Washington State Health Care Authority

Medicaid Provider Guide

Ambulance and Involuntary Treatment Act (ITA) Transportation

Refer to Chapter 182-546 WAC

A Billing Instruction

About This Publication

These billing instructions are designed to help ambulance providers and their staff understand Department of Social and Health Services (the Department) regulations and requirements necessary for reporting accurate and complete claim information.

This publication supersedes all previous Department/MPA *Ambulance and ITA Transportation Billing Instructions* published by the Washington State Department of Social and Health Services, Health and Recovery Services Administration.

> **Note:** The Department now reissues the entire billing manual when making updates, rather than just a page or section. The effective date and revision history are now at the front of the manual. This makes it easier to find the effective date and version history of the manual.

Effective Date

The effective date of this publication is: **05/09/2010**.

2010 Revision History

This publication has been revised by:

Document	Subject	Issue Date	Pages Affected
Web updates	**Clarifying language, housekeeping changes, and put back in Fee Schedule information that was inadvertently omitted.**	**June 4, 2010**	**6, 7, B.1, F.3, F.13, H.2, and I.1**

How Can I Get Department/MPA Provider Documents?

To download and print Department/MPA provider numbered memos and billing instructions, go to the HCA website (click the ***Mediciad provider guides and provider notices*** link).

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Important Contacts

Note: This section contains important contact information relevant to Ambulance and ITA Transportation. For more contact information, see the HCA *Resources Available* web page

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Definitions & Abbreviations

This section defines terms and abbreviations, including acronyms, used in these billing instructions. Please refer to the HCA *ProviderOne Billing and Resource Guide* for a more complete list of definitions.

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

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

Advanced Life Support (ALS) - The level of care that calls for invasive emergency medical services requiring advanced medical treatment skills. [WAC 182-546-0001]

Advanced Life Support Assessment – An assessment performed by an ALS crew as part of an emergency response that was necessary because the client's reported condition at the time of dispatch was such that only an ALS crew was qualified to perform the assessment. An ALS assessment does not necessarily result in a determination that the client requires an ALS level of service. [WAC 182-546-0001]

Advanced Life Support Intervention – A procedure that is beyond the scope of care of an emergency medical technician (EMT). [WAC 182-546-0001]

Aid Vehicle – A vehicle used to carry aid equipment and individuals trained in first aid or medical procedures. [WAC 182-546-0001]

Air Ambulance – A helicopter or airplane designed and used to provide transportation for the ill and injured, and to provide personnel, facilities, and equipment to treat clients before and during transportation. Air ambulance is considered an ALS service. [WAC 182-546-0001]

Ambulance - A ground or air vehicle designed and used to provide transportation for the ill and injured; and to provide personnel, facilities, and equipment to treat clients before and during transportation; and licensed per RCW 18.73.140. [WAC 182-546-0001]

Approved Medical Program Director - A person who is:

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

Authorization number – A nine-digit

number assigned by the Department that identifies individual requests for services or equipment. The same authorization number is used throughout the history of the request, whether it is approved, pended, or denied.

Base Rate - The Department's minimum payment amount per covered trip, which includes allowances for emergency medical personnel and their services, the costs of standing orders, reusable supplies and equipment, hardware, stretchers, oxygen and oxygen administration, intravenous supplies and IV administration, disposable supplies, normal waiting time, and the normal overhead costs of doing business. The base rate excludes mileage. [Refer to WAC 182-546-0001]

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

Basic Life Support (BLS) - The level of care that justifies ambulance transportation but requires only basic medical treatment skills. It does not include the need for or delivery of invasive medical procedures/services. [WAC 182-546-0001]

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

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

[WAC 182-546-0001]

Benefit Service Package - A grouping of benefits or services applicable to a client or group of clients.

Bordering City Hospital – A licensed hospital in a designated bordering city (see WAC 182-501-0175 for a list of bordering cities). [Refer to WAC 182-546-0001]

By Report (BR) – A method of payment in which the Department determines the amount it will pay for a service that is covered but does not have an established maximum allowable fee. Providers must submit a report describing the nature, extent, time, effort, and/or equipment necessary to deliver the service. [WAC 182-546-0001]

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

Destination – see "point of destination".

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

- Placing the patient's health in serious jeopardy;
- Serious impairment to bodily functions; or
- Serious dysfunction of any bodily organ or part. [WAC 182-531-0050]

Emergency Medical Service - Medical treatment and care which may be rendered at the scene of any medical emergency or while transporting any client in an ambulance to an appropriate medical facility, including ambulance transportation between medical facilities. [WAC 182-546-0001]

Emergency Medical Transportation – Ambulance transportation during which a client receives needed emergency medical services en route to an appropriate medical facility. [WAC 182-546-0001]

Ground Ambulance - A ground vehicle,

including a water ambulance, designed and used to transport the ill and injured and to provide personnel, facilities, and equipment to treat clients before and during transportation. [WAC 182-546-0001]

Hospital – An institution licensed as a hospital by the Department of Health. [WAC 182-500-0005]

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

Involuntary Treatment Act (ITA) – See chapter 71.05 RCW and chapter 182-865 WAC for adults. See chapter 71.34 RCW and chapter 182-865 WAC for minors.

