Washington State Health Care Authority

Washington Apple Health (Medicaid)

Ambulance Transportation Billing Guide

March 1, 2020

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 March 1, 2020 and supersedes earlier guides to this program.

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

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

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

What has changed?

Subject	Change	Reason for Change
Entire document	General housekeeping, including formatting changes, hyperlink fixes, and corrected typographical errors.	To improve usability of the document
	Added "Nonphysician Certification Statement (NPCS)" in addition to existing physician certification statement (PCS) throughout as needed.	To align with new CMS requirements, 42 CFR 410.40. This change is retroactive to dates of service on and after January 1, 2020.
Definitions	Added definition for "Nonphysician Certification Statement (NPCS)."	To align with new CMS requirements, 42 CFR 410.40.
Transfer to an equivalent or lower level of care	Removed note box regarding PCS is not valid authorization for hospital to hospital transfers.	Prior authorization for ground transfers is no longer required.

* This publication is a billing instruction.

Subject	Change	Reason for Change
When is a PCS or NPCS appropriate to use	Added clarification of when each form should be used and who can sign	To align with new CMS requirements, 42 CFR 410.40.
Who can sign a PCS	Added physicians are allowed to sign PCS.	Clarification on who can sign a PCS versus an NPCS.
Who can sign an NPCS	Added additional signers to include licensed practical nurse, social worker and case manager.	Clarification on who can sign an NPCS.
What must a PCS and NPCS include	Added note box to clarify that the amended CMS rules do not change the PCS requirements for scheduled, repetitive transports.	Scheduled, repetitive transports require the physician's signature on a PCS.

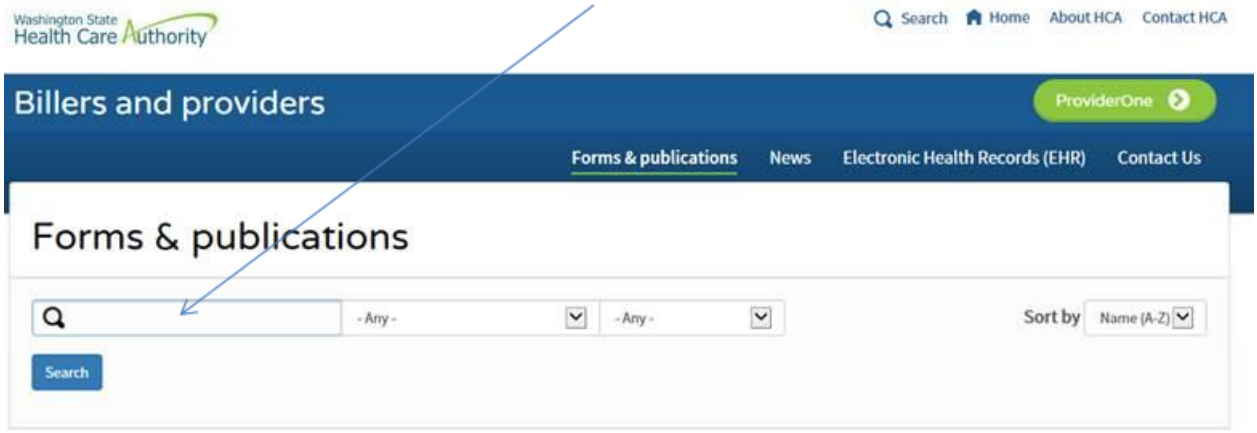
How can I get agency provider documents?

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 webpage.

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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Resources Available

Topic	Resource Information
Becoming a provider or submitting a change of address or ownership	See the agency's Billers and Providers page.
Finding out about payments, denials, claims processing, or agency managed care organizations	
Electronic billing	
Finding agency documents (e.g., billing guides, provider notices, and fee schedules)	
Private insurance or third-party liability, other than agency managed care	
How do I request prior authorization, a limitation extension, or an exception to rule?	
Where can I find provider information on nonemergency brokered transportation?	
How do I obtain the following forms? HCA 13-680, HCA 13-950, HCA 13-787, HCA 13-835, HCA 42-0003	Visit the agency's forms and publications webpage.
Prior Authorization	Providers may now submit prior authorization (PA) requests online through direct data entry into ProviderOne. See the agency's Prior authorization webpage for details.

Definitions

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

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

Advanced life support (ALS) - The level of care that requires advanced medical skills to perform invasive emergency treatment services, if needed.

Advanced life support assessment – An assessment performed by an ALS crew as part of an emergency response that was necessary because the client's reported condition at the time of dispatch was such that only an ALS crew was qualified to perform the assessment. An ALS assessment does not necessarily result in an ambulance transport or a determination that the client requires an ALS level of ambulance transportation.

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

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

Air ambulance – A helicopter or airplane designed and used to provide transportation for the ill and injured, and to provide personnel, facilities, and equipment to treat clients before and during transportation. Air ambulance is considered an ALS service.

Ambulance - A ground or air vehicle designed and used to provide transportation for the ill and injured; and to provide personnel, facilities, and equipment to treat clients before and during transportation. An ambulance must be licensed per RCW 18.73.140.

