

**Washington Apple Health (Medicaid)**

# Ground Emergency Medical Transportation (GEMT) Billing Guide

**May 1, 2019**

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

# About this guide\*

This publication takes effect May 1, 2019.

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

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

This guide is designed to help qualified publicly owned or operated Ground Emergency Medical Transportation providers and their staff understand agency regulations and requirements necessary for reporting the claim information considered for GEMT supplemental payment.

## What has changed?

This is the first publication of the Ground Emergency Medical Transport (GEMT) Billing Guide.

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\*This guide is a billing instruction.

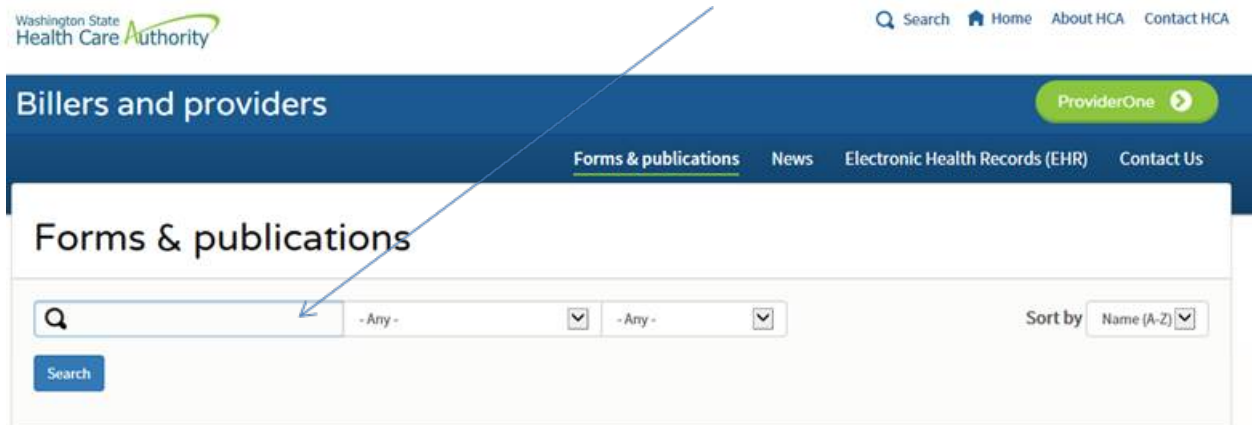
# How can I get agency provider documents?

To access provider alerts, go to the agency's [provider alerts](#) webpage.

To access provider documents, go to the agency's [provider billing guides and fee schedules](#) web page.

# Where can I download agency forms?

To download an agency provider form, go to HCA's [Billers and Providers webpage](#), select [Forms & publications](#). Type the HCA form number into the **Search box** as shown below (Example: 13-835).



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# Table of Contents

- Resources Available.....5
- Definitions.....6
- About the Program.....8
- Provider Eligibility.....9
  - What are the requirements for providers?.....9
  - How do providers enroll?.....9
  - How do providers renew enrollment?.....10
- Client Eligibility.....11
  - How can I verify a patient’s eligibility? .....11
- GEMT Supplemental Payments.....13
- GEMT Claims Submission and Cost Reporting .....15
  - Submitting claims .....15
  - Cost reporting.....17
- Final Reconciliation and Settlement .....19
  - Determining the final reconciliation and settlement.....19
  - HCA administration fees.....22

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**Alert!** This Table of Contents is automated. Click on a page number to go directly to the page.

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# Resources Available

Topic	Resource Information
Becoming a provider or submitting a change of address or ownership	
Finding out about payments, denials, claims processing, or agency managed care organizations	See the agency's <a href="#">Billers and Providers</a> page.
Electronic billing	
Finding agency documents (e.g., billing guides, provider notices, and fee schedules)	
Private insurance or third-party liability, other than agency managed care	For additional information regarding the Ground Emergency Medical Transportation (GEMT) Program, see the <a href="#">GEMT Program</a> page.
How do I request prior authorization, a limitation extension, or an exception to rule?	Send GEMT program questions to <a href="mailto:HCAGEMTAdmin@hca.wa.gov">HCAGEMTAdmin@hca.wa.gov</a>
Where can I find provider information on nonemergency brokered transportation?	