Invasive Procedure – A medical intervention that intrudes on the client's person or breaks the skin barrier. [WAC 182-546-0001]

Lift-off fee - Either of the two base rates the Department pays to air ambulance providers for transporting a client. The Department establishes separate lift-off fees for helicopters and airplanes. [WAC 182-546-0001]

Loaded Mileage – The number of miles the client is transported in the ambulance vehicle. [WAC 182-546-0001]

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

Medical Control – The medical authority upon whom an ambulance provider relies to coordinate prehospital emergency services, triage, and trauma center assignment/ destination for the patient being transported. The medical control is designated in the trauma care plan by the approved medical program director of the region in which the service is provided. [WAC 182-531-0050]

Medical Identification card(s) – See *Services Card*.

National Provider Identifier (NPI) – A federal system for uniquely identifying all providers of health care services, supplies, and equipment.

Non-emergency Ambulance Transportation – The use of a ground ambulance to transport a client who may be confined to a stretcher but typically does not require the provision of emergency medical services en route, or the use of an air ambulance when prior authorized by the Department. Non-emergency ambulance transportation is usually scheduled or prearranged. See also "Prone or Supine Transportation" and "Scheduled Transportation." [WAC 182-546-0001]

Paramedic - A person who:

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

Patient Identification Code (PIC) – See ProviderOne Client ID.

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

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

Point of Destination – A facility generally equipped to provide the needed medical or nursing care for the injury, illness, symptoms, or complaint involved. [WAC 182-546-0001]

Point of Pick-up – The location of the client at the time he or she is placed on board the ambulance or transport vehicle. [WAC 182-546-0001]

Prone or Supine Transportation – Transporting a client confined to a stretcher or gurney, with or without emergency medical services provided en route. [WAC 182-546-0001]

ProviderOne – Department of Social and Health Services (the Department) primary provider payment processing system.

ProviderOne Client ID- A system-assigned number that uniquely identifies a single client within the ProviderOne system; the number consists of nine numeric characters followed by WA.
For example: 123456789WA.

Psychiatric Indigent Inpatient (PII) Program – A state-funded, limited casualty (LCP) program specifically for mental health clients identified in need of inpatient psychiatric care by the Regional Support Network (RSN). (See page xii for a definition of Regional Support Network.) [WAC 182-865-0217(1)]

Record – Dated reports supporting claims submitted to the Department 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.

Scheduled Transportation – Prearranged

transportation for an eligible client, typically in a vehicle other than an ambulance, with no emergency medical services being required or provided en route to or from a covered medical service. The transportation is usually arranged and/or provided by Department-contracted transportation brokers. [WAC 182-546-0001]

Services Card – A plastic "swipe" card that the Department issues to each client on a "one- time basis." Providers have the option to acquire and use swipe card technology as one method to access up-to-date client eligibility information.

- The Services Card replaces the paper Medical Assistance ID Card that was mailed to clients on a monthly basis.
- The Services Card will be issued when ProviderOne becomes operational.
- The Services Card displays only the client's name and ProviderOne Client ID number.
- The Services Card does not display the eligibility type, coverage dates, or managed care plans.
- The Services Card does not guarantee eligibility. Providers are responsible to verify client identification and complete an eligibility inquiry.

Specialty Care Transport (SCT) – Interfacility transportation of a critically injured or ill client by a ground ambulance vehicle, including medically necessary supplies and services, at a level of service beyond the scope of the paramedic. [WAC 182-546-0001]

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

Transportation Broker – A person or organization contracted by Department to arrange, coordinate and manage the provision of necessary but non-emergency transportation services for eligible clients to and from covered medical services. [WAC 182-546-0005]

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

Trip – Transportation one-way from the point of pick-up to the point of destination by an authorized transportation provider. [WAC 182-546-0001]

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

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

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

Definitions Related to Involuntary Treatment Act (ITA) Transportation

Note: These definitions are related to Involuntary Treatment Act (ITA) Transportation and the Division of Behavioral Health and Recovery (DBHR).

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

Consumer – A person who has applied for, is eligible for, or who has received mental health services. For a child under the age of thirteen, or for a child age thirteen or older whose parents or legal guardians are involved in the treatment plan, the definition of consumer includes parents or legal guardians. [WAC 182-865-0150]

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.

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.

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

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

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

Division of Behavioral Health and Recovery (DBHR) – The Division of Behavioral Health and Recovery (DBHR) provides support for Mental Health, Chemical Dependency, and Problem Gambling Services. The public mental health programs promote recovery and resiliency and reduces the stigma associated with mental illness. The substance abuse prevention and chemical dependency treatment programs promote strategies that support healthy lifestyles by preventing the misuse of alcohol, tobacco, and other drugs, and support recovery from the disease of chemical dependency. The problem gambling program mitigates the effects of problem gambling on the family and helps families remain economically self-sufficient without requiring assistance from other state programs. DBHR brings operational elements like medical assistance, chemical dependency and mental health into closer working relationships that serve clients more effectively and efficiently than before.

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

Regional Support Network (RSN) - An entity that covers a county or a group of counties that is certified by DBHR to administer community mental health programs at a local level. Each RSN contracts with facilities and outpatient providers and distributes block grant funds for authorized mental health services. Visit the DBHR website for a list of RSNs at: http://www.dshs.wa.gov/dbhr/rsn.shtml

About the Program

The Department's Ambulance Transportation Program

[Refer to 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 the provider of Department-covered services that is closest and most appropriate to meet the client's medical need.