Approved Medical Program Director - A person who:

- Is licensed to practice medicine and surgery under chapter 18.71 RCW, or osteopathic medicine and surgery under chapter 18.57 RCW.
- Is qualified and knowledgeable in the administration and management of emergency care and services.
- Is so certified by the Department of Health for a county, a group of counties, or cities with populations over four hundred thousand in coordination with the recommendations of the local medical community and local emergency medical services and trauma care council. [Refer to RCW 18.71.205(4)]

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

Base rate - The agency's minimum payment amount per covered trip, which includes allowances for emergency medical personnel and their services, the costs of standing orders, reusable supplies and equipment, hardware, stretchers, oxygen and oxygen administration, intravenous supplies and IV administration, disposable supplies, normal waiting time, and the normal overhead costs of doing business. The base rate excludes mileage. For air ambulances, the base rate is the lift-off fee.

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

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

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

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

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

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

Designated Crisis Responder (DCR) – A behavioral health professional appointed by the county or other authorized authority to perform duties specified in RCW 71.05 and who has received chemical dependency training as determined by the Division of Behavioral Health and Recovery (DBHR).

Destination – see "point of destination."

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

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

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

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

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

Involuntary Treatment Act (ITA) – See chapter 71.05 RCW for adults. See chapter 71.34 RCW for minors.

Invasive procedure – A medical intervention that intrudes on the client's person or breaks the skin barrier.

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

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

Medical control – The medical authority upon whom an ambulance provider relies to coordinate prehospital emergency services, triage, and/or trauma center assignment/ destination when transporting a patient. The medical control is designated in the trauma care plan by the approved medical program director of the region in which the service is provided.

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

Nonphysician Certification Statement (NPCS) – A statement or form signed by a designated medical professional other than the client's attending physician. The individual must be employed by the client's attending physician or the hospital or facility where the client is being treated and for which the client is transported.

Paramedic - A person who:

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

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

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

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

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

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

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

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

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

Trip – Transportation one-way from the point of pick-up to the point of destination by an authorized transportation provider.

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

About the Program

What is the ambulance transportation program?

(WAC 182-546-0100)

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

The agency covers the following two types of ambulance transportation:

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

  Ground ambulance services include the following:

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

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

When does the agency pay for ambulance transportation?

(WAC 182-546-0200)

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

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

What are the guidelines for emergency medical transportation?

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

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

> **Exception:** Transportation decisions under the Involuntary Treatment Act (ITA) are made by designated crisis responder (DCR) and, in some cases, the clients attending physician.

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

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

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

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

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

For more information visit the agency's Transportation Services (nonemergency) webpage.

Client Eligibility

Most Apple Health clients are enrolled in an agency-contracted managed care organization (MCO). This means that Apple Health pays a monthly premium to an MCO for providing preventative, primary, specialty, and other health services to Apple Health clients. Clients in managed care must see only providers who are in their MCO's provider network, unless prior authorized or to treat urgent or emergent care. See the agency's Apple Health managed care page for further details. **All ambulance services, however, are covered through the agency's fee-for-service program, beginning January 1, 2018.**

It is important to always check a client's eligibility prior to providing any services because it affects who will pay for the services.

How do I verify a client's eligibility?

Check the client's Services Card or follow the two-step process below to verify that a client has Apple Health coverage for the date of service and that the client's benefit package covers the applicable service. This helps prevent delivering a service the agency will not pay for.

Verifying eligibility is a two-step process:

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

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

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

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

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

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

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

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

What ambulance services are clients eligible for?

(WAC 182-546-0150)

Except for clients in the agency's Family Planning Only program, all clients are eligible for ambulance transportation to covered services with the following limitations:

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

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

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

Are clients enrolled in an agency-contracted managed care organization eligible for ambulance services?

Yes. Ambulance services provided to clients who are enrolled in an agency-contracted managed care organization (MCO) are paid by the agency through fee-for-service (FFS). Ambulance providers must bill the agency directly. Coverage and billing guidelines found in this billing guide apply to both MCO clients and FFS clients.

When verifying eligibility using ProviderOne, if the client is enrolled in an agency-contracted MCO, managed care enrollment will be displayed on the Client Benefit Inquiry screen.

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

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

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

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

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

Who is responsible for payment of ambulance services for local inmates and state-incarcerated people?

The agency does not pay for ambulance services for people detained in public institutions, including correctional facilities, local jails, and work-release programs. See WAC 182-503-0505(5) and 182-546-0150(6).

The agency pays only for **inpatient** services provided to detained people who meet Medicaid eligibility criteria.

According to RCW 70.48.130 RCW, payment for emergency health services for a detained person is the responsibility of the governing unit. A detained person is one who is lawfully confined, totally or partially, under the provisions of RCW 71.05.020 and RCW 9.94A.030.

Example #1: If a client is legally detained (an inmate) in a state prison facility or local jail and has suspended Medicaid coverage but needs to be transported to the local emergency department (ED) for covered medical services, the transport from the prison is the financial responsibility of the prison.

Example #2: If a client is legally detained (an inmate) in a state prison facility or local jail, was admitted to a local hospital, has active Medicaid coverage, and needs to be transferred to another hospital for covered medical services, the interfacility transfer is the financial responsibility of the Medicaid agency.