# Definitions

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

**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. ([WAC 182-546-0001](#))

**Agency** – The Washington State Health Care Authority. ([WAC 182-546-0505](#))

**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). ([WAC 182-546-0505](#))

**Basic life support (BLS)** – Emergency first aid and cardiopulmonary resuscitation procedures to maintain life without invasive techniques. ([WAC 182-546-0001](#))

**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. ([WAC 182-546-0505](#))

**Direct costs** – All costs identified specifically with a particular final cost objective in order to meet emergent medical transportation requirements. ([WAC 182-546-0505](#))

**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. ([WAC 182-546-0505](#))

**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.

## Ground Emergency Medical Transport (GEMT)

**Indirect costs** – Costs for a common or joint purpose benefitting more than one cost objective and allocated to each objective using agency-approved indirect rate or an allocation methodology. ([WAC 182-546-0505](#))

**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. ([WAC 182-546-0505](#))

**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

([WAC 182-546-0505](#))

**Qualifying expenditure** – An expense for covered services provided to an eligible beneficiary. ([WAC 182-546-0505](#))

**Service period** – The state fiscal year (SFY) beginning July 1st and ending June 30th annually. ([WAC 182-546-0505](#))

**Shift** – A standard period of time assigned for a complete cycle of work as set by each GEMT provider. ([WAC 182-546-0505](#))

# About the Program

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

[\(WAC 182-546-0510\)](#)

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](#)**



# Provider Eligibility

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## 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](#)
- 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 following annually by November 30<sup>th</sup> to [HCAGEMTadmin@hca.wa.gov](mailto:HCAGEMTadmin@hca.wa.gov):

- Provider Participation Agreement
- The CMS-approved GEMT cost report

**Note:** If your fire department/district submits the GEMT annual participation agreement before November 30<sup>th</sup> and later decides not to participate for the agreed service period, send written notification to [HCAGEMTadmin@hca.wa.gov](mailto:HCAGEMTadmin@hca.wa.gov).

# Client Eligibility

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## 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 the agency will not pay for.

Verifying eligibility is a two-step process:

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

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

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

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

1. By visiting the Washington Healthplanfinder's website at: [www.wahealthplanfinder.org](http://www.wahealthplanfinder.org)
2. By calling the Customer Support Center toll-free at: 855-WAFINDER (855-923-4633) or 855-627-9604 (TTY)
3. By mailing the application to:  
Washington Healthplanfinder  
PO Box 946  
Olympia, WA 98507

In-person application assistance is also available. To get information about in-person application assistance available in their area, visit [www.wahealthplanfinder.org](http://www.wahealthplanfinder.org) or call the Customer Support Center.

## Which clients do not qualify for federal financial participation match?

The GEMT Program is a federal supplemental payment program for Medicaid clients only. GEMT supplemental payments do not apply to transports for clients who do not qualify for Medicaid.

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

**Note:** The agency does not apply GEMT pricing to Medicare/Medicaid recipients with dual eligibility. ([WAC 182-546-0510](#)).

# GEMT Supplemental Payments

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(WAC [182-546-0520](#))

The agency 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.
- The agency 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 the agency in order to receive GEMT supplemental and final settlement payments.

The agency uses the mailing address and bank information registered with the SWV number to send GEMT supplemental and final settlement payments. The agency 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](mailto:HCAGEMTAdmin@hca.wa.gov).

# GEMT Claims Submission and Cost Reporting

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[\(WAC 182-546-0525\)](#)

## Submitting claims

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

When submitting a claim:

- Use one of the appropriate emergency transportation procedure code: 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.

