Washington State Health Care Authority

Washington Apple Health (Medicaid)

Ground Emergency Medical Transportation (GEMT) Billing Guide

July 1, 2022

Washington State Health Care Authority

Disclaimer

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

Billing guides are updated on a regular basis. Due to the nature of content change on the internet, we do not fix broken links in past guides. If you find a broken link, please check the most recent version of the guide. If this is the most recent guide, please notify us at askmedicaid@hca.wa.gov.

About this guide*

This publication takes effect **July 1, 2022**, and supersedes earlier billing guides to this program. Unless otherwise specified, the program in this guide is governed by the rules found in WAC 182-546-0510 through 182-546-0545.

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

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

Refer also to HCA's ProviderOne billing and resource guide for valuable information to help you conduct business with HCA.

How can I get HCA Apple Health provider documents?

To access providers alerts, go to HCA's provider alerts webpage.

To access provider documents, go to HCA's provider billing guides and fee schedules webpage.

Where can I download HCA forms?

To download an HCA form, see HCA's Forms & Publications webpage. Type only the form number into the Search box (Example: 13-835).

* This publication is a billing instruction.

Washington State Health Care Authority

What has changed?

The table below briefly outlines how this publication differs from the previous one. This table is organized by subject matter. Each item in the *Subject* column is a hyperlink that, when clicked, will take you to the specific change summarized in that row of the table.

Subject	Change	Reason for Change
How do providers renew enrollment?	• Removed annual Participating Provider Agreement (PPA) submission requirement for GEMT program renewal • Revised notice instructions (in Note box) regarding the PPA for withdrawal from GEMT program	The PPA no longer has an expiration date and does not require annual submission

Washington State Health Care Authority

Table of Contents

Washington State Health Care Authority

Resources Available

Topic	Resource Information
Becoming a provider or submitting a change of address or ownership	See HCA's Billers and Providers page. For additional information regarding the Ground Emergency Medical Transportation (GEMT) Program, see the GEMT Program page. Send GEMT program questions to HCAGEMTAdmin@hca.wa.gov
Finding out about payments, denials, claims processing, or HCA managed care organizations	See HCA's Billers and Providers page. For additional information regarding the Ground Emergency Medical Transportation (GEMT) Program, see the GEMT Program page. Send GEMT program questions to HCAGEMTAdmin@hca.wa.gov
Electronic billing	See HCA's Billers and Providers page. For additional information regarding the Ground Emergency Medical Transportation (GEMT) Program, see the GEMT Program page. Send GEMT program questions to HCAGEMTAdmin@hca.wa.gov
Finding HCA documents (e.g., billing guides, provider notices, and fee schedules)	See HCA's Billers and Providers page. For additional information regarding the Ground Emergency Medical Transportation (GEMT) Program, see the GEMT Program page. Send GEMT program questions to HCAGEMTAdmin@hca.wa.gov
Private insurance or third-party liability, other than HCA managed care	See HCA's Billers and Providers page. For additional information regarding the Ground Emergency Medical Transportation (GEMT) Program, see the GEMT Program page. Send GEMT program questions to HCAGEMTAdmin@hca.wa.gov

Topic	Resource Information
How do I request prior authorization, a limitation extension, or an exception to rule?	See HCA's Billers and Providers page. For additional information regarding the Ground Emergency Medical Transportation (GEMT) Program, see the GEMT Program page. Send GEMT program questions to HCAGEMTAdmin@hca.wa.gov
Where can I find provider information on nonemergency brokered transportation?	See HCA's Billers and Providers page. For additional information regarding the Ground Emergency Medical Transportation (GEMT) Program, see the GEMT Program page. Send GEMT program questions to HCAGEMTAdmin@hca.wa.gov

Definitions

This section defines terms and abbreviations, including acronyms, used in this billing guide. Refer to chapter 182-500 WAC and WAC 182-546-0125 for a complete list of definitions for Washington Apple Health.