Provider Responsibilities

(WAC 182-546-0300)

What are the general requirements for ambulance providers?

Licensing

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

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

Staffing/training

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

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

Verifying client eligibility
(WAC 182-502-0100 (5))

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

Billing in a timely manner

(WAC 182-502-0150)

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

Documenting services billed/provided

(WAC 182-546-0300)

The transportation provider must submit a trip report /run sheet for the following types of specialty transportation:

- Involuntary or voluntary mental health or substance use disorder transportation services
- Transportation with mileage greater than or equal to 250 miles one way
- Round/multiple trips for the same client in the same day

The documentation is to justify claims adjudication decisions. The documentation must be legible, accurate, and complete. It must include, but is not limited to, the following information:

- Transported client's full name and date of birth
- Medical justification for each transport (e.g., need for speed and monitoring of suspected heart attack)
- Pertinent findings on examination (e.g., ambulatory, pulse rate, oxygen saturation, stated pain level)
- Specific location of origin and destination and any additional or non-scheduled destinations (e.g., intermediate stop at a physician's office to stabilize client)
    - ✓ **Origin:** Information must include the facility's full name and address, including state
    - ✓ **Destination:** Information must include the facility's full name and address, including state
- Beginning and ending odometer mileage for ground ambulance trips. Use statute miles for air ambulance trips. See WAC 182-546-0700(3)
- Information regarding who or what triggered the ambulance transport request and the reason why an ambulance was the only appropriate and effective means of transportation that did not endanger the client's health

- If air ambulance is used, justification for this mode of transportation must be clearly documented

- Specific examples of required documentation in some cases:

  - ✓ If prior authorization (PA) was obtained, include the authorization number on the claim. Keep copy of authorization in the client's file.

  - ✓ If ITA transportation, indicate SCI=I in *Claim Note/Billing Note* section and submit ITA form HCA 42-0003. Keep a copy of the proof of detention.

  - ✓ If transporting more than 250 miles one way, include either a PCS or NPCS, court order, and other supporting documentation with the claim.

  - ✓ If using the ferry system for part of the trip, include route information and ferry receipt with claim (e.g., Vashon to Tacoma).

  - ✓ If bypassing ferry system, which is part of the commute, explain why.

Record keeping and retention

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

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

Reporting material changes in provider status
(WAC 182-502-0016)

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

Material changes in status include a change in:

- Ownership
- Address
- Telephone number
- Business name

Knowing health care resources in service area

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

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

Coverage

What ambulance services does the agency cover?

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

When are ambulance transportation services covered?

(WAC 182-546-0200)

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

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

When does the agency pay for nonemergency ground ambulance services?

The agency pays for nonemergency ground ambulance transportation when the transportation is medically necessary according to WAC 182-546-1000.

Use HCPCS codes A0428 and A0426 (nonemergency transportation services) and HCPCS code A0425 (relative mileage) when the person has one of the following conditions:

- Altered mental status (e.g. Alzheimer's, dementia – excludes involuntary and voluntary behavioral health services).
- Bariatric
- Bedbound (not able to stand or bear weight unassisted)
- Continuous cardiac monitoring
- Hospital to hospital transfer (i.e. services are not available at sending facility, or there are no beds available at sending facility, and the client requires admission and the ambulance transportation is medically necessary)
- Intravenous (IV) infusion monitoring
- Quadriplegic
- Requires a ventilator
- Requires continuous oxygen usage en route
- Tracheostomy (needed for prolonged respiratory support)

A Physician Certification Statement (PCS) or Nonphysician Certification Statement (NPCS) is required for this service. The PCS/NPCS thoroughly documents the circumstances requiring nonemergency ambulance transportation.

When are ambulance services *not* separately payable?

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

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

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

(WAC 182-546-0425)

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

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

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

When does the agency not pay for ambulance services?

(WAC 182-546-0250)

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

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

- To transport a client from a medical facility to the client's residence (except when the residence is a nursing facility)
- Requested solely because a client has no other means of transportation
- Provided by other than licensed ambulance providers (e.g., wheelchair vans, cabulance, stretcher cars)
- Not to the nearest appropriate medical facility

What are examples of noncovered ambulance services?

"Treat but no transport" service calls

The agency's Ambulance and ITA Transportation program is a transportation service. The agency does not pay for services under the Ambulance and ITA Transportation program if no transport takes place, except as provided in WAC 182-546-0500(2) and WAC 182-546-0550.

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

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

ALS assessment only, no transport

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

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

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

Some nonemergency hospital transfers

Aside from hospital transfers to equivalent or lower level hospitals, there are other hospital transfer reasons for which the agency will not pay. These include:

- Doctor's preference (e.g., the client's primary physician practices at receiving hospital).
- Client's preference (e.g., to be closer to home or family).
- Transportation to meet insurance requirements or hospital/insurance agreements.

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

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

What ambulance coverage is available for interfacility transfers?