The Department covers the following types of ambulance transportation:

- Air Ambulance – emergency medical transportation by air;
- Ground Ambulance – transportation by ground or water ambulance that is either:
  - ✓ Emergency medical transportation; or
  - ✓ Transportation to Department-covered medical services requiring that the client:
    - ➢ Be transported by stretcher or gurney for medical or safety reasons[1]; or
    - ➢ Have medical attention from trained medical personnel available en route.

Medical Necessity for Ambulance Transportation

[Refer to WAC 182-546-0200]

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

The Department covers a client's transportation in an ambulance only if the client cannot be safely or legally transported any other way. If a client can safely travel by car, van, taxi, or other means, the ambulance transport is not medically necessary and the ambulance level of service is not covered by the Department[1].

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

Standards for Emergency Transportation

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

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

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

- *State of Washington Pre-hospital Trauma Triage Procedures* brochure (available from the Department of Health web site: http://www.doh.wa.gov/Portals/1/Documents/2900/ttt.pdf);
- Triage plans developed and implemented by the regional EMS and trauma care councils; and
- Client care procedures and protocols developed by the regional councils.

Scheduled or "Brokered" Non-emergency Medical Transportation

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

The Department's contract transportation brokers are listed on the *ProviderOne Billing and Resource Guide.*

Client Eligibility

Who Is Eligible? [Refer to WAC 182-546-0150]

Please see the *ProviderOne Billing and Resource Guide* for instructions on how to verify a client's eligibility.

> **Note:** Refer to the *Scope of Categories of Healthcare Services Table* for an up-to-date listing of Benefit Service Packages.

Are Clients Enrolled in a Department Managed Care Plan Eligible?

YES! When verifying eligibility using ProviderOne, if the client is enrolled in a Department managed care plan, managed care enrollment will be displayed on the Client Benefit Inquiry screen. Ambulance transportation services are covered under the Department's managed care plans, subject to each plan's coverage and limitations. Services include, but are not limited to:

- Basic Life Support (ground ambulance);
- Advanced Life Support (ground ambulance);
- Other required transportation costs, such as tolls and fares; and
- Air ambulance (rotary or fixed-wing aircraft).

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

Please contact the client's managed care plan to become familiar with their prior authorization and billing procedures.

> **Note:** To prevent billing denials, please check the client's eligibility **prior** to scheduling services and at the **time of the service** and make sure proper authorization or referral is obtained from the plan. See the *ProviderOne Billing and Resource Guide* for instructions on how to verify a client's eligibility.

Primary Care Case Management (PCCM)

For the client who has chosen to obtain care with a PCCM provider, this information will be displayed on the Client Benefit Inquiry screen in ProviderOne. These clients must obtain or be referred for services via a PCCM provider. The PCCM provider is responsible for coordination of care just like the PCP would be in a plan setting. Clients covered by a Primary Care Case Manager (PCCM) are eligible for ambulance services that are emergency medical services, or are approved by their PCCM in accordance with Department requirements.

Note: To prevent billing denials, please check the client's eligibility **prior** to scheduling services and at the **time of the service** and make sure proper authorization or referral is obtained from the PCCM provider. Please see the *ProviderOne Billing and Resource Guide* for instructions on how to verify a client's eligibility.

Provider Responsibilities

General Requirements for Ambulance Providers
[Refer to WAC 182-546-0300]

Licensing

- Ambulances must be licensed, operated, and equipped according to applicable federal, state, and local statutes, ordinances, and regulations; and

- All required licenses must be current and kept up to date.

> **Note:** The Department requires any out-of-state ground ambulance provider who is transporting Department clients within the state of Washington to comply with RCW 18.73.180 regarding stretcher transportation. [Refer to WAC 182-546-0800 (4)]

Staffing/Training

- Ambulances must be staffed and operated by appropriately trained and certified personnel. Personnel who provide any invasive procedure/emergency medical services for a client during an ambulance trip must be properly trained and authorized; and

- Ambulance providers must be in good standing to participate in the Department's Ambulance Transportation Program. Ambulance providers cannot be on Medicare's or any state Medicaid agency's sanctioned (disapproved) list.

Record Keeping

- The Department requires providers of ambulance services to document medical justification for transportation and related services billed to the Department. Documentation in the provider's client record must include adequate descriptions of the severity and complexity of the client's condition (including the circumstances that made the conditions acute and emergent) at the time of transportation. The Department may review the client record to ensure the Department's criteria were met.

- The Department requires providers to document why an ambulance was the only appropriate and effective means of transportation that did not endanger the client's health. Please ensure that proper documentation is included in the client's file.

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

Note: Refer to the *ProviderOne Billing and Resource Guide* for a complete list of records the Department providers must keep.

What Records Specific to Ambulance Providers Must Be Kept? **[Refer to WAC 182-546-0300 and WAC 182-546-0700 (3)]**

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

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

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

- The availability of special regional resources such as:

  - ✓ Trauma centers;
  - ✓ Burn centers; and
  - ✓ Toxicology treatment centers;

- The presence of regional health care networks;
- The existence of physician to physician relationships; and
- The availability of care at the destination hospital.

Quality of Care Audits and Reviews

- The Department expects providers to provide high quality care. The Department conducts reviews and/or audits to monitor and enforce quality standards.