Advanced Life support (ALS) – Special services designed to provide definitive prehospital emergency care, including but not limited to, cardiopulmonary resuscitation, cardiac monitoring, cardiac defibrillation, advanced airway management, intravenous therapy, administration with other drugs and other medicinal preparations, and other specified techniques and procedures.

Allowable costs – An expenditure which meets the test of appropriate Executive Office of the President of the United States' Office of Management and Budget Circular (OMB).

Basic life support (BLS) – Emergency first aid and cardiopulmonary resuscitation procedures to maintain life without invasive techniques.

Cognizant agency – The federal agency with the largest dollar value of direct federal awards with a governmental unit or component.

Cost Allocation Plan (CAP) – A document that identifies, accumulates, and distributes allowable direct and indirect costs to cost objectives. The CAP also identifies the allocation methods used for distribution to cost objectives, based on relative benefits received.

Direct costs – All costs identified specifically with a particular final cost objective in order to meet emergent medical transportation requirements.

Direct Federal Award – An award paid directly from the federal government. GEMT is not a direct award because it is paid through the Washington State Health Care Authority.

Emergency medical response (EMR) – Services performed at the point of injury or illness to evaluate or treat a health condition.

Emergency response – An activity such as fire suppression and EMR, which mitigates unexpected events that threaten to harm humans or damage property.

Federal financial participation (FFP) – The portion of medical assistance expenditures for emergency medical services that are paid or reimbursed by the Centers for Medicare and Medicaid Services (CMS) according to the state plan for medical assistance.

Federal matching assistance percentages (FMAP) – The percentage rates used to determine the amount of federal matching funds received by the state for expenditures under the Medicaid program.

Indirect costs – Costs for a common or joint purpose benefitting more than one cost objective and allocated to each objective using HCA-approved indirect rate or an allocation methodology.

Prehospital care – The assessment, stabilization, and care of a medical emergency during a medical emergency of an ill or injured patient by a paramedic or other person before the patient reaches the hospital.

Publicly owned or operated – A unit of government that is a state, city, county, special purpose district, or other governmental unit in the state that:

- Has direct access to tax revenues
- Has taxing authority
- Is an Indian tribe as defined in Section 4 of the Indian Self Determination and Education Assistance Act

Qualifying expenditure – An expense for covered services provided to an eligible beneficiary.

Service period – The state fiscal year (SFY) beginning July 1st and ending June 30th annually.

Shift – A standard period of time assigned for a complete cycle of work as set by each GEMT provider.

Washington State Health Care Authority

About the Program

What is the Ground Emergency Medical Transportation (GEMT) Program?

The Ground Emergency Medical Transportation (GEMT) Program is a voluntary program that allows publicly owned or operated emergency ground ambulance transportation providers to receive supplemental payments that cover the difference between a provider's actual costs per GEMT transport and the Medicaid base payment, mileage and other sources of reimbursement.

Providers receive cost-based, supplemental payments for emergency ground ambulance transportation of Medicaid fee-for-service clients under Title XIX of the federal Social Security Act and the Affordable Care Act (ACA) only.

For more information regarding emergency medical transportation guidelines, see the Ambulance and ITA Billing Guide

Washington State Health Care Authority

Provider Eligibility

What are the requirements for providers?

To qualify for voluntary participation under the GEMT program, providers must meet the following criteria:

- Provide GEMT services to Medicaid clients under Title XIX of the federal Social Security Act and the Affordable Care Act (ACA) only.
- Be publicly owned or operated by the state, a city, a county, a fire protection district, a community services district, or a federally recognized Indian tribe or any unit of government as defined in 42 CFR Sec. 433.50.
- Be an enrolled Medicaid provider with an active **Core Provider Agreement** for the claimed specified service period.

How do providers enroll?

To enroll in GEMT as a NEW provider, submit the following:

- **Provider Participation Agreement (PPA)**
- The Centers for Medicare and Medicaid Services (CMS)-approved GEMT cost report
- The mailing or physical address or both for the fire department/district
- The name of the fire department/district's main point of contact, and if applicable, the name of the fire department/district's second and third points of contact
- The email addresses for the fire department/district's first point of contact, and if applicable, the email addresses for the second and third points of contact
- The fire department/district's statewide vendor number

How do providers renew enrollment?