Transfer to a higher level of care

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

Sometimes a nonemergency hospital transfer is necessary when the transferring or discharging hospital has inadequate resources to provide the medical care required by the client (e.g., continuing trauma care, burn cases). In such cases, the agency covers medically necessary air ambulance transportation with prior authorization (PA). For nonemergency air ambulance transportation, PA must be obtained from the agency. If **no** PA is obtained from the agency, the transferring and receiving facilities are responsible for the air ambulance costs. **Neither a Physician Certification Statement (PCS) nor a Nonphysician Certification Statement (NPCS) is acceptable authorization for nonemergency air ambulance transportation.**

For nonemergency ground ambulance transportation to a higher level facility, a Physician Certification Statement (PCS) or a Nonphysician Certification Statement (NPCS) is required.

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

> **Note:** Nonemergency air ambulance transports under negotiated special agreement rates require special claims indicator RT (SCI=RT no spaces), much like the ITAs. Billers must also attach the letter of agreement (LOA) from HCA to the claims submission.

Transfer to an equivalent or lower level of care

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

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

Complete a *Nonemergency Transfer Request* form, HCA 13-950. See Where can I download agency forms?

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

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

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

Is out-of-state ambulance transportation covered?

(WAC 182-546-0800)

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

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

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

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

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

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

Is out-of-country ambulance transportation covered?

(WAC 182-546-0900)

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

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

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

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

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

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

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

How do providers submit institutional services on a crossover claim?

- Mark "Yes" on the electronic claim for the question, "Is this a Medicare Crossover Claim?" (If Medicare makes a payment or allows the services, Medicaid considers it a crossover.)
- Always attach the Medicare Explanation of Benefits (EOMB) to the claim when Medicare denies the service. See the ProviderOne Billing and Resource Guide and the Fact Sheets webpage to get more information about submitting Medicare payment information electronically and to find out when paper backup must be attached.
- Enter the third-party (e.g. Blue Cross) supplement plan name in the *Other Insurance Information* section of the electronic claim. Enter **only** payments by a third party supplement plan and attach the Explanation of Benefits (EOB). See the Submit an Institutional Claim with Primary Insurance other than Medicare webinar for further assistance with submitting third-party insurance information.

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

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

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

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

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

Frequently asked questions (FAQ) about ambulance transportation coverage

Does the agency pay for ambulance transportation home?

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

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

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

Transportation from a facility to a client's residence is noncovered according to WAC 182-546-0250. An exception to rule can be requested according to WAC 182-501-0160 on a case-by-case basis.

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

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

Yes. The agency pays for ambulance transportation to a kidney dialysis center when the claim is submitted with a signed PCS or NPCS form. (See WAC 182-546-1000).

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

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

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

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

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

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

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

(WAC 182-546-0200)

Yes. The agency pays if all of the following program criteria are met:

- The client is eligible for Washington Apple Health at the time of service and the transportation is within the scope of the client's medical care plan
- The transportation is medically necessary based on the client's medical condition at the time of the ambulance transport (medical necessity must be well documented in the client's records)
- The transportation is to one of the following destinations:
    - The nearest appropriate agency-contracted medical provider of an agency-covered service
    - The nearest appropriate medical facility in emergency cases
    - The appropriate designated trauma facility as identified in the emergency medical services and trauma regional patient care procedures manual approved by the Department of Health

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

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

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

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

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

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

Note: See the "Payment in special circumstances involving ground ambulance transportation" section of this guide for details on Transport rendezvous.

Coverage Table

Air ambulance

All air ambulance services provided to Washington Apple Health clients, including those enrolled in an agency-contracted manage organization (MCO), must be billed to the Health Care Authority.

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

HCPCS Code	Short Description	Policy/ Comments
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
A0435	Fixed wing air mileage, per statute mile	One way, per flight, equally divided by the number of clients transported
A0436	Rotary wing air mileage, per statute mile	One way, per flight, equally divided by the number of clients transported

Ground ambulance

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

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

HCPCS Code	Short Description	Policy/ Comments
A0434	Specialty care transport (SCT)	Origin and destination modifiers required. For each additional client, use modifier GM **in addition to** the origin and destination modifiers
Mileage		
A0425	Ground mileage, per statute mile	Origin and destination modifiers required
Other Services		
A0170	Transportation ancillary: parking fees, tolls, other	Invoice required. Origin and destination modifiers required
A0424	Extra ambulance attendant, ground (ALS or BLS) or air (fixed or rotary winged), (requires medical review)	Pertinent documentation to evaluate medical appropriateness should be included when this code is reported. Origin and destination modifiers required. Justification required: • The client weighs 300 pounds or more • The client is violent or difficult to move safely • More than one client is being transported, and each requires medical attention and/or close monitoring
Note: The agency pays for an extra attendant in ground ambulance transports only. No payment is made for an extra attendant in air ambulance transports.		
A0998	Ambulance response and treatment, no transport	Appropriate referral modifiers required. (See Treat and Refer Section)

Authorization

What requires prior authorization (PA)?

- Emergency ambulance transportation does not require PA.
- All nonemergency ground ambulance transportation requires PA in the form of a Physician Certification Statement (PCS) or a Nonphysician Certification Statement (NPCS). The provider must keep this form and make it available to the agency upon request. Providers do not need to contact the agency to obtain an authorization number for billing purposes.

