emergency ambulance transportation provided out-of-state? 66
Does the agency coordinate benefits for ambulance services provided out-of-state? 66
Does the agency authorize nonemergency air ambulance transportation to out-of-state treatment facilities? 67
Does the agency authorize nonemergency air ambulance transportation from out-of-state to in-state treatment facilities? 68
What does the agency pay for nonemergency air ambulance transportation to or from out-of-state treatment facilities? 69
Does the agency pay for out-of-country ambulance services? 69

Involuntary Treatment Act Transportation 70

What is the involuntary treatment act (ITA)? 70
Who is eligible for ITA services? 70
Who decides what transportation is necessary under ITA? 71
Who pays for ITA services? 72
Who pays for ITA transportation of managed care enrollees? 72
When are transportation services covered under ITA? 73
When are transportation services not covered under ITA? 73
Who pays for transportation to and from court hearings? 74
What is the children's long term inpatient program (CLIP)? 74
What is the parent initiated treatment (PIT) program? 75
Laws pertaining to PIT: 75
Are non-ambulance providers eligible to receive payment for ITA transportation services? 76
What are the requirements for non-ambulance ITA transportation providers? 76
Vehicle standards and maintenance 76
Driver requirements 77
Driver training 77

Transportation for Involuntary Substance Use Disorder Treatment 78

What is the Ricky Garcia Act? 78
Who is eligible for substance use disorder services? 78
Who decides what transportation is necessary under the Ricky Garcia Act? 79
Who authorizes and pays for substance use disorder services? 80
Who pays for substance use disorder transportation of managed care enrollees? 80
When are transportation services covered under the Ricky Garcia Act? 81
When are transportation services not covered under the Ricky Garcia Act? 81
Who pays for transportation to and from court hearings? 82

Audits 83

Post-payment reviews 83
Recoupment of improper payments 83
Quality of care audits and reviews 84

Billing and Claim Forms 85

How can I submit ITA claims electronically? 85
ITA electronic claims 3-step process: 85
86
How do providers bill for mileage? 87
How do providers complete the UB-04 claim form? 88
How do providers submit institutional services on a UB-04 crossover claim? 88
What is required from the provider-generated EOMB when processing a crossover claim? 89

How do providers submit institutional services on a UB-04 claim for inpatient clients eligible for Medicare Part B but not eligible for Medicare Part A, or for clients whose Medicare Part A is exhausted? 89

Important Changes to Apple Health Effective April 1, 2016

These changes are important to all providers because they may affect who will pay for services.

Providers serving any Apple Health client should always check eligibility and confirm plan enrollment by asking to see the client's Services Card and/or using the ProviderOne Managed Care Benefit Information Inquiry functionality (HIPAA transaction 270). The response (HIPAA transaction 271) will provide the current managed care organization (MCO), fee-for-service, and Behavioral Health Organization (BHO) information. See the Southwest Washington Provider Fact Sheet on the agency's Early Adopter Region Resources web page.

New MCO enrollment policy – earlier enrollment

Beginning April 1, 2016, Washington Apple Health (Medicaid) implemented a new managed care enrollment policy placing clients into an agency-contracted MCO **the same month** they are determined eligible for managed care as a new or renewing client. This policy eliminates a person being placed temporarily in fee-for-service while they are waiting to be enrolled in an MCO or reconnected with a prior MCO.

- **New clients** are those initially applying for benefits or those with changes in their existing eligibility program that consequently make them eligible for Apple Health Managed Care.

- **Renewing clients** are those who have been enrolled with an MCO but have had a break in enrollment and have subsequently renewed their eligibility.

Clients currently in fee-for-service or currently enrolled in an MCO are not affected by this change. Clients in fee-for-service who have a change in the program they are eligible for may be enrolled into Apple Health Managed Care depending on the program. In those cases, this enrollment policy will apply.

How does this policy affect providers?

- Providers must check eligibility and know when a client is enrolled and with which MCO. For help with enrolling, clients can refer to the Washington Healthplanfinder's **Get Help Enrolling** page.

- MCOs have retroactive authorization and notification policies in place. The provider must know the MCO's requirements and be compliant with the MCO's new policies.

Behavioral Health Organization (BHO)

The Department of Social and Health Services (DSHS) manages the contracts for behavioral health (mental health and substance use disorder (SUD)) services for nine of the Regional Service Areas (RSA) in the state, excluding Clark and Skamania counties in the Southwest Washington (SW WA) Region. BHOs will replace the Regional Support Networks (RSNs). Inpatient mental health services continue to be provided as described in the inpatient section of the Mental Health Services Billing Guide. BHOs use the Access to Care Standards (ACS) for mental health conditions and American Society of Addiction Medicine (ASAM) criteria for SUD conditions to determine client's appropriateness for this level of care.

Fully Integrated Managed Care (FIMC)

Clark and Skamania Counties, also known as SW WA region, is the first region in Washington State to implement the FIMC system. This means that physical health services, all levels of mental health services, and drug and alcohol treatment are coordinated through one managed care plan. Neither the RSN nor the BHO will provide behavioral health services in these counties.

Clients must choose to enroll in either Community Health Plan of Washington (CHPW) or Molina Healthcare of Washington (MHW). If they do not choose, they are auto-enrolled into one of the two plans. Each plan is responsible for providing integrated services that include inpatient and outpatient behavioral health services, including all SUD services, inpatient mental health and all levels of outpatient mental health services, as well as providing its own provider credentialing, prior authorization requirements and billing requirements.

Beacon Health Options provides mental health crisis services to the entire population in Southwest Washington. This includes inpatient mental health services that fall under the Involuntary Treatment Act for individuals who are not eligible for or enrolled in Medicaid, and short-term substance use disorder (SUD) crisis services in the SW WA region. Within their available funding, Beacon has the discretion to provide outpatient or voluntary inpatient mental health services for individuals who are not eligible for Medicaid. Beacon Health Options is also

responsible for managing voluntary psychiatric inpatient hospital admissions for non-Medicaid clients.

In the SW WA region some clients are not enrolled in CHPW or Molina for FIMC, but will remain in Apple Health fee-for-service managed by the agency. These clients include:

- Dual eligible – Medicare/Medicaid
- American Indian/Alaska Native (AI/AN)
- Medically needy
- Clients who have met their spenddown
- Noncitizen pregnant women
- Individuals in Institutions for Mental Diseases (IMD)
- Long-term care residents who are currently in fee-for-service
- Clients who have coverage with another carrier

Since there is no BHO (RSN) in these counties, Medicaid fee-for-service clients receive complex behavioral health services through the Behavioral Health Services Only (BHSO) program managed by MHW and CHPW in SW WA region. These clients choose from CHPW or MHW for behavioral health services offered with the BHSO or will be auto-enrolled into one of the two plans. A BHSO fact sheet is available online.

Apple Health Core Connections (AHCC)

Coordinated Care of Washington (CCW) will provide all physical health care (medical) benefits, lower-intensity outpatient mental health benefits, and care coordination for all Washington State foster care enrollees. These clients include:

- Children and youth under the age of 21 who are in foster care
- Children and youth under the age of 21 who are receiving adoption support
- Young adults age 18 to 26 years old who age out of foster care on or after their 18th birthday

American Indian/Alaska Native (AI/AN) children will **not** be auto-enrolled, but may opt into CCW. All other eligible clients will be auto-enrolled.

AHCC complex mental health and substance use disorder services

AHCC clients who **live in** Skamania or Clark County receive complex behavioral health benefits through the Behavioral Health Services Only (BHSO) program in the SW WA region. These clients will choose between CHPW or MHW for behavioral health services, or they will be auto-enrolled into one of the two plans. CHPW and MHW will use the BHO Access to Care Standards to support determining appropriate level of care, and whether the services should be provided by the BHSO program or CCW.

AHCC clients who **live outside** Skamania or Clark County will receive complex mental health and substance use disorder services from the BHO and managed by DSHS.

Contact Information for Southwest Washington

Beginning on April 1, 2016, there will not be an RSN/BHO in Clark and Skamania counties. Providers and clients must call the agency-contracted MCO for questions, or call Beacon Health Options for questions related to an individual who is not eligible for or enrolled in Medicaid.

If a provider does not know which MCO a client is enrolled in, this information can located by looking up the patient assignment in ProviderOne.

To contact Molina, Community Health Plan of Washington, or Beacon Health Options, please call:

MOLINA HEALTHCARE	Molina Healthcare of Washington, Inc. 1-800-869-7165

COMMUNITY HEALTH PLAN of Washington	Community Health Plan of Washington 1-866-418-1009

Beacon Health Options	Beacon Health Options 1-855-228-6502

Resources Available

Topic	Resource Information
Becoming a provider or submitting a change of address or ownership	See the agency's Billers and Providers page.
Finding out about payments, denials, claims processing, or agency managed care organizations	
Electronic or paper billing	
Finding agency documents (e.g., billing guides, provider notices, and fee schedules)	
Private insurance or third-party liability, other than agency managed care	
How do I request prior authorization, a limitation extension, or an exception to rule?	
Where can I find provider information on nonemergency brokered transportation?	
How do I obtain the following forms? HCA 13-822, HCA 13-950, HCA 13-787, HCA 13-835, HCA 14-002	Visit the agency's forms web page.

Definitions

This section defines terms and abbreviations, including acronyms, used in this billing guide. Refer to Chapter 182-500 WAC for a complete list of definitions for Washington Apple Health.

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 requires advanced medical skills to perform invasive emergency treatment services, if needed.

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 an ambulance transport or a determination that the client requires an ALS level of ambulance transportation.

Advanced life support intervention – A procedure that is beyond the scope of care of an emergency medical technician (EMT) but may be provided by a paramedic.

Aid vehicle – A vehicle used to carry aid equipment and individuals trained in first aid or medical procedures.

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.

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. An ambulance must be licensed per RCW 18.73.140.

Approved Medical Program Director - A person who:

- Is licensed to practice medicine and surgery under chapter 18.71 RCW, or osteopathic medicine and surgery under chapter 18.57 RCW.
- Is qualified and knowledgeable in the administration and management of emergency care and services.
- Is so certified by the Department of Health for a county, a 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)]

Authorization number – A nine-digit number assigned by the agency to identify individual requests for services or equipment. The same authorization number is used throughout the history of a request, whether the request is approved, pended, or denied by the agency.

Base rate - The agency'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. For air ambulances, the base rate is the lift-off fee.

Basic life support (BLS) - The level of care that justifies use of ambulance transportation but requires only basic medical treatment skills from the ambulance crew. BLS does not require the ability to provide or deliver invasive medical procedures/services.

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

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

Bordering city hospital – A licensed hospital in a designated bordering city (see WAC 182-501-0175 for a list of bordering cities).

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

Commitment – A determination by a court that a person should be detained for a period of evaluation, treatment, or both, in an inpatient or less restrictive setting. (This definition is specific to the Involuntary Treatment Act (ITA) Transportation.)

Designated Mental Health Professional (DMHP) – A mental health professional designated by one or more counties to perform the functions of a DMHP described in the Involuntary Treatment Act (ITA), chapters 71.05 RCW (adults) and 71.34 RCW (minors). A DMHP, 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 DMHP has the individual transported by local police, sheriff, or ambulance. (Specific to Involuntary Treatment Act (ITA) Transportation.)

Destination – see "point of destination."