- The Department conducts prepayment and/or postpayment reviews of providers. Based on national and local medical policies, the Department selects providers demonstrating aberrant billing patterns for these reviews. The Department conducts these postpayment reviews using the national and local policies effective when claims were processed. Based on these policies, the Department requests refunds for any services that were not medically necessary.

- The Department may conduct an on-site review of any ambulance facility. See WAC 182-501-0130, Administrative Controls, for additional information on audits conducted by Department staff.

Coverage

The Department's Ambulance program is a medical transportation service.

What Ambulance Transportation Services Are Covered?

The Department covers the following ambulance transportation:

- Ground ambulance when the eligible client:
  - ✓ Has a medical need for the transportation;
  - ✓ Needs medical attention to be available during the trip; or
  - ✓ Must be transported by stretcher or gurney (See RCW 18.73.180).
- Air ambulance when justified under the conditions specified by the Department in these billing instructions (in accordance with Chapter 182-546 WAC) or when the Department determines that air ambulance service is less costly than ground ambulance service in a particular case. In the latter case, the Department must prior authorize the air ambulance transportation.

When Are Ambulance Transportation Services Covered?

[Refer to WAC 182-546-0200]

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

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

What Happens if There Is Third-party Coverage for the Ambulance Transportation Services?

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

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

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

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

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

Ambulance Coverage during Inpatient Hospital Stays

[Refer to WAC 182-546-0425]

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

1. Transports to and from Other Diagnostic or Treatment Facilities

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

2. Hospital-to-Hospital Transfers

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

a. Accommodate a physician's or other health care provider's preference for facilities;

b. Move the client closer to family or home (i.e., for personal convenience); or

c. Meet insurance requirements or hospital/insurance agreements.

Transfer to a Higher Level of Care

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

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

Transfer to a Lower Level of Care

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

The Department considers requests for fee-for-service ambulance transportation of a client from an intervening hospital to the discharging hospital under the provisions of WAC 182-501-0160, Exception to Rule. The Department evaluates such transfer requests based on clinical considerations and cost-effectiveness. The Department approves transfer requests that are in the state's best interests. In this type of transfer (from a higher level to a lower level of care), fee-for-service payment is made only when the transport is prior authorized by the Department.

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

Non-emergency Ambulance Coverage

[Refer to WAC 182-546-0800, 182-546-1000, and 182-546-1500]

Non-emergency Ground Ambulance

- The Department covers non-emergency ground ambulance transportation under the following conditions:

  - ✓ The client is bed-confined and must be transported by stretcher or gurney (in the prone or supine position) for medical or safety reasons. Justification for stretcher or gurney must be documented in the client's record; or

  - ✓ The client's medical condition requires that he or she have basic ambulance level medical attention available during transportation, regardless of bed confinement.

- The Department requires ambulance providers to thoroughly document the circumstances requiring non-emergency ground ambulance transportation using the Physician Certification Statement - PCS. (See Section E – *Authorization Requirements*).

Non-emergency Air Ambulance

- The Department covers non-emergency air ambulance transportation only when the transport is prior authorized by the Department and all of the following conditions are met:

  - ✓ The client is eligible for ambulance transportation coverage;

  - ✓ The client's destination is an acute care hospital or approved rehabilitation facility; and

  - ✓ The client's physical or medical condition is such that travel by any other means endangers the client's health; or

  - ✓ Air ambulance is less costly than ground ambulance under the circumstances.

- The Department requires providers to thoroughly document the circumstances requiring a non-emergency air ambulance transport. The medical justification must be submitted to the Department prior to transport and must be documented in the client's medical record and ambulance trip report. Documentation must include adequate descriptions of the severity and complexity of the client's condition at the time of transportation.

Out-of-State Ambulance Coverage

[Refer to WAC 182-546-0800]

- The Department covers emergency transportation provided to the Department's eligible fee-for service clients who are out-of-state at the time of service. The Department requires out-of-state ambulance providers who provide covered medical services to eligible Department clients and want to be reimbursed by the Department for their services to:

  ✓ Meet the licensing requirements of the ambulance provider's home state; and
  ✓ Complete and sign a Department Core Provider Agreement.

- The Department does not cover out-of-state ambulance transportation for a fee-for service client when:

  ✓ The client's medical eligibility program covers medical services within Washington State and/or designated bordering cities only.

  ✓ The ambulance transport is taking the client to an out-of-state treatment facility for a medical service, treatment, or procedure that is available from a facility within Washington state or in a designated bordering city; or

  ✓ The transport was not an emergency transport and was not prior authorized by the Department.

Out-of-Country Ambulance Coverage

[Refer to WAC 182-546-0900]

The Department covers ambulance transportation for eligible fee-for-service clients traveling outside of the US and US territories, subject to the provisions and limitations of Chapter 182-546 WAC.

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

Noncovered Ambulance Services [Refer to WAC 182-546-0250]

The Department does not cover ambulance services when the transportation is:

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

The Department evaluates requests for services that are listed as noncovered in this section under the provisions of WAC 182-501-0160. See Section E, *Authorization Requirements*, for further information on requesting an Exception to Rule. For ambulance services that are otherwise covered under this section but are subject to one or more limitations or other restrictions, the Department evaluates, on a case-by-case basis, requests to exceed the specified limits or restrictions in accordance with WAC 182-501-0165.

Note: An ambulance provider may bill a client for noncovered services as described in this section if the requirements of WAC 182-502-0160 are met.