Who can authorize ambulance services?

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

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

A designated crisis responder (DCR) – A DCR authorizes ambulance transportation under the Involuntary Treatment Act (ITA) to transport a behavioral health individual detained by the DCR pursuant to RCW 71.05 to a certified evaluation and treatment (E&T) facility or a secure detoxification center

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

Providers may now submit prior authorization (PA) requests online through direct data entry into ProviderOne. See the agency's Prior authorization webpage for details.

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

Ambulance providers must thoroughly document the circumstances requiring the use of nonemergency ambulance transportation.

For all requests for prior authorization (PA) the following documentation is required: A completed, TYPED *General Information for Authorization* form, 13-835 **which MUST be the initial page when you submit your request, no coversheet. (**See Where can I download agency forms?)

Providers must complete the appropriate form(s) and provide the documentation necessary for informed decision-making and quality of care monitoring, and fax the form to the number listed on the *General Information for Authorization* form (13-835), when applicable.

Form Number	Title
HCA 13-680	*Authorization for Transportation to an Evaluation and Treatment Facility form*
HCA 13-950	*NonEmergency Transfer request.*
HCA 13-835	*General Information for Authorization.*
HCA 13-787	*Out-of-State Medical Services request.*
PCS	*Physician Certification Statement*
NPCS	*Nonphysician Certification Statement*

See Where can I download agency forms?

This documentation should be submitted:

- **By Fax**
  Fax prior authorization requests to: 866-668-1214

- **By Mail**
  Mail prior authorization requests to:

  Authorization Services Office PO
  Box 45535
  Olympia, WA 98504-5535

Which form must be completed for a transport to an alternative destination?

Use the *Authorization for Transportation to an Evaluation and Treatment Facility* form, HCA 13-680, as documentation that emergency medical personnel have assessed the client in accordance with RCW 70.168. The attestation is to ensure that the client meets the Department of Health (DOH) inclusion/exclusion criteria.

The agency requires completion of HCA 13-680, *Authorization for Transportation to an Evaluation and Treatment Facility*, for transportation to a mental health or substance use disorder facility, bypassing the local emergency department. The form must be signed by both the EMS personnel and the client. This form must be attached to the electronic claim submission and will be evaluated for reimbursement.

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

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

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

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

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

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

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

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

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

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

When is the *Authorization of Secure Ambulance Transportation to/from Behavioral Health Services* form, HCA 42-0003 required?

Use the *Authorization of Secure Ambulance Transportation to/from Behavioral Health Services* (HCA 42-0003) form as documentation that a designated crisis responder (DCR) ordered an ambulance provider to transport a behavioral health individual for detention in an evaluation and treatment (E&T) facility or secure detoxification center.

The HCA 42-0003 form is required for transportation involving the initial detention of a behavioral health client and the detention of a client whose conditional release has been revoked. The latter is also known as revocation of a less restrictive alternative (LRA).

The HCA 42-0003 form may be used, but is not required, for the transportation of detained people to and from court for probable cause hearings (civil commitment). A copy of the court order accompanied by a PCS signed by the attending physician at the detention facility or an NPCS signed by a designated medical professional, may be used for this purpose.

Note: The *Authorization of Secure Ambulance Transportation to/from Behavioral Health Services* (HCA 42-0003) form must be used for both voluntary and involuntary transportation services. See Voluntary/ITA Documentation Requirements section.

When is a Physician Certification Statement (PCS) or a Nonphysician Certification Statement (NPCS) appropriate to use?

A PCS is defined as a statement signed by the client's attending physician. An NPCS is defined as a statement signed by a medical professional other than the client's attending physician.

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

- Transporting a bed-confined individual to medical appointments (scheduled appointments that may be repetitive or non-repetitive).
- Kidney dialysis (repetitive).
- Transporting an ITA individual to and from court for a probable cause hearing.
- Transporting an ITA individual to a state hospital or long-term civil commitment bed.
- Transporting a minor to a mental health evaluation and treatment (E&T) facility or substance use disorder secure detoxification facility under the Parent Initiated Treatment (PIT) program.

Note: The physician signing a PCS for a client transported under the PIT must have been present in the ER when the parent(s) brought the minor in, and must have personally evaluated the minor's condition. Either a physician or a psychiatric nurse can sign a PCS form for a client transported under the PIT program.

Who can sign a PCS?

Effective January 1, 2020, an attending physician, with personal knowledge of the client's medical condition, can sign a PCS form. For transportation originating from the ER, the physician signing the PCS must have evaluated the client shortly before the start of the ambulance transportation service.

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

Who can sign an NPCS?

Effective January 1, 2020, one of the following medical professionals who has personal knowledge of the client's condition, other than the client's attending physician, may sign the NPCS form:

- ✓ Physician assistant
- ✓ Nurse practitioner
- ✓ Registered nurse
- ✓ Clinical nurse specialist
- ✓ Licensed practical nurse
- ✓ Social worker
- ✓ Case manager
- ✓ Discharge planner

For transportation originating from the ED, the NPCS signer must have evaluated the client shortly before the start of the ambulance transportation service. The NPCS signer must be employed by the client's attending physician or by the hospital or facility where the client is being treated and from which the client is transported.