Detention – The lawful confinement of a person whose involuntary status resulted from a DMHP petition for initial detention or revocation of conditional release under the provisions of chapter 71.05 RCW or chapter 71.34 RCW. (Specific to Involuntary Treatment Act (ITA) Transportation.)

Division of Behavioral Health and Recovery (DBHR) – The Division of Behavioral Health and Recovery (DBHR) with the Department of Social and Health Services that provides support for Mental Health, Chemical Dependency, and Problem Gambling Services. (Specific to Involuntary Treatment Act (ITA) Transportation

Emergency medical service - Medical treatment and care which may be rendered at the scene of any medical emergency or while transporting a client in an ambulance to an appropriate medical facility.

Emergency medical transportation – Ambulance transportation during which a client receives needed emergency medical services en route to an appropriate medical facility; It includes ambulance transportation between medical facilities.

Evaluation and treatment facility – A public or private facility or unit that is certified by the Department of Social and Health Services (DSHS) to provide emergency, inpatient, residential, or outpatient mental health evaluation and treatment services to persons suffering from a mental disorder. (Specific to Involuntary Treatment Act (ITA) Transportation.)

Ground ambulance - A ground vehicle, including a water ambulance, designed and used to transport the ill and injured to a treatment facility, and to provide personnel, facilities, and equipment to treat clients before and during transportation.

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.

Lift-off fee - Either of the two base rates the agency pays to air ambulance providers for transporting a client. The agency establishes separate lift-off fees for helicopters and airplanes.

Loaded mileage – The number of miles the client is transported in the ambulance vehicle.

Medical control – The medical authority upon whom an ambulance provider relies to coordinate prehospital emergency services, triage, and/or trauma center assignment/ destination when transporting a patient. 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.

Nonemergency ambulance transportation – The use of an ambulance to transport a client who may be confined to a stretcher but likely will not require the provision of emergency medical services en route. Nonemergency ambulance transportation typically involves ground ambulance but may involve air ambulance. Nonemergency ambulance transportation is scheduled or prearranged. See also "Prone or Supine Transportation" and "Scheduled Transportation".

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.
  - ✓ Perform endotracheal airway management and other authorized aids to ventilation.

- 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.

Physician Certification Statement (PCS) – A statement or form signed by a client's attending physician or other authorized designee certifying that the client's use of non-emergency ground ambulance services is medically necessary.

Point of destination – A facility generally equipped to provide the needed medical or nursing care for the injury, illness, symptoms, or complaint involved.

Point of pick-up – The location from which a client is picked up or placed on board the ambulance or transport vehicle.

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

Records – Dated reports supporting claims submitted to the agency 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.

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 a paramedic. [WAC 182-546-0001]

Transportation broker – A person or organization contracted by the agency to arrange, coordinate and manage the provision of necessary but non-emergency transportation services for eligible clients to and from covered medical services.

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.

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.

About the Program

What is the ambulance transportation program?

(WAC 182-546-0100)

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 a provider of agency-covered services that is closest and most appropriate to meet a client's medical need.

The agency covers the following two types of ambulance transportation:

- Air Ambulance – emergency medical transportation by air
- Ground Ambulance – transportation by ground or water ambulance for the following purposes:
  - ✓ Emergency medical transportation
  - ✓ Nonemergency medical transportation to agency-covered medical services when the client requires one of the following:
    - ➢ Must be transported by stretcher or gurney for medical or safety reasons*
    - ➢ Must have medical attention from trained medical personnel available en route

  Ground ambulance services include the following:

  - ✓ Basic Life Support (BLS)
  - ✓ Advanced Life Support (ALS)
  - ✓ Specialty Care Transport (SCT)

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

When does the agency pay for ambulance transportation?

(WAC 182-546-0200)

The agency pays for ambulance transportation services only when the client's condition makes ambulance transport medically necessary. Medical necessity must be documented in the client's record (see WAC 182-500-0070).

If a client can safely travel by car, van, taxi, or other means, transport by ambulance is not medically necessary and ambulance service is not covered by the agency.

What are the guidelines for emergency medical transportation?

In Washington State, all of the following are determined by certified emergency medical system (EMS) and trauma personnel, in conjunction with their regional Medical Control:

- The type of emergency transportation (e.g., air or ground)
- The mode of emergency transportation (e.g., ALS or BLS)
- The urgency of transport (emergency or nonemergency)
- The destination decision

> **Exception:** Transportation decisions under the Involuntary Treatment Act (ITA) are made by designated mental health professionals (DMHPs) and, in some cases, the clients attending physician.

These decisions are based on their professional judgment in consultation with emergency room physicians, and EMS Regional Councils. These guidelines are outlined in the following documents:

- State of Washington Prehospital Cardiac Triage (Destination) Procedure brochure
- Triage plans developed and implemented by the regional EMS and trauma care councils
- Client care procedures and protocols developed by the regional councils

What about scheduled or "brokered" (nonemergency) medical transportation?

Nonemergency medical transportation services make up most of the medical transportation the agency pays for.

With few exceptions, nonemergency medical transportation is provided through contracted local transportation brokers who subcontract with providers utilizing vehicles other than ambulances. However, nothing prohibits ambulance providers from entering into contracts with agency-contracted transportation brokers to provide nonemergency services at negotiated rates equal to or less than the agency's published fee schedules.

For more information visit the agency's Transportation Services (Non-Emergency) webpage.

Client Eligibility

(WAC 182-546-0150)

What ambulance services are clients in fee-for-service programs eligible for?

Except for clients in the Family Planning Only and TAKE CHARGE programs, fee-for-service clients are eligible for ambulance transportation to covered services with the following limitations:

- Clients in the following Washington Apple Health programs are eligible for ambulance services only within Washington State and the bordering cities designated in WAC 182-501-0175:

  - ✓ Medical care services as described in WAC 182-508-0005
  - ✓ Alien emergency medical services as described in chapter 182-507 WAC

- Clients in the Washington Apple Health categorically needy/qualified Medicare beneficiary (CN/QMB) and Washington Apple Health medically needy/qualified Medicare beneficiary (MN/QMB) programs are covered by Medicare and Medicaid, with the payment limitations described in WAC 182-546-0400(5).

How can I verify a patient's eligibility?

Providers must verify that a patient has Washington Apple Health coverage for the date of service, and that the client's benefit package covers the applicable service. This helps prevent delivering a service the agency will not pay for.

Verifying eligibility is a two-step process:

Step 1. **Verify the patient's eligibility for Washington Apple Health.** For detailed instructions on verifying a patient's eligibility for Washington Apple Health, see the *Client Eligibility, Benefit Packages, and Coverage Limits* section in the agency's current ProviderOne Billing and Resource Guide

If the patient is eligible for Washington Apple Health, proceed to **Step 2**. If the patient is **not** eligible, see the following note box.

Step 2. **Verify service coverage under the Washington Apple Health client's benefit package.** To determine if the requested service is a covered benefit under the

Washington Apple Health client's benefit package, see the agency's Program Benefit Packages and Scope of Services web page.

Note: Patients who are not Washington Apple Health clients may submit an application for health care coverage in one of the following ways:

1. By visiting the Washington Healthplanfinder's website at: www.wahealthplanfinder.org

2. By calling the Customer Support Center toll-free at: 855-WAFINDER (855-923-4633) or 855-627-9604 (TTY)

3. By mailing the application to:
   Washington Healthplanfinder
   PO Box 946
   Olympia, WA 98507

In-person application assistance is also available. To get information about in-person application assistance available in their area, people may visit www.wahealthplanfinder.org or call the Customer Support Center.

What ambulance services are clients enrolled in an agency-contracted managed care organization (MCO) eligible for?

Ambulance transportation services are covered under agency-contracted managed care organizations (MCOs), subject to each MCO's coverage and limitations. Covered services include, but are not limited to:

- Basic Life Support (BLS) services
- Advanced Life Support (ALS) services
- Specialty Care Transport (SCT)
- An extra attendant (when necessary)
- Other required transportation costs (such as bridge tolls and ferry charge fares).
- Nonemergency ground ambulance services under the following three circumstances only:

  ✓ When it is necessary to transport an enrollee between facilities to receive a contracted service;

  ✓ When it is necessary to transport an enrollee, who must be carried on a stretcher or may require medical attention en route (refer to RCW 18.73.180) to receive a covered service; or

- ✓ When it is medically necessary to transport an enrollee from home to a facility for a medical appointment (in situations when a client is ventilator dependent, bed-confined, or unable to hold a self-upright position, or when it is unsafe for wheelchair transport).

Managed care enrollees are eligible for air ambulance services (rotary or fixed wing aircraft) outside their MCO through fee-for-service.

Clients enrolled in an agency-contracted MCO must obtain:

- Air ambulance services through the agency under fee-for-service, subject to the coverage and limitations within this billing guide.
- Ground ambulance services through their designated MCO, subject to the MCO coverage and limitations.

Exception: Emergency ITA ambulance transportation is covered by the MCO, but authorized by a Designated Mental Health Professional (DMHP).

Contact the client's managed care plan to become familiar with their prior authorization and billing procedures. See Apple Health (managed care) for a list of agency-contracted managed care plans by county.

When verifying eligibility using ProviderOne, if the client is enrolled in an agency-contracted managed care plan, managed care enrollment will be displayed on the client benefit inquiry screen.

What ambulance services are clients enrolled in Primary Care Case Management (PCCM) eligible for?

Clients covered by a primary care case manager (PCCM) are eligible for ambulance services that are emergency medical services, or are services approved by the client's PCCM in accordance with agency requirements.

For a client who has chosen to obtain care with a PCCM provider, eligibility information will be displayed on the client benefit inquiry screen in ProviderOne. These clients must obtain services from, or be referred for services by, a PCCM provider. The PCCM provider is responsible for coordination of care just like the primary care physician (PCP) would be in a plan setting.

The agency pays for covered services for PCCM clients according to the agency's published billing guides and provider notices.

Note: To prevent billing denials, check the client's eligibility prior to scheduling services and at the time the service is provided. Make sure proper authorization or referral is obtained from the managed care plan or PCCM provider. See the agency's ProviderOne Billing and Resource Guide for instructions on how to verify a client's eligibility.

What ambulance services are clients under the Involuntary Treatment Act (ITA) eligible for?

Clients detained under the Involuntary Treatment Act (ITA) are eligible for ambulance transportation coverage only within the borders of the state of Washington. ITA clients are not eligible for ambulance transportation coverage outside the state of Washington.

For ITA purposes, designated bordering cities are outside the state of Washington, even though they are considered in-state for medical purposes. Therefore, ambulance transportation is not covered for individuals living in Washington State who are detained involuntarily for mental health treatment and are transported to or from ITA facilities in bordering cities. See also WAC 182-546-4000.

Who is responsible for payment of ambulance services for incarcerated people?

Transportation to or from the inpatient facility is the responsibility of the jail or correctional facility.

The agency does not pay for ambulance services for people residing or detained in public institutions, including correctional facilities, local jails, and work-release status. See WAC 182-503-0505(5) and 182-546-0150(5).

The agency pays for **inpatient** services provided to inmates who meet medical assistance eligibility criteria.

Provider Responsibilities

(WAC 182-546-0300)

What are the general requirements for ambulance providers?