Noncovered Ambulance Transport Destinations

Home

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

Hospital (Non-emergency Transfers)

As a rule, the Department does not cover non-emergency hospital-to-hospital ambulance transports. Examples of non-emergency transports the Department does not cover include:

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

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

Noncovered Ambulance Transport Destinations (*Cont'd*)

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

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

- When the ambulance stops at one of these entities in order to stabilize the client or because of a client's dire need for professional attention, **and immediately thereafter, the ambulance continues en route to the hospital**; or

- When a nursing facility resident is transported roundtrip for specialized services to the nearest hospital or non-hospital treatment facility (e.g., clinic, therapy center, or physician's office) to obtain necessary diagnostic and/or therapeutic services (such as CT scan or radiation therapy) **not available** at the institution where the client is an inpatient. However, this benefit is subject to all existing coverage requirements and is limited to those cases where the transportation of the client is less costly than bringing the service to the client.

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

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

"Treat But No Transport" Service Calls

- The Department's Ambulance and ITA Transportation program is a transportation service. The Department 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 Department does not pay providers if no transport occurs because the client dies:

  ✓ Before the ambulance arrives at the scene; or
  ✓ After the ambulance arrives at the scene, but before medical intervention is provided.

- When an ambulance provider provides medical services to a client at the scene, but the client dies before transport is made, the Department pays the provider the **appropriate base rate**, commensurate with the level of service provided. Providers must document in their files what medical interventions were provided to the client by the ambulance crew at the scene before the client died. [WAC 182-546-0500 (2)]

- An ALS assessment is not sufficient to trigger payment to the provider unless transport takes place.

- "Treat but no transport" calls are **noncovered services**, except as provided in WAC 182-546-0500 (2).

Coverage Table

Air Ambulance

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

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

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

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

Ground Ambulance

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

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

Procedure Code	Modifier	Brief Description	EPA/PA	Policy/ Comments
A0434		Specialty care transport (SCT)		Origin and destination modifiers required. For each additional client, use modifier GM in addition to the origin and destination modifiers.
Mileage				
A0425		Ground mileage, per statute mile.		Origin and destination modifiers required.
Other Services				
A0170		Transportation ancillary: parking fees, tolls, other		Invoice required. Origin and destination modifiers required.
A0424		Extra ambulance attendant, ground (ALS or BLS) or air (fixed or rotary winged); (requires medical review)		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; or • Client is violent or difficult to move safely; or • More than one client is being transported, and each requires medical attention and/or close monitoring.
Note: The Department pays for an extra attendant in ground ambulance transports only. No payment is made for an extra attendant in air ambulance transports.				
T2006		Ambulance response and treatment, no transport.		Code not payable. Used for data collection purposes only.

Involuntary Treatment Act (ITA) Transportation

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

- The mileage rate is only for those miles that the involuntarily detained consumer is on-board the vehicle (loaded mileage). The Division of Behavioral Health and Recovery (DBHR) does not allow any additional charges beyond the rate per mile allowance, except for the extra attendant when specified conditions are met.

- DBHR reimburses for transportation services at a provider's usual and customary rate or the above maximum allowable per mile, whichever is less, for each eligible involuntarily detained consumer.

- DBHR payment is payment in full. DBHR allows no additional charge to the involuntarily detained consumer.

Authorization Requirements

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

Ambulance usage in non-emergency situations requires authorization:

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

Note: Please see the *ProviderOne Billing and Resource Guide* for more information on requesting authorization.

Out-of-State Transportation [Refer to WAC 182-546-0800(6)]

Ambulance providers who provide medical transportation that takes a client out-of-state or that brings a client into Washington State from an out-of-state location must obtain PA from the Department. Fax request and justification to the Department: 1-866-668-1214.

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

Non-emergency Ground Ambulance Transportation

The Department requires ambulance providers to thoroughly document the circumstances requiring non-emergency ground ambulance transportation using the Physician Certification Statement (PCS).

Physician Certification Statement (PCS) [Refer to WAC 182-546-1000]

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

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

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

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

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

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

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

Exception-to-Rule

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

To request an Exception to Rule (see WAC 182-501-0160) to transfer a newborn to its home community hospital, the transferring hospital must submit to the Department the following information:

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

If the Department approves the ETR request, the transferring hospital must give the ambulance provider copies of authorization documentation pertinent to the transport. See the *Important Contacts* section for information on contacting the Department for ETR.

Reimbursement

Ambulance Transports Included in Bundled Payment to Other Providers

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

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

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

What Is Included in the Base Rate?

The base rate includes:

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

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

What Is Not Included in the Base Rate?

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

General Limitations on Payment for Ambulance Services

[Refer to WAC 182-546-0400]

- The Department pays providers the lesser of the provider's usual and customary charge or the maximum allowable rate established by the Department. The Department's fee schedule payment for ambulance services includes a base rate or lift-off fee plus mileage.

- The Department does not pay providers under fee-for-service for ambulance services provided to a client who is enrolled in a Department managed care plan. Payment in such cases is the responsibility of the prepaid managed care plan.

- The Department does not pay providers for mileage incurred traveling to the point of pick-up or any other distances traveled when the client is not on board the ambulance. The Department pays for loaded mileage only.

  - ✓ The Department pays ground ambulance providers for the actual mileage incurred for covered trips by paying from the client's point of pick-up to the point of destination.