To renew GEMT enrollment, submit the CMS-approved GEMT cost report annually by November 30 to **HCAGEMTadmin@hca.wa.gov**.

> **Note**: Enrolled providers who no longer wish to participate in the GEMT program must submit written notification to **HCAGEMTAdmin@hca.wa.gov**

Washington State Health Care Authority

Client Eligibility

How can I verify a patient's eligibility?

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

Verifying eligibility is a two-step process:

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

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

Step 2. **Verify service coverage under the Washington Apple Health client's benefit package**. To determine if the requested service is a covered benefit under the Washington Apple Health client's benefit package, see HCA's Program Benefit Packages and Scope of Services webpage.

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

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

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

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

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

Washington State Health Care Authority

Which clients do not qualify for federal financial participation match?

The GEMT Program is a federal supplemental payment program for clients eligible for Medicaid under the Affordable Care Act (ACA) and Title XIX of the federal Social Security Act.

See the **ProviderOne Billing and Resource Guide** for more information on how to identify eligible Medicaid clients and recipient aid categories (RAC).

GEMT supplemental payments do not apply to transports for clients who do not qualify for Medicaid.

> **Note**: HCA does not apply GEMT pricing to Medicare/Medicaid recipients with dual eligibility. (WAC 182-546-0510).

Washington State Health Care Authority

GEMT Supplemental Payments

HCA pays GEMT supplemental payments using the certified public expenditure payment method.

- GEMT providers must certify uncompensated and allowable expenses using the CMS-approved cost identification principles and standards, such as the most current editions of the CMS Provider Reimbursement Manual and the United States Office of Management and Budget (OMB) Circular A-87.
- HCA makes supplemental payments for uncompensated and allowable costs incurred while providing GEMT services to Medicaid fee-for-service clients to cover the difference between actual costs and the Medicaid base payment, mileage and other sources of reimbursement.
- If the provider does not have uncompensated care costs, the provider will not receive supplemental payment under this program.
- The total supplemental payment, when combined with the amount received from all other sources of reimbursement, cannot exceed 100% of actual costs.

How are statewide vendor numbers used in the GEMT Program?

Providers must have a statewide vendor (SWV) number on file with HCA in order to receive GEMT supplemental and final settlement payments.

HCA uses the mailing address and bank information registered with the SWV number to send GEMT supplemental and final settlement payments. HCA mails payments by check to the registered mailing address and deposits final settlement payments to the registered bank account.

All GEMT providers must verify their SWV number information using the **Statewide Vendor Number Lookup tool**.

Refer to the **Office of Financial Management** website for answers to frequently asked questions concerning SWV numbers.

To revise the mailing address, bank account information, business or company name, contact name, email, phone/fax number or payment preferences, complete and submit the Statewide Payee Registration Form via fax or mail to the information located at the bottom of the form.

If the statewide vendor number changes, send written notification to **HCAGEMTAdmin@hca.wa.gov**

GEMT Claims Submission and Cost Reporting

Submitting claims

Providers must submit all claims for eligible services through ProviderOne in a timely manner.

When submitting a GEMT claim:

- Use one of the appropriate emergency transportation procedure codes: A0429, A0427, A0433 or A0434
- Use mileage procedure code A0425
- Both transportation and mileage codes must be billed and paid for providers to receive GEMT supplemental reimbursement.
- Refer to the **Ambulance and ITA Billing Guide** for more information on procedure codes.
- An additional line item entry using procedure code A0999 is required for providers to receive GEMT supplemental payments. This procedure code is set to pay the federal share of the difference between the Medicaid payable amount (for both the trip and mileage) and the established average cost per transport (interim supplemental payment).
- Providers must also include modifier SE for the procedure code A0999 line item to identify that the procedure code is for GEMT and not for standard miscellaneous supplies or medication. The modifier must be entered in the "modifiers" field. No place of origin/destination modifier is needed for this line item.

HCA disburses supplemental payments during the normal payment process and lists them on the Remittance Advice sent to each provider.