Licensing

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

> **Note:** The agency requires any out-of-state ground ambulance provider who transports agency clients within the State of Washington to comply with RCW 18.73.180 regarding stretcher transportation.

Staffing/training

Ambulances must be staffed and operated by appropriately trained and certified personnel. Personnel who provide any invasive medical procedure or service for a client during an ambulance trip must be properly authorized and trained per RCW 18.73.150 and RCW 18.73.170.

> **Note:** Some emergency medical technicians (EMTs) have authorization from their Medical Control to perform some higher level procedures after receiving the necessary training.

Verifying client eligibility

(WAC 182-502-0100(5))

The provider is responsible for verifying whether a client has medical assistance coverage for the dates of service.

Billing in a timely manner

(WAC 182-502-0150)

Providers must bill the agency in a timely manner for covered services provided to eligible clients.

Documenting services billed/provided

(WAC 182-546-0300)

The transportation provider must submit a trip report /run sheet to justify decisions about the destination, type of transport for each client, and the services provided. The documentation must be legible, accurate, and complete. It must include, but is not limited to, the following information:

- Transported client's full name and date of birth
- Medical justification for each transport (e.g., need for speed and monitoring of suspected heart attack)
- Pertinent findings on examination (e.g., ambulatory, pulse rate, oxygen saturation, stated pain level)
- Specific location of origin and destination and any additional or non-scheduled destinations (e.g., intermediate stop at a 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 odometer mileage for ground ambulance trips. Use statute miles for air ambulance trips. See WAC 182-546-0700(3)
- Information regarding who or what triggered the ambulance transport request and how the transport destination was determined and the reason why an ambulance was the only appropriate and effective means of transportation that did not endanger the client's health
- If air ambulance is used, justification for this mode of transportation must be clearly shown
- Specific examples of required documentation in some cases:
    - ✓ If prior authorization (PA) was obtained, include the authorization number on the claim. Keep copy of authorization in the client's file.
    - ✓ If ITA transportation, indicate SCI=I in claim note/Remarks field and submit ITA form 14-002. Keep a copy of the proof of detention.
    - ✓ If transporting more than 100 miles one way, include PCS, court order, and other supporting documentation with the claim.

- ✓ If using the ferry system for part of the trip, include route information with claim (e.g., Vashon to Tacoma).
- ✓ If bypassing ferry system, which is part of the commute, explain why.

Record keeping and retention

Providers must make charts and records available to the agency, its authorized contractors, and the US Department of Health and Human Services, upon 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.

> **Note:** See the agency's ProviderOne Billing and Resource Guide for a complete list of records that providers must keep.

Reporting material changes in provider status

(WAC 182-502-0016)

Ambulance providers must be in good standing to participate in the agency's Medicaid Program. Ambulance providers cannot be on Medicare's or any state Medicaid agency's sanctioned (disapproved) list. Providers must promptly report to the agency any change in status that might affect their eligibility for participation in Medicaid.

Material changes in status include a change in:

- Ownership.
- Address.
- Telephone number.
- Business name.

Knowing health care resources in service area

The ambulance provider must be knowledgeable about its service area health care resources such as:

- Regional Healthcare networks.
- Specialized facilities including:
  - ✓ Trauma care centers.
  - ✓ Cardiac and stroke care centers.
  - ✓ Burn treatment centers.
  - ✓ Toxicology treatment centers.
  - ✓ Mental health treatment centers.
- Patient transport capabilities.

Coverage

What ambulance services does the agency cover?

The agency covers ground and air ambulance services. The agency covers both emergency and nonemergency ambulance services, subject to the limitations in Chapter 182-546 WAC, other applicable WACs, and this billing guide.

When ambulance transportation services are covered?

(WAC 182-546-0200)

The agency pays for ambulance transportation to and from covered medical services when the transportation meets all of the following requirements. The transportation must be:

- Within the scope of an eligible client's medical care program
- Medically necessary based on the client's medical condition at the time of the ambulance transport (must be well-documented in the client's record)
- Appropriate to the client's actual medical need
- To one of the following destinations:
  - ✓ The nearest appropriate agency-contracted medical provider of agency-covered services
  - ✓ The nearest appropriate medical provider in emergency cases
  - ✓ The appropriate designated trauma facility as identified in the emergency medical services and trauma regional patient care procedures manual approved by the Department of Health

When does the agency pay for nonemergency ground ambulance services?

The agency pays for nonemergency ground ambulance transportation when it is medically necessary to transport a client:

- Between facilities to receive a contracted service.
- Who must be carried on a stretcher, or who may require medical attention en route to receive a covered service.
- From home to a facility for a medical appointment only in situations when a client is ventilator dependent, bed-confined, or unable to hold a self-upright position, or when it is unsafe for wheelchair transport.

The agency requires ambulance providers to thoroughly document the circumstances requiring nonemergency ground ambulance transportation.

A provider may use the physician certification statement (PCS) to show medical necessity, in accordance with WAC 182-546-1000. In some circumstances, the agency requires a completed *Non-Emergency Transfer Request* form, HCA 13-950 to be submitted (see Authorization).

When are ambulance services *not* separately payable?

The agency does not pay an ambulance provider separately for a covered ambulance service when the service is included in a bundled payment.

In certain situations, ambulance services are covered by the agency but do not qualify for separate payment to ambulance providers. This occurs when the ambulance service is included in a bundled payment to a hospital or an agency-contracted MCO. In such cases, the ambulance provider may not bill the agency or the agency's client for the transport. The hospital or other entity receiving the bundled payment is responsible for the reimbursement of the ambulance transport.

Transporting an inpatient client to and from other diagnostic or treatment facilities

(WAC 182-546-0425)

The agency does not pay separately for ambulance transportation under fee-for-service when a client is transported to and from another facility for diagnostic or treatment services (e.g., MRI scans, kidney dialysis) necessary for the client's course of treatment without being discharged from the first facility. Usually, the diagnostic or treatment service for which the client was transported to another facility is not available at the admitting facility.

Ambulance transportation of a client subsequent to admission and prior to discharge for necessary diagnostic or treatment services is the responsibility of the hospital in which the client is an inpatient, regardless of the payment method the agency uses to pay the hospital for its services. Although the agency does not reimburse the ambulance provider separately, the ambulance provider may not bill the agency's client for the service.

> **Example**: A client who is a registered inpatient of one hospital is transported by ambulance to another facility for a CAT scan and is transported back to the first hospital when the CAT scan is done. The hospital in which the client is a registered inpatient is responsible for paying the ambulance provider for the round trip transport.

When does the agency not pay for ambulance services?

(WAC 182-546-0250)

The agency does not pay for ambulance services when the ambulance transportation is any of the following:

- Not medically necessary based on the client's condition at the time of service
- Refused by the client (see exception for Involuntary Treatment Act (ITA) Transportation clients)
- For a client who is already deceased at the time the ambulance arrives at the scene
- For a client who dies prior to transport and the ambulance crew provided little or no medical interventions/supplies at the scene
- Requested for the convenience of the client or the client's family (e.g., move the client to a facility closer to home to facilitate family visits)

- More expensive than bringing the necessary medical service(s) to the client's location in non-emergency situations (e.g., taking a client by ambulance to a nearby doctor's office for a routine office visit)
- To transport 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)
- Not to the nearest appropriate medical facility

What are examples of noncovered ambulance services?

"Treat but no transport" service calls

The agency's Ambulance and ITA Transportation program is a transportation service. The agency does not pay for services under the Ambulance and ITA Transportation program if no transport takes place, except as provided in WAC 182-546-0500(2).

- The agency does not pay for ambulance services when a client dies:
  - ✓ Before the ambulance arrives at the scene.
  - ✓ After the ambulance arrives at the scene, but before medical intervention is provided.

Note: There is one situation in which the agency pays when no ambulance transportation take place. When an ambulance provider provides medical services to a client at the scene, but the client dies before transportation could take place, the agency pays the provider the **appropriate base rate**, commensurate with the level of service provided. Providers must document in their files what medical interventions the ambulance crew provided on-scene before the client died. [WAC 182-546-0500(2)]

ALS assessment only, no transport

An ALS assessment provided to an Apple Health client (e.g., in response to a 911 call) that did not result in an ambulance transport is not sufficient to trigger payment to the ambulance provider.

Back door to front door transports (or vice versa) within the same hospital complex

These transports are included in the bundled payment to the hospital where the client is an inpatient. Payment to the ambulance provider is the hospital's responsibility.

Some nonemergency hospital transfers

Aside from hospital transfers to equivalent or lower level hospitals, there are other hospital transfer reasons for which the agency will not pay. These 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).
- Transportation to meet insurance requirements or hospital/insurance agreements.

In the above situations, the current facility is able to take care of the client's medical needs.

> **Note:** An ambulance provider may bill a client for noncovered services or covered services if the requirements of WAC 182-502-0160, Billing a Client, are met.

What ambulance coverage is available for interfacility transfers?

Transfer to a higher level of care

Ambulance transportation, whether ground or air, used to transfer a client to a higher level of care in an emergency situation does not require prior authorization.

Sometimes a nonemergency hospital transfer is necessary when the transferring or discharging hospital has inadequate resources to provide the medical care required by the client (e.g., continuing trauma care, burn cases). In such cases, the agency covers medically necessary air ambulance transportation with prior authorization (PA).

For nonemergency ground ambulance transportation to a higher level facility, a physician certification statement (PCS) is required. For nonemergency air ambulance transportation, PA must be obtained from the agency. If **no** PA is obtained from the agency, the transferring and receiving facilities are responsible for the air ambulance costs. **A physician certification statement (PCS) is not acceptable authorization for nonemergency air ambulance transportation.**

The medical justification for a nonemergency hospital transfer must be clearly documented in the PCS. The client's hospital charts and the ambulance trip report must also show the medical necessity.

Transfer to an equivalent or lower level of care

The agency does not pay for ambulance transportation to transfer a client from a hospital providing a higher level of care to a hospital providing an equivalent or lower level of care.

The agency may consider a request for payment of ground ambulance transportation for a client in such cases under the provisions of WAC 182-501-0160, Exception to Rule (ETR). The agency evaluates such transfer requests based on clinical considerations and cost-effectiveness. The agency approves transfer requests that are in the state's best interests. In this type of transfer (from a higher level to an equivalent or lower level of care), payment is made to the ambulance provider only when the transport is prior authorized by the agency.

Complete a *Non-Emergency Transfer Request* form, HCA 13-950, Fax the completed form to 360-725-1966, then leave a voice mail at 360-725-5144 and staff will return the call with a decision regarding the transfer.

> Note: A physician certification statement (PCS) is not valid authorization for a hospital-to-hospital transfer from higher to equal or lower level of care.

The reason for transferring a client from one hospital to another must be clearly documented in the client's hospital chart and in the ambulance trip record.

The agency does not pay for an air ambulance in a hospital-to-hospital transfer situation involving transfer from a higher level of care to an equivalent or lower level of care.

Is out-of-state ambulance transportation covered?

(WAC 182-546-0800)

Yes. The agency covers **emergency** ambulance transportation provided for the agency's eligible fee-for service clients who are out-of-state at the time of the emergency medical event.

The agency requires an out-of-state ambulance provider who wants to be paid by the agency for providing services to:

- Be a licensed ambulance provider in its home state.
- Complete and sign a Core Provider Agreement with the agency.