Note: The PCS and NPCS are legal documents. By signing, the attending physician or designee is attesting to the truthfulness of the information provided.

What must a PCS and NPCS include?

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

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

Note: The federal rules at 42 CFR 410.40 were amended to allow an NPCS, but do NOT change the PCS requirements for scheduled, repetitive transports.

Reimbursement

What are the limitations on ambulance payment?

(WAC 182-546-0400)

The agency pays:

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

The agency **does not** pay:

- For mileage incurred traveling to the point of pick-up or any other distances traveled when the client is not on board the ambulance.
- When the client is not transported.
- When the client is transported, but not to an appropriate treatment facility.
- When scheduled ambulance transportation is canceled.
- When the client dies before the ambulance trip begins (see the single exception for ground ambulance providers).

What is the importance of origin and destination modifiers?

(WAC 182-546-0600)

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

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

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

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

Origin/Destination Modifiers

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

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

Client Referral Modifiers

Modifiers are required for referral services related to Treat and Refer Program services.

Modifier	Detailed Description of each Modifier
No Modifier	Response and Treatment, No Transport
U1	Treat at home, refer to a licensed health care provider
U2	Treat at home, refer to crisis response (i.e. Designated Crisis Responder (DCR) called to the scene)
U3	Treat at home, refer to a behavioral health (BH) provider
U4	Treat at home, refer to a chemical dependency/substance use
U5	Treat at home, refer to urgent care clinic
U6	Treat at home, refer to C.A.R.E.S team

Other Modifiers

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

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

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

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

GZ – Not reasonable/Not medically necessary

Remember:

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

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

Example #1: If a person is inpatient at an evaluation and treatment (E&T) facility and has to be transported to court for a hearing, the provider must key origin/destination modifier "EE". "E" denotes such places as an E&T facility, a secure detoxification facility, a state hospital, or behavioral health court hearing.

Example #2: If a person is being transported to a court hearing and is dual eligible (Medicare/Medicaid), the provider must key the origin/destination modifier (i.e. EE) in the first field and modifier "GY" in the second field. Medicare considers ambulance transportation to/from court as a noncovered service. The GY modifier is used to indicate that the transport is excluded or does not meet Medicare's definition of a covered benefit.

When does the agency pay for air ambulance services?

(WAC 182-546-0700)

Payable circumstances for air ambulance services

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

- The necessary medical treatment is not available locally, or the client's point of pick-up is not accessible by ground
- The vehicle and crew meet the Provider Responsibilities
- The client's destination is an acute care hospital
- The client's physical/medical condition requires immediate and rapid ambulance transportation that cannot be provided by ground ambulance
- Prior authorization has been obtained from the agency if it is a nonemergency transport
- The client's physical or mental condition is such that traveling on a commercial flight is not safe

Prior authorization (PA) requirement for nonemergency air ambulance transportation

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

> **Note:** Neither a PCS nor an NPCS is an acceptable authorization for nonemergency air ambulance transportation.

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

Components of air ambulance payment

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

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

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

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

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

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

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

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

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

Special circumstances involving air ambulance transportation

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

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

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

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

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

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

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

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

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

  ✓ If the negotiated rate for a nonemergency transfer by air ambulance to or from an out-of-state facility specifically covers only the air ambulance portion, the agency pays the air ambulance provider the contracted amount and pays the ground ambulance provider separately based on the agency's ambulance fee schedule. The ground ambulance provider must have signed a *Core Provider Agreement* (CPA) (HCA 09-015) to get paid.

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

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

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

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

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

When does the agency pay for ground ambulance services?

(WAC 182-546-0450)

Levels of ground ambulance service

The agency pays for three levels of service for ground ambulance transportation: Basic Life Support (BLS), Advanced Life Support (ALS) and Specialty Care Transport (SCT).

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

  ✓ Controlling bleeding
  ✓ Splinting fracture(s)
  ✓ Treating for shock
  ✓ Performing cardiopulmonary resuscitation (CPR)

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

  ✓ Administration of medication by intravenous push/bolus or by continuous infusion (to obtain hemodynamic stability)
  ✓ Airway intubation
  ✓ Cardiac pacing
  ✓ Chemical restraint
  ✓ Chest decompression
  ✓ Creation of surgical airway

- ✓ Initiation of intravenous therapy
- ✓ Manual defibrillation/cardioversion
- ✓ Placement of central venous line
- ✓ Placement of intraosseous line

- An **SCT** trip is an interfacility transport of a critically injured or ill client, by a ground ambulance provider, at a level of service beyond the scope of a paramedic. Examples of ailments/conditions that can be accommodated by a SCT transport are as follows:

  - ✓ Post cardiac arrest
  - ✓ Head injuries
  - ✓ Respiratory failure
  - ✓ Threat to maternal/fetal life

Factors affecting ALS or BLS classification

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

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

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

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

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

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

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

Payment for ground ambulance base rate

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

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

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

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

Payment for mileage

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

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

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

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

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

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

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

Payment for extra attendant

(WAC 182-546-0450(7))

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

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

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

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

> **For Example:** A suspected heart attack client in most cases does not require an extra attendant. If the suspected heart attack client is extremely obese an extra attendant may be warranted. Provide documentation of the need for an extra attendant.