Washington State Health Care Authority

GEMT claims submission & payment formula examples

Note: For the purpose of the examples, the transport was a BLS emergency transport, distance from the client's residence to the emergency room was ten (10) miles, the average cost per transport was $1500.00 and the applicable FMAP was 50%

GEMT claim submission example					
Service provided	**Procedure code**	**Modifiers**	**Description**	**Billed amounts**	**Paid amounts**
Transportation	A0427	RH	Base rate for BLS or ALS level emergency transports	$421.00	$115.34
Mileage	A0425	RH	Mileage per fee schedule ($5.08/mile)	$73.70	$50.80
GEMT procedure code	A0999	SE	Federal supplemental payment	$1500.00 *Average cost per transport	$833.07
GEMT claims payment formula			**Example**		
Average cost per transport (ACPT)			$1500.00		
- Medicaid reimbursement for transportation and mileage			-$115.84 - $50.80 = $1,333.86		
x FMAP			x 50% = $666.93		
+ Medicaid reimbursement for transportation and mileage			+ $115.84 + $50.80		
= Total amount paid to the provider			= $833.07		

Cost reporting

All GEMT providers must annually certify direct and indirect costs as qualifying expenditures eligible for federal financial participation (FFP). Providers certify that the reported information is true and accurate to the best of their knowledge, and that the expenditures claimed have not previously been, nor will be, claimed at any other time to receive federal funds under Medicaid or any other program. Misrepresentation of information constitutes a violation of both state and federal law.

Cost reporting must:

- Be necessary to GEMT
- Allocate direct and indirect costs to appropriate cost objectives
- Include personnel cost exclusive to GEMT services (fire suppression is not included)
- Be in accordance to CMS-approved cost identification in the **CMS Provider Reimbursement Manual** and the **OMB Circular A-87**
- Exclude foundation grants and private fundraising because these are not expenditures of a government entity
- Indicate average cost per transport

> **Formula**: Sum total of the actual allowable direct and indirect costs ÷ Total number of medical transports provided during the service period

Complete an annual cost report

All GEMT providers must complete an annual cost report detailing the total CMS-approved, Medicaid-allowable, direct and indirect costs of delivering Medicaid covered services using the CMS-approved cost-allocation methodology.

Providers can certify the costs of releasing a client without transportation to a medical facility as an expenditure necessary to provide GEMT services.

Correct formats for cost report and due dates

Providers must submit to HCA an Excel version of the cost report AND a PDF version, including a signed and dated certification page, by November 30th. HCA considers extensions to the cost report deadline on a case-by-case basis. Send cost reports and deadline extension requests to **HCAGEMTAdmin@hca.wa.gov.**

HCA review of cost report

HCA will review the cost reports and notify the provider of the status (acceptance, rejection or request for additional documentation) within 90 days of receipt. Providers may be asked to submit additional documentation. If the cost report is rejected, the provider must make the necessary corrections and resubmit the information within 30 days of the rejection notification. Failure to provide the requested information may result in termination from the program for that reporting year.

Washington State Health Care Authority

Final Reconciliation and Settlement

Determining the final reconciliation and settlement

HCA determines the final reconciliation and settlement as follows:

- Within five months after the close of the state fiscal year (SFY), all participating GEMT providers must submit CMS-approved cost reports certifying the average cost per transport.
- The final cost reconciliation and settlement process begins approximately 2 years after the close of the SFY. For example, the 2019 SFY ends June 30, 2019. The cost report for the 2019 final settlement and reconciliation would occur June 30, 2021 or after. This is the two-year maturation period.
- HCA compares the interim supplemental payments disbursed through ProviderOne to payment amounts fire department/districts receive for GEMT services after the two-year maturation period.