The agency 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.
- The transport was not an emergency transport and was not prior authorized by the agency.

Note: See Out-of-State Services for information about transportation to or from out-of-state treatment facilities.

Is out-of-country ambulance transportation covered?

(WAC 182-546-0900)

No. The agency does not cover ambulance transportation for medical assistance clients traveling outside of the United States and US territories (WAC 182-546-0900). The agency covers emergency ambulance transportation for eligible clients in British Columbia, Canada, subject to the provisions and limitations in WAC 182-501-0184.

What if a client has third-party coverage for ambulance transportation?

If a client has third-party coverage for ambulance transportation services, providers must bill the client's primary health insurance before billing the agency.

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

If the third party insurer denies coverage of an ambulance trip on the grounds of lack of medical necessity, the agency requires the ambulance provider to do both of the following:

- Report the third party determination on the claim it submits to the agency
- Include documentation showing that the trip meets the agency's medical necessity criteria

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

Frequently asked questions (FAQ) about ambulance transportation coverage

Does the agency pay for ambulance transportation home?

In general, no. The agency does not pay for ambulance transportation to take a client home after discharge, except when the client needs one or more of the following:

- To go "home" to a nursing facility
- To be transported in a prone or supine position
- Medical attention/monitoring en route

When a client is discharged home, the presumption is that the medical condition that gave rise to the emergency situation has been resolved, and the client is now medically stable.

To get paid for transporting a client home from a hospital, nursing home, or hospice, the ambulance provider must request an exception to rule (ETR) according to WAC 182-501-0160. The agency evaluates ETR requests on a case-by-case basis.

Claims submitted for ambulance transportation home from a hospital, skilled nursing facility, hospice, or other medical service must include documentation showing the reason(s) why the client could not have gone home by any other means without endangering the client's health.

Note: Ambulance transport home requires PA by the agency in order to get paid. In these cases, a Physician Certification Statement (PCS) is not acceptable authorization for an exception to rule.

Does the agency pay for ambulance transportation to a kidney dialysis center?

Yes. The agency pays for ambulance transportation to a kidney dialysis center with prior authorization (usually a PCS). (See WAC 182-546-1000(2)(a)).

Does the agency pay for ambulance transportation to a free-standing emergency department?

Yes. An emergency department (ER) is defined as an organized hospital-based facility that is open 24 hours a day. Ambulance transportation to an ER, whether freestanding or hospital-based, and is generally presumed to be an emergency and medically necessary.

Note: Make sure that all supporting documentation is in the client's file.

Does the agency pay for nonemergency ambulance transportation to a physician's office?

Yes. An office visit to a physician typically involves a scheduled appointment (a nonemergency event). The agency covers nonemergency ambulance transportation to a physician's office for a client whose medical condition requires the client to be transported in a prone or supine position, or if the client needs to have medical attention available en route. See WAC 182-546-1000(1).

Ambulance transportation for a routine office visit (evaluation and management) by a client residing in a nursing facility is not payable if the client did not need to be transported in a prone or supine position, did not need medical attention en route, or could have used a wheelchair van. Use of ambulance transportation for a routine office visit by a client who did not require specialty services and could have been treated at the nursing facility is an inappropriate use of limited resources. **"Specialty services"** are services that could not be done or provided at the nursing facility (e.g., complex lab tests and special imaging procedures).

Nonemergency ambulance transportation to a physician's office requires prior authorization, usually in the form of a Physician Certification Statement (PCS).

Does the agency pay for ambulance transportation resulting from a 911 or emergency call center request?

Yes. The agency pays if program criteria (eligibility, spend down, etc.) are met.

Does the agency pay for ambulance transportation to an urgent care/24-hour walk-in clinic?

In general, no. The agency considers 24-hour walk-in clinics and urgent care centers as physician-based or physician-directed clinics, but an urgent care clinic is not a client's primary care provider. The agency does not cover nonemergency ambulance transportation to these facilities.

A physician office visit is usually a scheduled appointment (nonemergency). When an emergency condition arises after normal office hours that requires ambulance transportation, the client should be taken to an appropriate facility (emergency room).

In limited circumstances however, the agency will pay for ambulance transportation to these clinics without prior authorization. For example, an ambulance transporting a client whose condition is dire stops to seek a physician's help in stabilizing the client, and immediately thereafter, the ambulance continues en route to a hospital.

Does the agency pay for ambulance transportation based on a patient's expressed preference to be transported by ambulance?

No. The agency does not pay for ambulance transportation based on patient preference without medical justification. Payment for ambulance transportation for the convenience of the client or the clients family is prohibited (see WAC 182-546-0250(1)(e)).

Coverage Table

Air ambulance

All air ambulance services provided to Washington Apple Health clients, including those enrolled in an agency-contracted managed care organization (MCO) must be billed to the Health Care Authority. The MCOs remain responsible for all ground ambulance services for their enrollees.

The medical necessity for air ambulance transportation must be clearly documented in the client's medical records.

HCPCS Code	Modifier	Short 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

Ground ambulance

Modifiers are required on all codes. See Origin/Destination Modifiers for descriptions.

HCPCS Code	Modifier	Short Description	EPA/PA	Policy/ Comments
Basic Life Support (BLS)				
A0428		Ambulance service, basic life support, nonemergency 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 nonemergency 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

HCPCS Code	Modifier	Short 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)		Pertinent documentation to evaluate medical appropriateness should be included when this code is reported. Origin and destination modifiers required. Justification required: • The client weighs 300 pounds or more • The client is violent or difficult to move safely • More than one client is being transported, and each requires medical attention and/or close monitoring
Note: The agency pays for an extra attendant in ground ambulance transports only. No payment is made for an extra attendant in air ambulance transports.				
A0998		Ambulance response and treatment, no transport		Code not payable. Used for data collection purposes only

Authorization

What requires prior authorization (PA)?

- Emergency ambulance transportation does not require PA.
- All nonemergency ambulance transportation requires PA. PA may take the form of a physician certification statement (PCS) or an authorization number from the agency.

Who can authorize ambulance services?

The agency (Medical Director or designee) - Only the agency can authorize ambulance services that are exceptions to rule (ETR).

> **What is an exception to rule (ETR)?**
>
> An ETR is a client's and/or client's provider's request to the agency to pay for a noncovered health care service. The agency's Medical Director or designee evaluates and considers ETR requests on a case-by-case basis, and has final authority to approve or deny an ETR request. Clients do not have a right to a fair hearing on exception to rule decisions. See WAC 182-501-0160 for more information.

A designated mental health professional (DMHP) – A DMHP authorizes ambulance transportation under the Involuntary Treatment Act (ITA) to transport a mentally ill individual whom a Superior Court judge has ordered detained to a designated Evaluation and Treatment (E&T) facility.

A primary care physician (PCP) – A client's primary care or attending physician can authorize nonemergency ambulance transportation services in specified conditions.

What form(s) should be used to request PA?

Ambulance providers must thoroughly document the circumstances requiring the use of nonemergency ambulance transportation. PA requests must be in writing.

Providers must complete the appropriate form(s) and provide the documentation necessary for informed decision-making and quality of care monitoring, and fax the form to the number listed on the form, if applicable.

Form Number	Title
HCA 13-950	Non-Emergency Transfer request.
HCA 13-835	General Information for Authorization.
HCA 13-787	Out-of-State Medical Services request.
HCA 14-002	Authorization for Ambulance/ Secure transportation under the Involuntary Treatment Act (ITA).
PCS	Physician Certification Statement

When is *Non-Emergency Transfer Request* form, HCA 13-950, required?

Use Non-Emergency Transfer Request, HCA 13-950 form, along with the General Information for Authorization, HCA 13-835 form, as the cover sheet to request prior authorization for the following:

- **Nonemergency air ambulance transportation between in-state and/or bordering city hospitals.** The agency will not pay for nonemergency air ambulance transportation without PA by the agency. A Physician Certification Statement (PCS) is not authorization of payment for this type of transportation.

- **Interfacility transfers from a higher level facility to an equivalent or lower level facility.** This type of transfer may involve ground or air ambulance. A PCS will not allow payment for this transport.

  Example: Requests for transfers from a higher level hospital to a lower level hospital typically involve returning a newborn to its home community hospital. The *Non-Emergency Transfer request*, HCA 13-950 form, is completed and submitted by the discharging hospital. Among the information the agency requires the transferring hospital to provide is the estimated length of stay at the receiving hospital and extenuating circumstances.

- **Transportation home (not to a nursing facility).** The agency does not cover ambulance transportation that is not medically necessary. When a client is discharged home the presumption is that the medical emergency that necessitated treatment has passed (the client's medical condition is stable). Therefore, ambulance transportation home is not medically justified. However, there may be extenuating circumstances. Requests for transportation home typically involve bariatric patients, patients on a ventilator, or patients who have a quadriplegic condition who are unable to go by wheelchair van. A request for ambulance transportation home may be made by a client, the client's physician, a discharging facility, or the ambulance provider rendering the service. **A PCS is required for this type of transportation.**

- **Transportation of clients in the Children's Long-Term Inpatient Program (CLIP).** Requests for transportation of clients in this program are completed by the CLIP Coordinator. **A PCS is required for this type of transportation.**

The agency assigns an authorization number to an approved request. This authorization number must be shared by the requesting entity with the ambulance provider doing the transport. The ambulance provider must include this authorization number when billing the agency.

When is the *Out-of-State Medical Services request* form, HCA 13-787 and companion *General Information for Authorization* form, HCA 13-835, required?

When a client needs a medical treatment that is not available in-state or in designated bordering cities, the client's physician may want to refer the client to an out-of-state provider who can provide the service. The physician may request prior authorization from the agency to send the client out-of-state for the medically necessary treatment or therapy (**not experimental!**). The referring physician must complete *Out-of-State Medical Services request* form, HCA 13-787 and *General Information for Authorization* form, HCA 13-835.

The agency uses Stanford University Medical Center and Lucile Packard Children's Hospital as its primary Centers of Excellence for out-of-state services.

The agency covers nonemergency transportation to or from out-of-state facilities with prior authorization. The agency authorizes the most appropriate means of transportation for the client's medical condition: air ambulance, commercial flight, train, etc.

Ambulance transportation to or from an out-of-state facility is arranged by agency staff. Other travel arrangements are handled by the agency's contracted transportation brokers.

When is the *Involuntary Treatment Act (ITA)* form, HCA 14-002 required?

Use the Authorization for Ambulance/ Secure transportation under the *Involuntary Treatment Act (ITA)* form, HCA 14-002 as documentation that a designated mental health professional (DMHP) ordered an ambulance provider to transport a mentally ill individual for detention in an evaluation and treatment (E&T) facility.

An HCA 14-002 is required for transportation involving the initial detention of a mentally ill individual and the detention of an individual whose conditional release has been revoked. The latter is also known as revocation of a less restrictive alternative (LRA).

HCA 14-002 may be used, but is not required, for the transportation of detained individuals to and from court for competency hearings (civil commitment). A PCS signed by a physician at the detention facility may be used for this purpose.

When is a physician certification statement (PCS) appropriate to use?

A PCS is appropriate to use in most nonemergency ambulance transportation situations, such as:

- Transporting a bed-confined client to medical appointments (scheduled appointments that may be repetitive or non-repetitive).
- Kidney dialysis (repetitive).
- Transporting an ITA client to and from court for a competency hearing (civil commitment only).
- Transporting a minor to a mental health Evaluation and Treatment (E&T) facility under the Parent Initiated Treatment (PIT) program.