Payment for ferry and bridge tolls

(WAC 182-546-0450(8))

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

Payment for waiting time

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

Payment in special circumstances involving ground ambulance transportation

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

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

- **Transport rendezvous**

  A transport rendezvous is a special circumstance ground ambulance transport where more than one ambulance provider is participating in the long-distance transport of a client. Each provider must submit a claim for their portion of the shared transport. The two participating providers must have an agreement between them for this process and be able to provide the agreement to the agency upon request.

  - ✓ The agency pays ambulance provider #1 for one transport base rate and the relative mileage from the place of origin to the point of hand-off.

  - ✓ The agency pays ambulance provider #2 for one transport base rate and the relative mileage from the point of hand-off to the place of destination.

  In situations where the level of transport changes, while in route, provider #2 must provide detailed narrative as to why the level of transport changes. If the transport began as an Advance Life Support (ALS) transport and changed to a Basic Life Support (BLS), the trip report/run sheet must detail that no invasive procedure was rendered. If the transport began as a BLS and needed to be escalated to an ALS, the trip report/run sheet must detail which ALS interventions were rendered.

Example: Provider #1 picks up a patient from a hospital in Seattle. They transport the patient from Seattle to Ellensburg. Provider #2 meets provider #1 in Ellensburg and takes over the care, transporting the patient the remainder of the way to Spokane.

Claim submission for provider #1 – A0428 (BLS base rate) and A0425 (mileage) from Seattle to Ellensburg. Provider would use modifier HS (hospital to scene of incident.

Claim submission for provider #2 – A0428 (BLS base rate) and A0425 (mileage) from Ellensburg to Spokane. Provider would use modifier SH (scene of incident to hospital).

- **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 agency as follows:

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

  ✓ No mileage charge for the additional client.

  The specific billing procedure is as follows:

  ✓ The provider is required to bill on two separate claims – one for each client

  - Client #1 – This claim should be billed with the appropriate HCPCS codes for both the transport and the relative mileage.

  - Client #2 – This claim should be billed with the appropriate HCPCS code for the actual transport only. Modifier "GM" is required for this claim in addition to the place of origin/destination 2-digit modifier. When this modifier is used, the transport will be reimbursed at 75% of the fee schedule amount and **must** include a note in the comment section indicating *"second client onboard same transport."*

  Example: A provider submits a claim for an ALS trip with 2 clients on board. If all other coding, documentation, and submission requirements are met, the provider would be reimbursed $168.43 for the transport (A0427) plus $5.08 for each loaded mile for the first client/claim. The provider would also be reimbursed 75% of the allowable amount for the actual transport (A0427) and no mileage for the second client.

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

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

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

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

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

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

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

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

- **Specialty care transport**
  (WAC 182-546-0425(6))

  Specialty care transport (SCT) is hospital-to-hospital transportation by ground ambulance of a critically injured or ill client, at a level of service beyond the scope of a paramedic. This means a nurse or physician may be on board the ambulance to provide care for the injured or ill client. The agency pays an ambulance provider the advanced life support (ALS) rate for an SCT-level transport when both of the following occur:

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

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

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

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

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

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

(WAC 182-546-0800)

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

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

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

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

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

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

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

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

- If Medicare covers the service, the agency will pay the lesser of:
  - ✓ The full coinsurance and deductible amounts due based upon Medicaid's allowed amount.
  - ✓ The agency's maximum allowable for that service minus the amount paid by Medicare.

- If Medicare does not cover or denies an ambulance service that the agency covers, the agency pays for that service, unless the client has QMB-only, SLMB, QI-1, or QDWI eligibility. The agency does not pay for ambulance services for clients in the QMB-only, SLMB, QI-1, or QDWI programs.

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

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

(WAC **182-546-3000**)

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

Where is the ambulance fee schedule?

See the Ambulance Transportation Fee Schedule.

Emergency ambulance transportation

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

Nonemergency ambulance transportation

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

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

Ambulance Services Provided Out-of-State

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

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

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

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

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

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

(WAC **182-546-2500**)

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

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

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

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

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

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

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

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

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

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

  ✓ The service/treatment is not experimental

- The request for an air ambulance may be made at the same time as the request for out-of-state treatment, but the requests are evaluated separately by the agency

- If the agency authorizes the air ambulance transport for the out-of-state treatment, call the Washington Apple Health Ambulance Clinical Nurse Consultant at 360-725-5144 or fax to 360-725-1966 to arrange for the air ambulance transport

- Air ambulance transports in these cases are reimbursed at negotiated rates. The agency payment is payment-in-full

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

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

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

After the agency approves the request for the transfer, call the Washington Apple Health Ambulance Clinical Nurse Consultant at 360-725-5144 or fax to 360-725-1966 to arrange for air ambulance transport.