  - ✓ The Department pays air ambulance providers for the statute miles incurred for covered trips by paying from the client's point of pick-up to the point of destination.

- The Department does not pay for ambulance services if:

  - ✓ The client is not transported;

  - ✓ The client is transported but not to an appropriate treatment facility; or

  - ✓ The client dies before the ambulance trip begins (see the single exception for ground ambulance providers on page F.8).

- For clients in the Categorically Needy/Qualified Medicare Beneficiary (CN/QMB) and Medically Needy/Qualified Medicare Beneficiary (MN/QMB) Benefit Service Packages, the Department's payment is as follows:

  ✓ If Medicare covers the service, the Department will pay the lesser of:

  - The full coinsurance and deductible amounts due, based upon Medicaid's allowed amount; or
  - The Department's maximum allowable for that service minus the amount paid by Medicare.

  ✓ If Medicare does not cover or denies the ambulance services that the Department covers, the Department pays at the Department's maximum allowable; **except** the Department does not pay for clients on the QMB-only program.

Qualified Trauma Cases [Refer to WAC 182-546-3000]

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

Reimbursement for Out-of-State Transportation

[Refer to WAC 182-546-0800]

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

- The provider's billed amount; or
- The rate established by the Department.

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

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

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

Reasons for Recoupment of Payment

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

Modifiers **[Refer to WAC 182-546-0600]**

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

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

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

Other Modifiers

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

Reimbursement Specific to Ground Ambulance

[Refer to WAC 182-546-0450]

Levels of Transporting Service [Refer to WAC 182-546-0450(1)]

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

- A **BLS** ambulance trip is one in which the client requires and receives basic services at the scene and/or en route from the scene of the acute and emergency illness or injury to a hospital or other appropriate treatment facility. Examples of basic medical services are:

  - ✓ Controlling bleeding;
  - ✓ Splinting fracture(s);
  - ✓ Treating for shock; and
  - ✓ Performing cardiopulmonary resuscitation (CPR).

- An **ALS** trip is one in which the client requires and receives more complex services at the scene and/or en route from the scene of the acute and emergency illness or injury to a hospital. To qualify for payment at the ALS level, certified paramedics or other ALS-qualified personnel on-board must provide the advanced medical services in a properly equipped vehicle. Examples of complex medical services or ALS procedures are:

  - ✓ Administration of medication by intravenous push/bolus or by continuous infusion;
  - ✓ Airway intubation;
  - ✓ Cardiac pacing;
  - ✓ Chemical restraint;
  - ✓ Chest decompression;
  - ✓ Creation of surgical airway;
  - ✓ Initiation of intravenous therapy;
  - ✓ Manual defibrillation/cardioversion;
  - ✓ Placement of central venous line; and
  - ✓ Placement of intraosseous line.

Base Rate [WAC 182-546-0450(2)(3)]

- The Department's base rate includes:

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

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

- A ground ambulance trip is classified and paid at a BLS level, even if certified paramedics or ALS-qualified personnel are on board the ambulance, if no ALS-type interventions were provided en route. The base rate billed for each transport must reflect the level of care and types of medical interventions by trained and certified personnel on-board. The Department classifies a ground ambulance transport as BLS even with paramedics or ALS-qualified personnel on board if no ALS-type interventions are provided en route. Medical necessity, **not the level of personnel on board an ambulance**, dictates which level (BLS or ALS) of ground ambulance service is billed to the Department.

  For example: A client with an IV is transported from the hospital to a nursing facility. Hospital staff set up and started the IV administration. The ambulance personnel provided no other interventions except to monitor the client during the transport. This transport qualifies only for the BLS base rate.

- An ALS assessment does not qualify as an ALS transport if no ALS-type interventions were provided to the client en route to the treatment facility.

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

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

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

Mileage [WAC 182-546-0450(2)-(5)]

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

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

> **Note:** The Department 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 Department pays for extra mileage only with sufficient justification. The justification must be documented in the client's record and the ambulance trip report. Acceptable reasons for extra mileage include, but are not limited to the following:

  - ✓ A hospital was on "divert" status and not accepting patients; or
  - ✓ A construction site caused a detour, or had to be avoided to save time.

Extra Attendant [WAC 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, an additional payment for an extra attendant may be allowed when the justification for those services is documented in the client's file. Justification for an extra attendant would be:

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

When billing the Department, the provider must send justification/documentation of the unusual circumstances that warranted the need for an extra attendant.

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

Ferry and Bridge Tolls [WAC 182-546-0450(8)]

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

Waiting Time

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

Special Circumstances

- ***Multiple Providers Responding*** **[WAC 182-546-0450(6)]**

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

- ***Multiple Clients, Same Transport*** **[WAC 182-546-0500(1)]**

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

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

  ✓ No mileage charge for the additional client.

- ***Death of a Client*** **[WAC 182-546-0500(2)]**

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

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

- ***BLS-ALS Combined Response*** **[WAC 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 Department's fee schedule definition of an ALS intervention, the transporting BLS provider may bill the Department the ALS rate for the transport, provided a written reimbursement agreement between the BLS and ALS entities exists.