Note: The person signing a PCS for a client transported under PIT must have been present in the ER when the parent(s) brought the minor in, and must have personally evaluated the minor's condition.

Who can sign a PCS?

The person signing a PCS must have personal knowledge of the client's medical condition. For transportation originating from the ER, the PCS signer must have evaluated the client shortly before the start of the ambulance transportation service.

- A client's primary care provider (PCP) or attending physician or his/her designee. An attending physician's designee may include:

  - ✓ A physician assistant.
  - ✓ A nurse practitioner.
  - ✓ A registered nurse.
  - ✓ A clinical nurse specialist.
  - ✓ A hospital discharge planner.

Exception: Only a physician or psychiatric nurse may sign a PCS for a client transported under the Parent Initiated Treatment (PIT) program.

Note: A PCS is a legal document. By signing a PCS, the attending physician or designee is attesting to the truthfulness of the information provided.

What must a PCS include?

The agency does not have a prescribed format for a PCS, but it must contain all the information necessary to identify the client and support medical necessity justification for the ambulance transport. At a minimum, the PCS must contain:

- The client's name and date of birth, address, and diagnosis.
- The intended destination and the reason why the client could not safely use any other means of transportation.
- The expected duration of treatment (span of dates) for which nonemergency ambulance transportation is needed and/or the frequency of trips during that period.
- The printed name and title of the PCS signer.
- The signature of the signer and the date the PCS was signed.

See WAC 182-546-1000 for more information.

Reimbursement

What are the general limitations on ambulance payment?

(WAC 182-546-0400)

The agency pays:

- Ambulance providers the lesser of the provider's usual and customary charge or the maximum allowable rate established by the agency. The agency's fee schedule payment for ambulance services includes a base rate (ground ambulance) or a lift-off fee (air ambulance), plus mileage.
- Ground ambulance providers for the actual mileage incurred for covered trips. Mileage is calculated from the client's point of pick-up to the point of destination (see WAC 182-546-0200(1)(d)(i)).
- 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 (takeoff to landing field).
- All air ambulance services under fee-for-service, including air ambulance services provided to managed care enrollees, for dates of services on and after May 1, 2013.

The agency **does not** pay:

- Ground ambulance providers for services provided to a client who is enrolled in an agency managed care plan. Payment in such cases is the responsibility of the prepaid managed care plan.
- For mileage incurred traveling to the point of pick-up or any other distances traveled when the client is not on board the ambulance.
- For ambulance services requiring prior authorization when prior authorization is not obtained.
- When the client is not transported.
- When the client is transported, but not to an appropriate treatment facility.
- When a scheduled ambulance transportation is canceled.

- When the client dies before the ambulance trip begins (see the single exception for ground ambulance providers).

What is the importance of origin and destination modifiers?

(WAC 182-546-0600)

The Ambulance Program is a medical transportation service. It is important to know the location of where a client is coming from and is being transported to.

Providers must use a combination of **two characters** to identify origin and destination (e.g., A0428 NH, A0425 NH). The first character indicates the transport's place of origin. The destination is indicated by the second character. Enter these modifiers in field 24D on the CMS-1500 claim form.

Providers must use the appropriate modifiers for all services related to the same trip for the same client (see WAC 182-546-0600).

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

Origin/Destination Modifiers

Modifiers are required for all services related to the same trip for the same client.

Modifier	Detailed Description of each Modifier	Examples
D	Diagnostic or Therapeutic site other than "P" or "H" when used as origin	Diagnostic Radiology, Physical Therapy
E	Residential or Custodial Facility (SUD and ITA)	Evaluation & Treatment Facility
G	Hospital-based dialysis facility (hospital or hospital-related)	Hospital-based Renal Dialysis
H	Hospital	Acute Care Facility
I	Site of transfer between types of ambulance	Airport or Helicopter Pad
J	Non-hospital based dialysis facility	Non-hospital based Renal Dialysis
N	Skilled Nursing Facility (SNF)	Nursing Home, Assisted Living Facility
P	Physician's office (includes HMO non-hospital facility)	Medical Clinic, Urgent Care Facility
R	Residence/Domiciliary Location	Private Residence, Adult Family Home
S	Scene of Accident or Acute Event	Location of Emergency Location
X	(DESTINATION CODE ONLY) Intermediate stop at physician's office on the way to the hospital	Doctor's Office or Medical Clinic

Other Modifiers

Modifiers are required for all services related to the same trip for the same client.

QL - Use if services are provided but client dies prior to transport.

GM - Use **in addition** to the 2-digit origin and destination modifier for each additional client per transport.

DC – Use for Department of Corrections (DOC) ambulance transports. DOC staff will enter this modifier in the special claims indicator field.

GZ – Not reasonable/Not medically necessary

Remember:

- When billing for an ITA patient transported to or from court, use modifier "E" to denote court, whether as origin or destination.

- When billing for a dual eligible client, add the modifier "GY" when the transport is to or from court. The GY modifier pair is in addition to, not in lieu of, origin and destination modifiers. (Medicare does not pay for ambulance transportation to or from court.)

When does the agency pay for air ambulance services?

(WAC 182-546-0700)

Payable circumstances for air ambulance services

The agency 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 Responsibilities
- The client's destination is an acute care hospital
- The client's physical/medical condition requires immediate and rapid ambulance transportation that cannot be provided by ground ambulance
- Prior authorization has been obtained from the agency if it is a nonemergency transport
- The client's physical or mental condition is such that traveling on a commercial flight is not safe

Note: All air ambulance transportation is paid **fee-for-service** on and after dates of service May 1, 2013.

Prior authorization (PA) requirement for nonemergency air ambulance transportation

All nonemergency air ambulance transportation requires PA from the agency. The agency will deny payment for nonemergency air ambulance transportation not prior authorized by the agency.

Note: A Physician Certification Statement (PCS) is not acceptable authorization for nonemergency air ambulance transportation.

Nonemergency air transportation to or from out-of-state treatment facilities includes commercial flights. For clients who are ambulatory, the agency uses scheduled carriers when the client's medical condition permits the client to travel by other means. The agency's brokered transportation system facilitates travel arrangements for these clients.

Components of air ambulance payment

The agency's payment for air ambulance services includes lift-off fee and mileage. There is no separate payment for equipment and supplies; these are included in the lift-off fee.

Lift-off
(WAC 182-546-0700(6))

The agency pays providers for one lift-off fee per client, per trip. The lift off fee includes attendants, equipment, and supplies.

Mileage
(WAC 182-546-0700(4))

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

The agency pays for extra air mileage with sufficient justification. The justification for the added mileage must be documented in the client's record and the ambulance trip report.

Acceptable reasons for incurring extra mileage for an air ambulance transport include, but are not limited to:

- Avoiding a **no fly zone**.
- Landing at an alternate airport/destination due to severe weather.

The agency does not pay for extra mileage in transports involving negotiated rates.

Special circumstances involving air ambulance transportation

- **Multiple clients on the same transport (WAC 182-546-0700(5))**

  The agency pays a lift-off fee for each client when two or more ill or injured clients are transported at the same time in the same air ambulance. In such cases, the provider must divide equally the total air mileage by the number of clients transported and bill the agency for the mileage portion attributable to each eligible client.

- **Multiple lift-offs for the same client (WAC 182-546-0700(6))**

  When transporting a client by air ambulance requires more than one leg (travel segment) to complete, the agency limits its payment as follows:

- ✓ If the trip involves more than one lift-off by the same aircraft, the agency pays only one air ambulance lift-off fee for the same client one way.

- ✓ If the transportation involves the use of both rotary and fixed-wing aircraft for the same client one way, the lift-off fee and mileage payment will be based on the mode of air transport used for the greater distance traveled.

- **Multiple lift-offs for the same client, same date, separate incidents**

  If the same client is transported by air ambulance more than once on the same day for separate causal events, every lift-off is separately billable. When multiple lift-offs are part of a single trip involving multiple legs of travel, the agency pays only one lift-off fee (see above). Records must reflect why multiple trips have occurred on the same day.

- **Prior authorized air ambulance transportation to or from out-of-state facilities**

  - ✓ If the negotiated rate for a nonemergency transfer by air ambulance to or from an out-of-state facility specifically covers only the air ambulance portion, the agency pays the air ambulance provider the contracted amount and pays the ground ambulance provider separately based on the agency's ambulance fee schedule. The ground ambulance provider must have signed a core provider agreement (CPA) to get paid.

  - ✓ If the negotiated rate for a nonemergency transfer by air ambulance to or from an out-of-state facility is all-inclusive, the agency pays the air ambulance provider the contracted amount and does not pay the ground ambulance providers involved in the transport. The air ambulance provider is responsible for paying the ground ambulance providers for their ground transportation services. A ground ambulance provider is not required to sign a CPA in these cases.

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

- **Air transportation services provided by private organizations (WAC 182-546-0700(7))**

  The agency does not pay private organizations for volunteer medical air ambulance transportation services, unless the organization has the agency's prior authorization for the transportation services and fees. If the agency authorizes a private organization to provide air transportation to a client, the agency's payment to the private entity is the lesser of the entity's actual cost to provide the service or the agency's established rates.

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

When does the agency pay for ground ambulance services?

(WAC 182-546-0450)

Levels of ground ambulance service

The agency 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 all of the following:

  - ✓ Controlling bleeding.
  - ✓ Splinting fracture(s).
  - ✓ Treating for shock.
  - ✓ 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 all of the following:

  - ✓ 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
  - ✓ Placement of intraosseous line

Factors affecting ALS or BLS classification

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

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

- Even if certified paramedics or ALS-qualified personnel are on board the ambulance, a ground ambulance trip is classified and paid at a BLS level, 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 provided by trained and certified personnel on-board. Medical necessity, not the level of personnel on board an ambulance, dictates which level (BLS or ALS) of ground ambulance service is billed to the agency.

  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 of the same client on the same day, **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 to the second transport on the return trip.

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

Payment for ground ambulance base rate

(WAC 182-546-0450(2) and (3))

- The agency's base rate includes all of the following:

  - ✓ Necessary personnel and services
  - ✓ Oxygen and oxygen administration
  - ✓ Intravenous supplies and IV administration
  - ✓ Reusable supplies
  - ✓ Disposable supplies
  - ✓ Required equipment
  - ✓ Waiting time
  - ✓ Other overhead costs

- 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.

Payment for mileage

(WAC 182-546-0450(2)-(5))

- The agency pays ground ambulance providers the same mileage rate for ALS and BLS transports.

- Providers may bill the agency only for mileage incurred from the client's point of pickup to the nearest appropriate destination. A fraction of a mile must be rounded up to the next whole number.

- The agency pays ground mileage to providers for every loaded mile traveled while on ferry. To receive payment, providers must attach the ferry route documentation along with their trip report/run sheet and claim.

> **Note:** The agency 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.