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

# Claims payment example

Providers must enter three (3) line items on the claim submission during the process as follows:

- A0427, A0429, A0433 or A0434 – Base rate for BLS, ALS or Specialty Care transports
- A0425 – Mileage per fee schedule
- A0999 – Procedure code for average cost per transport

<b>Average Cost per Transport (ACPT)</b>	
	\$1,500.00
<b>Base Rate</b>	
■	\$115.34
<b>Mileage</b>	
■	\$50.80
<b>Variance</b>	
	\$1,333.86
<b>Variance</b>	
	\$1,333.86
<b>Federal Medical Assistance Percentage (FMAP)</b>	
✕	50%
	\$666.93
<b>FMAP</b>	
	\$666.93
<b>Base Rate</b>	
+	\$115.34
<b>Mileage</b>	
+	\$50.80
<b>Total amount paid the provider</b>	
	\$833.07

Note: For the purpose of this example, the transport is a BLS level transport, the trip was for a total of ten (10) miles and the determined average cost per transport is \$1500.00

**Formula:**

$$\begin{aligned} &\text{Average cost per transport (ACPT)} \\ &\quad - \text{Medicaid payable amounts} \\ &\quad \quad \text{for both the base rate and} \\ &\quad \quad \text{mileage} \\ &= \text{Variance} \end{aligned}$$

$$\begin{aligned} &\text{Variance} * \text{FMAP} \\ &= \text{Federal Financial Participation} \\ &\quad \quad \text{(FFP)} \end{aligned}$$

$$\begin{aligned} &\text{FFP} + \text{Medicaid payable amounts} \\ &\quad \text{for both the base rate and mileage} \\ &= \text{Total amount paid to the} \\ &\quad \quad \text{provider} \end{aligned}$$



# 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 & 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 the agency an Excel version of the cost report **AND** a PDF version, including a signed and dated certification page, by November 30<sup>th</sup>. The agency 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](mailto:HCAGEMTAdmin@hca.wa.gov).

## **Ground Emergency Medical Transport (GEMT)**

### **Agency review of cost report**

The agency 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.

# Final Reconciliation and Settlement

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[\(WAC 182-546-0535\)](#)

## Determining the final reconciliation and settlement

The agency determines the final reconciliation and settlement as follows:

- The state fiscal year (SFY) or service period begins July 1<sup>st</sup> and ends June 30<sup>th</sup> of each year.
- Within five months after the close of the 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 each service period.
- The agency compares the average cost per transport certified on the cost report to the interim supplemental payments data-recorded in ProviderOne for that service period.
- If GEMT interim supplement payments exceed the actual average cost per qualifying transport reported for that particular service period, the agency recovers the overpayment from the fire department/district.
- If GEMT interim supplemental payments are less than the actual average cost per qualifying transport reported for that particular service period, the agency 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 the agency within 30 days to reimburse CMS for the federal share.
- If the provider is paid less than their determined average cost per transport, the agency 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](#).

## Ground Emergency Medical Transport (GEMT)

- If a provider disputes the agency's determination that the provider has been overpaid, the provider may request a hearing under [WAC 182-502-0230](#).
- The agency reports to CMS any difference between the payments of federal funds made to the providers and the federal share of the qualifying expenditures. The agency returns excess funds to CMS.

## GEMT records maintenance

[\(WAC 182-546-0540\)](#)

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 the agency, 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. The agency does not separately reimburse for copying of health care records, reports, client charts and/or radiographs, and related copying expenses.

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

## **GEMT auditing**

**[\(WAC 182-546-0545\)](#)**

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

- The agency 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 resolved, even if the period of retention extends beyond the required six-year period required under [WAC 182-502-0020](#).

The agency 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 the agency 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.

The calculation of administrative fees due begins with determining the total number of Medicaid transports performed by all GEMT providers combined.

For the purpose of demonstrating administrative fee calculations, the agency assumes the following:

- Total administrative costs were \$100,000 for the service period
  - All GEMT providers performed 8,000 transports combined
1. Divide the administrative costs by the total number of GEMT transports to determine the cost per transport for the service period.

$$\text{\$100,000} \div 8000 = \text{\$12.50} \text{ cost per transport}$$

2. Multiply the cost per transport by the number of transports each individual fire department/district performed to determine the provider-specific administrative fee due at final reconciliation and settlement.

$$\text{\$12.50} \text{ cost per transport} \times 500 = \text{\$6,250} \text{ administrative fee due from "ABC Fire Protection District."}$$

*To demonstrate administrative fee calculations, assume "ABC Fire Protection District" provided a total of 500 transports during the service period.*