1234567890		**Good Guys Fire Department**		
Invoice date	**Final settlement**	**GEMT amount received @ Interim**	**Provider share admin cost**	**Net payment / (owed)**
	A	B	C	D=A-B-C
08/23/2019	$778,000	$778,000	$6,250	($6,250)

- If GEMT interim supplement payments dispersed through ProviderOne exceed the payment amounts fire departments/districts receive for GEMT services after the two-year maturation period, HCA recovers the overpayment from the fire department/district.
- If GEMT interim supplemental payments disbursed through ProviderOne exceed the payment amounts fire departments/districts receive for GEMT services after the two-year maturation period, HCA reimburses the provider the difference.
- If the provider is paid more than the determined average cost per transport (ACPT), the provider must pay the excess amount back to HCA within 30 days to reimburse CMS for the federal share.
- If the provider is paid less than their determined average cost per transport, HCA issues an additional supplemental payment within 60 days.
- If a provider disputes the reimbursement rate before there is an overpayment, the provider may appeal under WAC 182-502-0220.
- If a provider disputes HCA's determination that the provider has been overpaid, the provider may request a hearing under WAC 182-502-0230.

- HCA reports to CMS any difference between the payments of federal funds made to the providers and the federal share of the qualifying expenditures. HCA returns excess funds to CMS.

GEMT records maintenance

GEMT providers must maintain the client's medical or health care records according to WAC 182-502-0020, which includes, but is not limited to, the following:

- Client's name and date of birth
- Name and title of person performing the service
- Chief complaint or reason for each visit
- Equipment and supplies prescribed or provided
- Subjective and objective findings
- Specific claims and payments received for services
- Advance directives, when required under WAC 182-501-0125
- Informed consent documentation
- Legible, accurate, and complete charts and records
- Charts authenticated by the person who gave the order, provided the care, or performed the observation, examination, assessment, treatment or other service
- Records of accounting procedures and practices that reflect all direct and indirect costs, of any nature, spent performing GEMT services

Providers must make charts and records available to HCA, its contractors or designees, and the United States Department of Health and Human Services (DHHS) upon request, for six years from the date of service or longer if required specifically by federal or state law or regulation. HCA does not separately reimburse for copying of health care records, reports, client charts and/or radiographs, and related copying expenses.

Providers must permit HCA, DHHS, and its agents or designated contractors, access to its physical facilities and its records to enable HCA and DHHS to conduct audits, inspections, or reviews without notice.

GEMT auditing

Providers must follow the terms and conditions outlined in HCA's Core Provider Agreement.

- HCA may conduct audit or investigation activities, as described under chapters 74.09 RCW and Chapter 182-502A WAC, to determine compliance with the rules and regulations of the core provider agreement, as well as of the GEMT Program.
- If an audit or investigation is initiated, the provider must retain all original records and supporting documentation until the audit or investigation is

completed and all issues are re-solved, even if the period of retention extends beyond the required six-year period required under WAC 182-502-0020.

HCA may require supporting documentation to make decisions concerning GEMT audits and investigations. Examples of appropriate supporting documentation include, but are not limited to:

- Cash receipts
- Copies of invoices
- Personnel records
- Proof of disbursements/payments
- Service contracts

HCA administration fees

GEMT providers must agree to reimburse HCA for all administrative costs associated with the administration of the GEMT program. The administrative fee due from the provider is based on the number of transports performed during the service period by the provider. Administrative fees due from the provider cannot be included as an expense in the annual cost report and will be collected during final cost settlement and reconciliation.

GEMT administrative fee formula	Example
Total cost to administer the GEMT program	$100,000
÷ Total number of Medicaid transports performed by all GEMT providers who participated in the program during the specified service period	$100,000 ÷ 8,000
= Administrative fee per transport	= $12.50
x Total number of Medicaid transport performed by specific GEMT provider	$12.50 x 500
= Administrative fee due from the specified GEMT provider	= $6,250

Example 1:

Administrative costs	Total number of Medicaid transports	Administrative fee per transport	Provider A #of transports	Fee for Provider A
A	B	A/B=C	D	C x D
$100,000	8,000	$12.50	500	$6,250

Example 2:

Administrative costs	Total number of Medicaid transports	Administrative fee per transport	Provider B #of transports	Fee for Provider B
A	B	A/B=C	D	C x D
$100,000	8,000	$12.50	50	$625