- The agency 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:

  - ✓ The initial hospital destination was on "divert" status and not accepting patients
  - ✓ A construction site caused a detour
  - ✓ An alternate route had to be taken to avoid an impassable road obstruction

Payment for extra attendant

(WAC 182-546-0450(7))

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

Any of the following reasons are acceptable justification for an extra attendant:

- The client weighs 300 pounds or more
- The client is violent or difficult to move safely
- The client is being transported for Involuntary Treatment Act (ITA) purposes and the client must be restrained during the trip
- More than one client requiring medical attention and/or close monitoring is transported in the same ambulance

When billing the agency, 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 does not require an extra attendant. If the suspected heart attack client is extremely obese an extra attendant may be warranted. Provide documentation of the need for an extra attendant.

Payment for ferry and bridge tolls

(WAC 182-546-0450(8))

The agency pays ambulance providers by-report (BR) for ferry and bridge tolls incurred when transporting agency clients. To receive payment, providers must attach the receipt(s) for the toll(s) to the claim.

Payment for waiting time

There is no separate payment for waiting time. Ground ambulance base rates include the cost of additional waiting time.

Payment in special circumstances involving ground ambulance transportation

- **Multiple providers responding**
  (WAC 182-546-0450(6))

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

- **Multiple clients, same transport**
  (WAC 182-546-0500**(1)(b))**

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

  ✓ At a reduced base rate for the additional client (note: use modifier GM in addition to the 2-digit origin/destination modifier when billing for the second client).

  ✓ No mileage charge for the additional client.

- **Death of a client**
  (WAC 182-546-0500(2))

  The agency pays an ambulance provider the appropriate base rate (BLS or ALS) when a client dies at the scene prior to transport, but after the ambulance crew has performed medical interventions/provided medical supplies. See Base Rate 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 transportation takes place.

- **BLS-ALS combined response**
  (WAC 182-546-0500(3))

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

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

- **Residents/nonresidents**
  (WAC 182-546-0500(4))

  In areas that distinguish between residents and nonresidents, a provider must bill the agency the same rate for ambulance services provided to an agency 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**
  (WAC 182-546-0425(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. This means a nurse or physician may be on board the ambulance to provide care for the injured or ill client. The agency pays an ambulance provider the advanced life support (ALS) rate for an SCT-level transport when both of the following occur:

  ✓ The criteria for covered hospital transfers under fee-for-service are met.

  ✓ There is a written reimbursement agreement between the ambulance provider and SCT personnel. The ambulance provider must give the agency a copy of the agreement upon request. If there is no written reimbursement agreement between the ambulance provider and SCT personnel, the agency pays the provider at the basic life support (BLS) rate.

- **Nonemergency ground ambulance transportation**
  (WAC 182-546-1000)

  The agency pays for nonemergency ground ambulance transportation at the BLS ambulance level of service when the conditions in WAC 182-546-1000 (1) and (2) are met.

  Ground ambulance providers may choose to enter into contracts with the agency's transportation brokers to provide nonemergency transportation at a negotiated payment rate. Any such subcontracted rate may not exceed the costs the agency would incur under WAC 182-546-1000 (1) and (3).

- **"Treat But No Transport" tracking code (A0998)**

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

When does the agency pay for out-of-state emergency ambulance services?

(WAC 182-546-0800)

The agency pays for out of state emergency ambulance transportation provided to clients at the lesser of:

- The provider's billed amount.
- The rate established by the agency.

Ambulance providers must have a current, signed core provider agreement on file with the agency to receive payment.

When does the agency pay for prior authorized ambulance services to or from and out-of-state facilities?

The agency pays ambulance providers an agreed upon amount for each prior authorized interstate ambulance transport. The cost of all necessary services, personnel, and equipment are included in the contractual amount, unless otherwise specified in the confirmation letter.

The contractual amount for an air ambulance transport to or from an out-of-state facility may include ground ambulance transportation from the discharging hospital to the flight embarkation point and from the landing point to the receiving hospital.

When does the agency pay for ambulance services provided to qualified Medicare beneficiaries?

For clients with Categorically Needy/Qualified Medicare Beneficiary (CN/QMB) and Medically Needy/Qualified Medicare Beneficiary (MN/QMB) benefits, the agency pays for ambulance services as follows:

- If Medicare covers the service, the agency will pay the lesser of:
  - ✓ The full coinsurance and deductible amounts due based upon Medicaid's allowed amount.
  - ✓ The agency's maximum allowable for that service minus the amount paid by Medicare.
- If Medicare does not cover or denies an ambulance service that the agency covers, the agency pays for that service, unless the client has QMB-only, SLMB, QI-1, or QDWI eligibility. The agency does not pay for ambulance services for clients in the QMB-only, SLMB, QI-1, or QDWI programs.

When the agency pays for a service that Medicare does not cover, payment for that service is capped at the agency's maximum allowable fee.

When does the agency pay for ambulance transportation of qualified trauma cases?

(WAC 182-546-3000)

The agency does not make **supplemental** payments to ambulance providers who meet Department of Health (DOH) criteria for participation in the statewide trauma network for transportation involving qualified trauma cases described in WAC 182-550-5450. Subject to the availability of the trauma care fund (TCF) monies allocated for such purpose, the agency may make supplemental payments to these ambulance providers, also known as verified pre-hospital providers.

When does the agency pay for ITA transportation?

ITA transportation - general

The mileage rate is only for those miles that an involuntarily detained person is on board the vehicle (loaded mileage). The Department of Social and Health Services Division of Behavioral Health and Recovery (DBHR) does not allow additional charges beyond the rate per mile allowance, except for an extra attendant when appropriately documented. Documentation of medical appropriateness and necessity must be included when this code is submitted. Origin and destination modifiers are also required.

ITA ambulance transportation

ITA transportation provided by an ambulance provider is paid according to the agency's fee schedule (base rate plus mileage).

ITA non-ambulance transportation

ITA transportation provided by a non-ambulance provider (e.g., law enforcement) is paid only for the mileage, not the base rate.

The DBHR pays for an extra attendant when appropriately documented. Documentation of medical appropriateness and necessity must be included when this code is submitted. Origin and destination modifiers are also required.

Note: DBHR payment is payment in full. DBHR allows no additional charge to the involuntarily detained individual, in accordance with 42 C.F.R. § 447.15.

Where is the ambulance fee schedule?

See the Ambulance Transportation Fee Schedule.

Emergency ambulance transportation

Emergency ambulance transportation (ground or air) is paid according to the agency's published fee schedule.

Nonemergency ambulance transportation

Nonemergency ground ambulance transportation that meets program coverage criteria is paid according to the agency's published fee schedule.

The agency does not pay for nonemergency air ambulance transportation, except in a limited number of cases involving prior authorized treatment out-of-state. In such cases, the agency pays the air ambulance provider a negotiated amount.

Ambulance Services Provided Out-of-State

Does the agency cover emergency ambulance transportation provided out-of-state?

When an eligible client is traveling in another state or in a U.S. territory and an emergency situation develops requiring ambulance transportation (ground or air) for the client, the agency will pay for the emergency ambulance transportation, provided that both of the following are true:

- The client's eligibility program allows for out-of-state coverage
- The out-of-state provider signs a Core Provider Agreement (if not already an enrolled provider with the agency)

Emergency ambulance services provided out-of-state do not require prior authorization. Payment is made according to the agency's Ambulance and ITA Transportation fee schedule.

Ground ambulance services provided to a managed care enrollee are the responsibility of the client's managed care organization.

Note: Under no circumstances will the agency pay for out-of-state transportation for clients under the Involuntary Treatment Act (ITA) program.

Does the agency coordinate benefits for ambulance services provided out-of-state?

(WAC 182-546-2500)

The agency does not pay for a client's ambulance 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 a client who is otherwise eligible for out-of-state coverage (see Client Eligibility), but has other third-party insurance, the agency does not pay for ambulance transportation to or from an out-of-state treatment facility when the client's primary insurance denies the client's request for medical services out-of-state for lack of medical necessity.

When a client with third party insurance requires out-of-state treatment, and the third party insurer authorizes the medical services but denies transportation coverage, the agency considers a request for transportation to the out-of-state treatment facility under Exception to Rule (see WAC 182-501-0160). The agency considers such a request for a client with other third-party insurance when the client has tried **all** of the following:

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

If the agency authorizes transportation to or from an out-of-state treatment facility for a client with other third-party insurance, the agency'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 the agency in consultation with the client's referring physician.

Does the agency authorize nonemergency air ambulance transportation to out-of-state treatment facilities?

- The agency authorizes air ambulance transportation to an out-of-state treatment facility for a client only when the medical services to be provided to the client by the out-of-state treatment facility have been prior authorized by the agency. The client's medical provider (hospital or attending physician) must submit a written request for PA of the out-of-state treatment, and a request for air ambulance transportation, if needed. (See Resources Available).

  Note: All nonemergency air ambulance transportation requires PA by the agency. A PCS is not appropriate authorization for air ambulance transportation.

- The agency considers both of 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

  ✓ The service/treatment is not experimental

- 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 the agency
- If the agency authorizes the air ambulance transport for the out-of-state treatment, call the Washington Apple Health Ambulance Clinical Nurse Consultant at 360-725-1611 to arrange for the air ambulance transport
- Air ambulance transports in these cases are reimbursed at negotiated rates. The agency payment is payment-in-full

Example: Arrangements are made to take a toddler from Lucile Packard Children's Hospital back to Seattle Children's Hospital following heart surgery. On the scheduled date the client develops complications, and the decision is made not to transfer the child until the client is more stable. The air ambulance provider had flown from its base in Colorado and was already on the ground in Palo Alto when the decision to reschedule the flight was made. The provider incurred costs because of the overnight delay, and will not be reimbursed by the agency for those costs. The agency will pay only the agreed upon amount.

- The agency uses commercial airline companies when the client's medical condition allows the client to travel on a commercial flight

Does the agency authorize nonemergency air ambulance transportation from out-of-state to in-state treatment facilities?

The agency considers requests for air ambulance transportation from out-of-state to in-state facilities on a case-by-case basis. If air ambulance transportation is required, the client's medical provider (hospital or attending physician) must submit a written request for prior authorization (PA) of the transfer (See Resources Available).

After the agency approves the request for the transfer, call the Washington Apple Health Ambulance Clinical Nurse Consultant at 360-725-1611 to arrange for air ambulance transport.

The agency uses commercial airline companies whenever the client's medical condition allows.

What does the agency pay for nonemergency air ambulance transportation to or from out-of-state treatment facilities?

The agency pays an air ambulance provider a contractually agreed upon amount for each nonemergency transport prior authorized by the agency to or from an out-of-state treatment facility. The agency makes no additional payment when the provider incurs additional costs due to circumstances beyond its control (e.g., the need to delay a flight because of a sudden worsening in the client's condition). Therefore, a provider contracted to do a nonemergency air ambulance transport of a client to or from an out-of-state facility should maintain close contact with the discharging and/or receiving facility to ensure proper coordination of the transfer process and avoid wasting resources.

Does the agency pay for out-of-country ambulance services?

(WAC 182-546-0900)

The agency does not pay for ambulance transportation provided to medical assistance clients traveling outside of the United States and its territories, except for British Columbia, Canada, subject to the provisions of WAC 182-501-0184.

Involuntary Treatment Act Transportation

What is 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 evaluated by a Behavioral Health Organization (BHO), Designated Mental Health Professional (DMHP) and assessed as one of the following:

- A danger to themselves
- A danger to others
- Gravely disabled

Who is eligible for ITA services?

The Involuntary Treatment Act (ITA) applies to all individuals within the borders of the state of Washington, including individuals who are not Medicaid-eligible.