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

- ***Residents/Nonresidents*** **[Refer to WAC 182-546-0500(4)]**

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

- ***Specialty Care Transport*** **[Refer to WAC 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. The Department pays an ambulance provider the advanced life support (ALS) rate for an SCT-level transport provided:

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

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

- ***Non-emergency Ground Ambulance Transportation***
  [Refer to WAC 182-546-1000]

  The Department pays for non-emergency 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 Department's transportation brokers to provide non-emergency transportation at a negotiated payment rate. Any such subcontracted rate may not exceed the costs the Department would incur under WAC 182-546-1000 (1).

- ***"Treat But No Transport" Tracking Code (T2006)***

  This code is not payable, but the Department 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 Department will use the data collected in developing program policy.

Reimbursement Specific to Air Ambulance [WAC 182-546-0700]

Air Ambulance

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

What Is Covered? [WAC 182-546-0700]

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

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

Lift-off

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

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

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

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

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

Special Circumstances

- ***Multiple Clients*** **[WAC 182-546-0700(5)]**

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

- ***Multiple Lift-offs*** **[WAC 182-546-0700(6)]**

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

  ✓ If air ambulance is used and the trip involves more than one lift-off, the Department pays only one air ambulance transport for the same client one way. If the transport involves both helicopter and airplane, the lift-off fee and mileage payment will be based on the mode of air transport used for the greater distance traveled.

  ✓ If both air and ground ambulances are used, the Department pays one lift-off fee and total air miles to the air ambulance provider, and the applicable base rate and ground mileage to each ground ambulance provider involved in the trip, except when ground ambulance fees are included in the negotiated trip payment as provided on page D.4.

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

- ***Transports by Private Organizations*** **[WAC 182-546-0700(7)]**

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

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

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

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

  ✓ Medically necessary, the Department may deny or recoup its payment and/or limit payment based on the Department's established rate for a ground ambulance trip provided ground ambulance transportation was medically necessary; or

  ✓ To the nearest available and appropriate hospital, the Department may deny or recoup its payment and/or limit its maximum payment for the trip based on the nearest available and appropriate facility.

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

- ***Non-emergency Transports Require Prior Authorization***

  Providers must have prior authorization from the Department for any non-emergency air transportation, whether by air ambulance or other mode of air transportation. Non-emergency air transportation includes scheduled transports to or from out-of-state treatment facilities.

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

- ***Cancelled Trips***

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

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

Fee Schedule

Go to the following link, to view the Ambulance Transportation and ITA Transportation Fee Schedules, online.

Ground/Air Ambulance

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

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

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

ITA Transportation

The mileage rate is only for those miles that the involuntarily detained consumer is on-board the vehicle (loaded mileage). DBHR does not allow any additional charges beyond the rate per mile allowance, except for the extra attendant when specified conditions are met.

DBHR reimburses for transportation services at a provider's usual and customary rate or the above maximum allowable per mile, whichever is less, for each eligible involuntarily detained consumer.

DBHR payment is payment in full. DBHR allows no additional charge to the involuntarily detained consumer.

Out-of-State Services

Transportation to or from Out-of-State Treatment Facilities – Coordination of Benefits [Refer to WAC 182-546-2500]

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

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

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

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

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

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

For clients eligible for out-of-state coverage but have other third-party insurance, the Department considers requests for transportation to or from out-of-state treatment facilities as an Exception to Rule (see WAC 182-501-0160).

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

Air Ambulance Services to Out-of-State Treatment Facilities

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

- The Department considers the following criteria when reviewing a request for out-of-state services:

  - ✓ There is no equally effective, less costly alternative available in Washington State and/or in designated bordering cities; and

  - ✓ The service/treatment is not experimental.

- If the Department authorizes the out-of-state treatment, and the client needs air ambulance services, the referring provider must request authorization for air ambulance transport. The request for an air ambulance may be made at the same time as the request for out-of-state treatment, but the requests are evaluated separately by the Department.

- If the Department authorizes the air ambulance transport for the out-of-state treatment, call the Ambulance Program Manager at 360-725-1835 to arrange for the air ambulance transport.

- Air ambulance transports in these cases are reimbursed at negotiated rates. The Department payment is payment-in-full (see note on page G.3).

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

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

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

  After authorization is received from the Department for the transport to an in-state treatment facility, call the Ambulance Transportation Program Manager at 360-725-1835 to arrange for air ambulance transport, if air ambulance services are required.

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

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

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

Involuntary Treatment Act (ITA) Transportation

Transportation under the Involuntary Treatment Act (ITA)

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

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

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

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

The local police or sheriff

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

Ambulance

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

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

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

ITA Transportation Client Eligibility - Verification of Eligible Involuntarily Detained Consumers

Please see the ProviderOne Billing and Resource Guide for instructions on how to verify a client's eligibility.

If the detained individual is currently eligible for Department-covered ambulance services, providers may bill electronically with the special claims indicator "SCI=I" in field 19 of the CMS-1500 claim form. Refer to **3a "Direct Data Entry (DDE) Into ProviderOne"** or **3b "Online Claims Batch Submission"** in the "Submit Fee-for-Service Claims to Medical Assistance" section of the *ProviderOne Billing and Resource Guide* for more information.

If the detained individual is not currently eligible for Department-covered ambulance services, providers must submit the CMS-1500 claim form with backup documentation showing that transport was for an individual assessed by a DMHP and found to be a danger to self, danger to others, or gravely disabled.