See the agency's ProviderOne Billing and Resource Guide for instructions to verify client eligibility.

If the detained individual is not currently eligible for agency-covered ambulance services, providers must submit the CMS-1500 claim form with a DMHP-generated form following Superior Court Mental Proceedings Rule 2.2.

Note: Effective for dates of service on and after September 1, 2013, use the *Authorization for Ambulance/Secure Transportation Under the Involuntary Treatment Act (ITA)*, HCA 14-002 form, for transportation related to initial detention and/or revocation of less restrictive alternatives.

The DMHP form must contain all of the following information:

- Be dated within 20 days of providing transportation services
- Name of the person taken into custody
- Attest the transport was for an individual found to be a danger to themselves, a danger to others, or gravely disabled when assessed by a DMHP
- State the agent who undertakes the involuntary detention is authorized to take custody of the person according to RCW 71.05.150(4) or RCW 71.05.153(1)
- State the person was taken into custody for the purpose of delivering that person to an evaluation and treatment facility for a period of up to 72 hours excluding Saturdays, Sundays, and holidays as provided in RCW 71.05.180
- Specify the name and location of the evaluation and treatment facility where the individual will be detained

All documentation must be properly completed, kept in the patient file, and made available to the agency for 6 years from the date of service in accordance with WAC 182-502-0020. (Also see Provider Responsibilities and Record keeping).

Visit the Department of Social and Health Services Division of Behavioral Health and Recovery (DBHR) website for a list of BHOs to contact regarding ITA services.

Note: The Health Care Authority receives and processes claims, but ITA claims are paid with DBHR funds.

Who decides what transportation is necessary under ITA?

When a DMHP detains an individual, the DMHP follows the statewide protocol to choose an appropriate method of transportation, if needed, from one of the following:

- Local police or sheriff
- Ambulance
- Other providers of secure transportation

When ITA ambulance services are provided, ambulance providers must bill the agency using the procedures outlined within this billing guide to receive reimbursement. The agency does not guarantee payment for ambulance transportation that a DMHP has not authorized.

Who pays for ITA services?

Individuals who are involuntarily detained according to Chapter 71.05 RCW for the purpose of evaluation and treatment are responsible for the cost of such care and treatment (see RCW 71.05.100). The Department of Social and Health Services (DSHS) will pay the ITA transportation costs for an individual when a DMHP determines the services are non-covered by insurance or Medicare (e.g., when an ambulance must be used to transport the individual to a court hearing for ITA purposes) **and** one of the following applies:

- There is no other TPL payment source and the involuntarily detained individual does not have the resources to pay
- Requiring the individual to pay would result in a substantial hardship upon the individual or the individual's family
- The services are non-covered by insurance or Medicare (e.g., when an ambulance must be used to transport the individual to a court hearing for ITA purposes)

Who pays for ITA transportation of managed care enrollees?

Authorization for the ITA ambulance transportation of a managed care enrollee to an evaluation and treatment (E&T) facility is the responsibility of a DMHP, not the client's MCO.

Payment for ITA ambulance transportation of a managed care enrollee to an E&T facility is the responsibility of the client's MCO.

Payment for transportation of a managed care enrollee to and from court for a civil commitment hearing is DBHR's responsibility.

When are transportation services covered under ITA?

- The Department of Social and Health Services', Division of Behavioral Health and Recovery (DBHR) covers ITA transportation services when provided from one of the following:

  - ✓ The site of the initial detention
  - ✓ A court hearing
  - ✓ A hospital
  - ✓ An evaluation and treatment facility

- DBHR covers ITA transportation services when provided to one of the following:

  - ✓ A less restrictive alternative setting (except home)
  - ✓ A court hearing
  - ✓ A hospital
  - ✓ An evaluation and treatment facility

When are transportation services not covered under ITA?

The ITA program does not cover ambulance transportation for voluntary psychiatric admissions.

The Department of Social and Health Services', Division of Behavioral Health and Recovery (DBHR) does not reimburse providers for non-ITA transportation such as the transporting of individuals to and from outpatient mental health services.

> **Note:** Ambulance transportation should not be an automatic transportation choice for mental health clients. Transporting by ambulance must be justified with medical necessity. The agency requires backup documentation showing justification of medical necessity when billing for non-ITA transports (e.g., voluntary inpatient admission).

Ambulance transports for voluntary psychiatric admissions are covered under the medical program when there is a medical justification for the ambulance transport. Use of ambulance transportation for voluntary inpatient psychiatric admission requires prior authorization. The agency will not cover ambulance services when requested for the convenience of the client or the client's family.

For information regarding non-ITA transportation, see the following:

- For emergency and nonemergency ambulance transportation, see Coverage.
- For all other nonemergency or scheduled transportation, refer to the agency's Transportation services (nonemergency) web page and the agency's ProviderOne Billing and Resource Guide.

Who pays for transportation to and from court hearings?

DBHR ITA transportation to and from court is paid with state funds only with no federal match assistance.

> **Note:** Providers must clearly indicate that court is the origin or destination for the transport by using modifier "**E**" (in the modifier field, place an "**E"** in the **first position** for the origin, or in the **second position** for the destination.)

What is the children's long term inpatient program (CLIP)?

The CLIP program provides intensive inpatient psychiatric services to Washington residents between 5-18 years of age. Individuals 13 years of age and older may be placed in CLIP facilities under ITA orders.

CLIP transports are a form of nonemergency medical transportation that requires prior authorization (PA).

There are four CLIP facilities in the State of Washington:

- Child Study & Treatment Center in Lakewood
- McGraw Center in Seattle
- Pearl Street Center in Tacoma
- Tamarack Center in Spokane

The CLIP coordinator is responsible for facilitating placement of clients and requesting authorization for CLIP transports.

What is the parent initiated treatment (PIT) program?

Washington State law related to PIT specifies that the consent of a minor child is not required for parent-initiated admission to inpatient or outpatient mental health treatment.

RCW 71.34.660 states: "A minor child shall have no cause of action against an evaluation and treatment facility, inpatient facility, or provider of outpatient mental health treatment for admitting or accepting the minor in good faith for evaluation or treatment in accordance with RCW 71.34.600 or RCW 71.34.650 based solely upon the fact that the minor did not consent to evaluation or treatment if the minor's parent has consented to the evaluation or treatment."

For ambulance program purposes, the agency considers PIT-related transportation as nonemergency (intended for voluntary inpatient admission).

Nonemergency ambulance transportation for voluntary inpatient admission requires prior authorization, in the form of a PCS signed by a physician or psychiatric nurse (not a discharge planner).

Laws pertaining to PIT:

- **RCW** 71.34.010 Purpose - Parental participation in treatment decisions — Parental control of minor children during treatment.
- **RCW** 71.34.375 Parent-initiated treatment - Notice to parents of available treatment options.
- **RCW** 71.34.395 Availability of treatment does not create right to obtain public funds.
- **RCW** 71.34.400 Eligibility for medical assistance under chapter 74.09 RCW - Payment by the agency.
- **RCW** 71.34.405 Liability for costs of minor's treatment and care — Rules.
- **RCW** 71.34.500 Minor thirteen or older may be admitted for inpatient mental treatment without parental consent — Professional person in charge must concur - Written renewal of consent required.
- **RCW** 71.34.650 Parent may request determination whether minor has mental disorder requiring outpatient treatment — Consent of minor not required - Discharge of minor.
- **RCW** 71.34.700 Evaluation of minor thirteen or older brought for immediate mental health services - Temporary detention.

Note: Use of nonemergency ambulance transportation to an inpatient psychiatric facility must clearly show medical necessity based on the client's documented medical condition at the time of transport.

Are non-ambulance providers eligible to receive payment for ITA transportation services?

Yes. Non-ambulance providers (e.g. law enforcement) are eligible to receive payment for ITA transportation services. Providers are paid mileage only without a base rate.

What are the requirements for non-ambulance ITA transportation providers?

Provision of ITA transportation services is not restricted to ambulance providers and law enforcement officers. Entities able to provide secure transportation for ITA clients are eligible to enroll as ITA transportation providers with Medicaid.

Vehicle standards and maintenance

- Vehicles and equipment must be maintained in good working order and may be inspected by agency staff on request.
- All of the following equipment must be installed on each vehicle transporting physically restricted individuals:
  - ✓ The appropriate equipment to ensure that detained individuals are unable to interfere with the driver's operation of the vehicle. (e.g., divider between driver area and patient area)
  - ✓ Door(s) that can be secured by the driver from being opened by the individual from the inside of the vehicle. (When the individual is not accompanied by an escort person other than the driver)
  - ✓ Appropriate restraint devices
- In addition to the equipment listed above, each vehicle transporting physically restricted individuals must have the following equipment:
  - ✓ American Red Cross first aid kit or equivalent

- ✓ Fire extinguisher
- ✓ Flares, or other warning devices
- ✓ Flashlight
- ✓ Traction devices or tire chains when required by the Department of Transportation

Driver requirements

Designated providers must verify that all of the following are true:

- The driver has a valid driver's license
- The driver has had no major moving traffic violations in the past 3 years
- The driver has not been involved in any at-fault accidents within the past 2 years
- The driver is physically capable of safely transporting ITA clients and safely driving the vehicles

It is recommended that verification of these abilities is in the form of a written medical statement, or, if not available, some other form of credible verification.

Driver training

Drivers must be trained to do their job in a safe manner. A driver-training program includes both of the following:

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

Transportation for Involuntary Substance Use Disorder Treatment

What is the Ricky Garcia Act?

The Ricky Garcia Act, RCW 70.96A.140, provides for the involuntary detention of people evaluated by a designated chemical dependency specialist and assessed as one of the following:

- A danger to themselves
- A danger to others
- Gravely disabled

Who is eligible for substance use disorder services?

The Ricky Garcia Act applies to all people within the borders of the state of Washington, including people who are not Medicaid-eligible.

See the agency's ProviderOne Billing and Resource Guide for instructions to verify client eligibility.

If the detained person is not currently eligible for agency-covered ambulance services, providers must submit the claim with a designated chemical dependency specialist generated form following Superior Court Substance use disorder Proceedings Rule 2.2.

The substance use disorder form must:

- Be dated within 20 days of providing transportation services
- Contain the name of the person taken into custody
- Attest that transportation was for a person found to be a danger to themselves, a danger to others, or gravely disabled when assessed by a designated substance use disorder specialist

- State that the agent who undertakes the involuntary detention is authorized to take custody of the person according to RCW 70.96A.140

- State that the person was taken into custody for the purpose of delivering that person to an evaluation and treatment facility for a period of up to 72 hours excluding Saturdays, Sundays, and holidays as provided in RCW 70.96A.110 or 70.96A.120

- Specify the name and location of the evaluation and treatment facility where the person will be detained

All documentation must be properly completed, kept in the patient file, and made available to the agency for 6 years from the date of service in accordance with WAC 182-502-0020.

A list of service providers can be found on the Department of Social and Health Services Division of Behavioral Health and Recovery (DBHR) website.

Note: The Health Care Authority receives and processes claims, but claims are paid with funds from the Department of Social and Health Services Division of Behavioral Health and Recovery.

Who decides what transportation is necessary under the Ricky Garcia Act?

When a designated chemical dependency specialist detains a person, the designated chemical dependency specialist follows the statewide protocol to choose an appropriate method of transportation, if needed, from one of the following providers:

- Local police or sheriff
- Ambulance
- Other providers of secure transportation

When ambulance services are provided for a person with substance use disorder, ambulance providers must bill the agency using the procedures outlined within this billing guide to receive reimbursement. The agency does not guarantee payment for ambulance transportation not authorized by a designated chemical dependency specialist.

Who authorizes and pays for substance use disorder services?

People who are involuntarily detained according to Chapter 70.96A RCW for the purpose of evaluation and treatment are responsible for the cost of care and treatment (see RCW 71.05.100). The Department of Social and Health Services will pay the transportation costs when a designated chemical dependency specialist determines the services are noncovered by insurance or Medicare (e.g., when an ambulance must be used to transport the individual to a court hearing for ITA purposes) **and** one of the following applies:

- There is no other third party liability payment source and the involuntarily detained person does not have the resources to pay
- Requiring the person to pay would result in a substantial hardship upon the person or the person's family
- The services are noncovered by insurance or Medicare (e.g., when an ambulance must be used to transport the individual to a court hearing for ITA purposes)

Who pays for substance use disorder transportation of managed care enrollees?

Authorization for the ambulance transportation of a managed care enrollee to an evaluation and treatment (E&T) facility, secure detoxification facility, or approved substance use disorder treatment program is the responsibility of a designated chemical dependency specialist, not the person's Managed Care Organization (MCO).

Payment for ambulance transportation of a managed care enrollee to an E&T facility, secure detoxification facility, or approved substance use disorder treatment program is the responsibility of the client's MCO.

Payment for transportation of a managed care enrollee to and from court for a civil commitment hearing is the responsibility of the Department of Social and Health Services Division of Behavioral Health and Recovery (DBHR).

When are transportation services covered under the Ricky Garcia Act?

- The DBHR covers substance use disorder transportation services when provided from one of the following:

  - ✓ The site of the initial detention
  - ✓ A court hearing
  - ✓ A hospital
  - ✓ An evaluation and treatment facility

- The DBHR covers substance use disorder transportation services when provided to one of the following:

  - ✓ A less restrictive alternative setting (except home)
  - ✓ A court hearing
  - ✓ A hospital
  - ✓ An evaluation and treatment facility

When are transportation services not covered under the Ricky Garcia Act?

Under the Substance Use Disorder Program, DBHR does **not** pay for ambulance transportation for voluntary substance use disorder admissions.

The DBHR does not pay providers for transporting people to and from outpatient substance use disorder services.

Note: Ambulance transportation should not be an automatic transportation choice for substance use disorder clients. Transporting by ambulance must be justified with medical necessity. The agency requires backup documentation showing justification of medical necessity when billing for non-transports (e.g., voluntary inpatient admission).

Ambulance transportation for voluntary substance use disorder admissions is covered under the program when there is a medical justification for the ambulance transport. Use of ambulance transportation for voluntary inpatient substance use disorder admission requires prior authorization. The agency does not pay for ambulance services when requested for the convenience of the person or the person's family.

Who pays for transportation to and from court hearings?

For a person in an evaluation and treatment facility, DBHR transportation to and from court hearings is paid according to RCW 70.96A.140.

Note: Providers must clearly indicate that court is the origin or destination for the transport by using modifier "**E**" (in the modifier field, place an "**E"** in the **first position** for the origin, or in the **second position** for the destination.)

Audits

(Chapter 182-502A WAC)

The agency conducts prepayment and/or post-payment reviews of providers. Based on national and local medical policies, the agency selects providers demonstrating aberrant billing patterns for these reviews. The agency may conduct an on-site review of any ambulance facility (see 182-502A-0500).

Post-payment reviews

The agency conducts post-payment reviews using the national and local policies in effect on the selected dates of service.

Recoupment of improper payments

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

As a result of post-pay audits/reviews, the agency may consider a range of options (see 182-502A-1300). Foremost, the agency will recoup improper payments for claims.

In general, the agency recoups payments to ambulance providers when the agency determines:

- Ambulance transportation was not medically necessary in a particular case (the client could have safely traveled by other means).
- The ambulance transportation was not to the nearest appropriate facility. (This is a rebuttable presumption; providers must show a legitimate reason for going outside the local community for treatment).
- The mode of ambulance transportation used was not appropriate to the client's medical needs. For example, a client was involved in an injury accident and an air ambulance was used to transport the client to a nearby hospital. If the agency later determines that ground ambulance transportation would have been sufficient based on the client's documented medical condition at the time of service, the agency may recoup the payment for the air ambulance transport and pay the provider an amount equal to the rate for ALS ground service.

The agency may also take a narrower approach to recoupment. For example, the agency may:

- Reduce payment for a ground ambulance transport from ALS to BLS if the agency determines that BLS was sufficient based on information available at the time of service and from the trip report).

- Deny mileage reimbursement for the distance traveled beyond the closest appropriate facility if the agency determines that a client should have been transported to a closer hospital.

Tip: Keep adequate documentation (clinical and fiscal records) to support claims for services billed to the agency.

Quality of care audits and reviews

The agency expects providers to provide high quality care. The agency conducts reviews and/or audits to monitor and enforce community standards of care. See WAC 182-502A-0540(4).

Billing and Claim Forms

How can I submit ITA claims electronically?

Providers must submit ITA claims electronically. This helps with continuity of claims processing and creates better data for tracking and reporting.

ITA electronic claims 3-step process:

Step 1

Determine whether or not the patient has a ProviderOne client identification number.

If the patient has a ProviderOne client identification number, regardless of current/active status, submit the ITA transport claim electronically as you would all other ambulance claims. The *"SCI=I*" (without spaces) special claims indicator and all ITA supporting documentation is required. If the patient does not have a ProviderOne client identification number, proceed to step 2.

Step 2

Request a ProviderOne client identification number via a ProviderOne help ticket.

The provider must request an ITA client ID number using the following email address: mmishelp@hca.wa.gov. The subject line must read "*ITA ProviderOne Client ID Request"* and all required ITA documentation must be attached (see the information boxes on next page). The body of the email should request an active ProviderOne client identification number based on the attached ITA documents. The agency will review the documents and respond to the ticket with a new ProviderOne client identification number. Turnaround time is 24-72 hours. Upon receipt of the identification number, proceed to step 3.

Mental Health (MH) ITA Transports	Substance Use (SUD) ITA Transports
Claim Submission – Must have ALL of the following: • Ambulance provider trip report/run sheet AND • HCA 14-002 Form OR **Must be accompanied by one of the following:** • Authorization for Emergency Apprehension and Detention signed by a Designated Mental Health Professional (DMHP) • Notice of Emergency Detention signed by a DMHP • Petition for Emergency Detention under RCW 71.05/71.34 signed by a DMHP • Physician Certification Statement (PCS), when no DMHP is involved, and signed by either a Physician Assistant, Nurse Practitioner, Discharge Planner, Clinical Nurse Specialist, or Registered Nurse	**Claim Submission – Must have ALL of the following:** • Ambulance provider trip report/run sheet AND • HCA 13-850 Form OR **Must be accompanied by one of the following:** • Authorization for Emergency Apprehension and Detention signed by a Designated Chemical Dependency Specialist (DCDS) • Notice of Emergency Detention signed by a DCDS • Petition for Emergency Detention under RCW 70.96A signed by a DCDS • Physician Certification Statement (PCS), when no DCDS is involved, and signed by either a Physician Assistant, Nurse Practitioner, Discharge Planner, Clinical Nurse Specialist, or Registered Nurse

Step 3

Electronically submit the ITA transport claim with all required documentation.

Once the new ProviderOne client identification number is received, the provider must electronically submit the claim using the number received. Electronic submission can be done via DDE – Direct Data Entry (web submission) or 837P HIPAA batch.

Notes: If you have not received a response to your help ticket within 72 business hours, please contact our Customer Service Center at (800) 562-3022 and follow the prompts.

How do providers bill for mileage?

- Bill mileage only from the client's point of pick-up to the point of destination. Miles traveled by an ambulance without a medical assistance client on board are not payable.

- Fractional mileage at the end of a transport must be rounded up to the next whole unit/mile.

- If an air ambulance transports more than one client on a single trip, the agency will pay the lift-off rate for each client. Document the pick-up point and destination, for each client. The number of air 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. Modifier GM must be used **in addition** to the origin and destination modifier pair.

- If a ground ambulance provider makes a second or third transport for the same client during the same 24-hour period, the claim must indicate that it is a second or third transport, with appropriate pick-up and destination modifiers. Documentation maintained in the client's file must clearly show multiple transports on the same day.

- For ground ambulance transportation, when more than one client is transported on the same trip, no mileage charge is payable for the additional client(s).

Note: For one way distances greater than 100 miles, documentation must clearly show origin and destination. Submit a copy of the ambulance trip report with the claim.

How do providers complete the UB-04 claim form?

Note: Ambulance providers submitting a return trip claim must add a claim note in the comment field appropriate for the claim submission type. The claim note should read "Not a Duplicate." **Claims for return trips will automatically be denied if this note is not added.**

How do providers submit institutional services on a UB-04 crossover claim?

- Complete the claim form as if billing for a non-Medicare client.
- Always attach the Medicare Explanation of Medicare Benefits (EOMB).
- Enter the third party (e.g. Blue Cross) supplement plan name in the appropriate space. Enter **only** payments by a third party supplement plan and attach the Explanation of Benefits (EOB).

What is required from the provider-generated EOMB when processing a crossover claim?

Header level information on the EOMB must include all the following:

- Medicare as the clearly identified payer
- The Medicare claim paid or process date
- The client's name (if not in the column level)
- Medicare Reason codes
- Text in font size 12 or greater

Column-level labels on the EOMB for the UB-04 must include all the following:

- The client's name
- From and through dates of service
- Billed amount
- Deductible
- Co-insurance
- Amount paid by Medicare (PROV PD)
- Medicare Reason codes
- Text that is font size 12

How do providers submit institutional services on a UB-04 claim for inpatient clients eligible for Medicare Part B but not eligible for Medicare Part A, or for clients whose Medicare Part A is exhausted?

For all claims, include one of the following comments in the Remarks section:

- No Part A benefits
- Part A exhausted prior to stay
- Part A exhausted during stay

If Medicare benefits are exhausted, report the last Medicare Part A coverage date using Occurrence Code A3.

When including "No Part A benefits" or "Part A exhausted prior to stay," follow this process:

- **If your facility is reimbursed using PPS method (DRG and Per Diem):**

  ✓ Enter "Part B" in form locator 50 (A, B, C).

  ✓ Enter the amount Medicare paid for the Part B hospital charges in the corresponding line of form locator 54 (A, B, C).

  ✓ Attach the EOMB Parts A and B to the claim.

- **If your facility is reimbursed using the RCC (Ratio of Cost to Charges) method:**

  ✓ **Do not** enter "Part B" in form locator 50 (A, B, C).

  ✓ Bill using Type of Bill 111.

  ✓ Enter the amount covered by Medicare Part B for each service in the noncovered column at line level, as applicable.

  ✓ Attach the EOMB Parts A and B to the claim.

Note: The agency will deny your claim if one of the following condition codes is submitted:
Condition Code 04 – Information Only Bill
Condition Code 21 – Billing for Denial Notice