The backup documentation must be dated within 20 days of transport and consist of a DMHP-generated form following Superior Court Mental Proceedings Rule 2.2. An acceptable form would indicate:

- The name of the person taken into custody.
- A statement that the person authorized to take custody is authorized pursuant to RCW 71.05.150(1) (d) or RCW 71.05.150(2).
- A statement that the person is to be 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. The 72-hour period begins when the evaluation and treatment facility provisionally accepts the person as provided in RCW 71.05.170.
- A statement specifying the name and location of the evaluation and treatment facility where such person will be detained.

Note: The Involuntary Treatment Act applies to all individuals within the borders of the state of Washington. An involuntarily–detained consumer does not have to be Medicaid eligible. The Department will pay the ITA transportation costs for any consumer that a DMHP determines is in need of ITA services.

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

Please visit the Division of Behavioral Health and Recovery (DBHR) website for a list of RSNs that you may contact regarding ITA services:

- The Department receives and processes claims, but **all** claims are funded through DBHR.

When Are Transportation Services Covered under ITA?

- DBHR covers transportation for ITA consumers when provided **from**:

  ✓ The site of the initial detention;
  ✓ A court hearing; or
  ✓ A hospital or an evaluation and treatment facility.

- DBHR covers transportation for ITA consumers when provided **to**:

  ✓ A hospital or an evaluation and treatment facility;
  ✓ A less restrictive alternative setting (except home); or
  ✓ A court hearing.

What Transportation Services Are Not Payable under ITA?

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

- For emergency and non-emergency ambulance transportation, refer to the *Table of Contents* of these billing instructions; and

- For all other non-emergency or scheduled transportation, refer to Department's Brokered Transportation program and the Department/MPA *ProviderOne Billing and Resource Guide*.

  The Department's contract transportation brokers

  The *ProviderOne Billing and Resource Guide*.

Driver and Vehicle Requirements for Non-Ambulance ITA Providers

Vehicle Standards and Maintenance

- Vehicles and equipment must be maintained in good working order and may be inspected by Department staff on request. The following equipment must be installed on each vehicle transporting physically restricted consumers:

  - ✓ The vehicle must be equipped so consumers are unable to interfere with the driver's operation of the vehicle;

  - ✓ Door(s) adjacent to a consumer must be secured from being opened from the inside of the vehicle when the consumer is not accompanied by an escort person other than the driver;

  - ✓ American Red Cross first aid box or equivalent;

  - ✓ Fire extinguisher;

  - ✓ Flares, or other warning devices;

  - ✓ Flashlight; and

  - ✓ Traction devices or tire chains when required by the Department of Transportation.

Driver Requirements

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

- Verify that the driver has a valid state driver's license;

- Verify that the driver has not had any major moving traffic violations for the past three years and has not been involved in any at-fault accidents within the past two years; and

- Verify that the driver is physically capable of safely handling consumers and capable of safely driving the vehicles. It is recommended that verification of these abilities be in the form of a written medical statement, or, if not available, some other form of credible verification.

Driver Training

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

- First aid training including current cardio-pulmonary resuscitation (CPR) certification; and

- The operation and use of all equipment associated with the job.

Billing and Claim Forms

What Are the General Billing Requirements?

Providers must follow the *ProviderOne Billing and Resource Guide*. These billing requirements include, but are not limited to:

- Time limits for submitting and resubmitting claims and adjustments;
- What fee to bill the Department for eligible clients;
- When providers may bill a client;
- How to bill for services provided to primary care case management (PCCM) clients;
- Billing for clients eligible for both Medicare and Medicaid; and
- Third-party liability.

How Do I Bill for Mileage?

- Bill mileage only from the client's point of pick-up to the point of destination.

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

- If an air ambulance transports more than one client on a single trip, the Department will pay the lift-off rate for each client. If more than one client is served with a single transport, document each pick-up point, destination, number of air miles. The miles associated with the trip must be divided equally by the number of clients transported. Modifier GM is required to indicate multiple patients on one ambulance trip.

- For ground ambulance only, if the provider makes a second or third transport for the same client during the same 24-hour period, the client's file must document or the billing must indicate that it is a second or third transport, with appropriate pick-up and destination modifiers.

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

Completing the CMS-1500 Claim Form

Note: Refer to the Department/MPA *ProviderOne Billing and Resource Guide* for general instructions on completing the CMS-1500 Claim Form.

The following CMS-1500 Claim Form instructions relate to ambulance/ITA transportation providers:

Field No.	Name	Entry
19.	**Reserved For Local Use**	Enter special claims indicator "B**"** to indicate *Baby on Parent's ProviderOne Client ID.* **Medicare/Medicaid Eligible Clients:** Also when applicable, enter *non-emergent* here when you are billing for a non-emergency service provided to a client whose physical condition was such that the use of any other transportation method was inadvisable. **ITA Transportation:** For ITA transports this is a required field. Enter special claims indicator "SCI=I"
24B.	**Place of Service**	Enter: 41 Ambulance, land 42 Ambulance, air 99 ITA transport
24E	**Diagnosis Code**	**Ambulance Services:** Enter the ICD-9-CM diagnosis code or V68.9. When code V68.9 is used, written justification noting condition requiring level of service is necessary (enter in *field 21*). **ITA Transports:** Enter the ICD-9-CM diagnosis code or V40.9.
24G.	**Days or Units**	Multiple units valid only on Mileage and Waiting Time codes. For all other codes enter a "1".