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

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

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

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

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

(WAC 182-546-0900)

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

Treat and Refer Program

What is the Treat and Refer program?

The Treat and Refer Program is a voluntary program that allows publicly owned or operated providers to receive payment for services provided under the community assistance referral and educational services program (RCW 35.21.930).

The purpose of the program is to reduce the number of avoidable emergency department transports (i.e. transports that are nonemergency or nonurgent).

Treat and refer services are covered health care services for a client who has accessed 911 or a similar public dispatch number, and whose condition does not require ambulance transport to an emergency department (ED) based on the clinical information available at the time of service.

Payment

To receive payment, providers must meet the following criteria:

- Be a publicly owned and operated city/town fire department, fire protection district organized under Title 52 RCW, regional fire protection service authority organized under chapter 52.26 RCW, provider of emergency medical services that levy a tax under RCW 84.52.069, or a federally recognized Indian Tribe.
- Be an enrolled Medicaid provider with an active Core Provider Agreement (CPA) for the service period specified in the claim.
- Have an established community assistance referral and education service program under RCW 35.21.930.

Prior to billing and receiving payment, providers must submit a participation agreement and attestation form *(HCA 60-0024)* to the agency's Provider Enrollment, certifying their compliance with RCW 35.21.930.

Providers must notify the agency immediately if they no longer meet the requirements of RCW 35.21.930. Providers who continue to bill and received payment but no longer meet the requirements must return the overpayment under RCW 41.05A.170.

Additionally, the health care professionals providing treat and refer services must:

- Be state-certified emergency medical technicians, state-certified advanced emergency medical technicians, or state-certified paramedics under chapters 18.71 and 18.73 RCW.
- Be under the supervision and direction of an approved medical director according to RCW 35.21.930(1).
- Not perform medical procedures they are not trained and certified to perform, according to RCW 35.21.930(1).

Documentation

Providers must document treat and refer services in a standard medical incident report that includes a clinical or mental health assessment. Providers must retain the incident report according to WAC 182-502-0020.

Billing

Providers must bill **all** treat and refer services as fee-for-service claims. This includes treat and refer services provided to clients enrolled in an agency-contracted managed care organization (MCO).

Providers must submit their claims electronically through the ProviderOne billing system. A line item entry for one (1) unit of procedure code A0998 is required. CMS-approved modifiers are required for this code depending upon the outcome of the call:

- Modifier U1 – Treat on scene, refer to licensed health care provider
- Modifier U2 – Treat on scene, refer to crisis response (i.e. Designated Crisis Responder (DCR) called to the scene)
- Modifier U3 – Treat on scene, refer to a behavioral health (BH) provider
- Modifier U4 – Treat on scene, refer to chemical dependency
- Modifier U5 – Treat on scene, refer to urgent care
- Modifier U6 – Treat on scene, refer to community assistance referral and educational services team

> **Note:** Payments under this program are subject to review and audit under chapter 182-502A WAC.

Alternative Destination Transports for People with Mental Health or Substance Use Disorders

In 2015 the Washington State Legislature passed legislation (Substitute House Bill 1721) permitting emergency ambulance and aid services to transport people from the field to an alternative mental health or substance use disorder (SUD) destination.

Expedited prior authorization

Use the following appropriate expedited prior authorization (EPA) number for electronic claims submission for **code A0428 (basic life support transportation**) when the EPA criteria is met:

EPA Number	Description	EPA Criteria
870001398	Emergency ground ambulance to a mental health facility	• Use when the client has a mental health complaint and is willing to be transported to an alternative destination. • The provider must submit an authorization form (HCA 13-680) completed and signed by: ✓ The emergency personnel and the client, OR ✓ The County Medical Program Director
870001399	Emergency ground ambulance to a substance use disorder treatment facility	• Use when the client is incapacitated or gravely disabled by drugs or alcohol and is willing to be transported to an alternative destination. • The provider must submit an authorization form (HCA 13-680) completed and signed by: ✓ The emergency personnel and the client, OR ✓ The County Medical Program Director

See Where can I download agency forms?

Screening Criteria for Alternative Destination Transportation Services (RCW 71.05)

Screening procedure:

- Assess for scene safety and crisis de-escalation.
- Consider contacting law enforcement to assist with on scene mitigation of suicidal patients who are not voluntary and for agitated or combative patients.
- Ask the patient if they normally take medication for mental health and chronic medical problems. Record medications and dosages if possible.
- Obtain history regarding alcohol and illicit drug use.
- Assess for inclusion and exclusion criteria.
- For patients who meet screening criteria, contact receiving center for resource availability.
- Contact medical control for approval.
- Secure a safe method of transportation.
- Document all findings and inclusion/exclusion criteria for all patient contact on the patient care report and checklist.
- Patients who meet exclusion criteria or decline alternative destination should be transported to a local hospital emergency department using agency specific standard operating procedures.
- At time of patient care transfer, the completed *Authorization for Transportation to an Evaluation & Treatment Facility form* (HCA 13-680) authorization form and the inclusion/exclusion checklist should be provided to the receiving facility. (See Where can I download agency forms?)
- If at any time the receiving facility determines the patient condition has changed and emergency department evaluation is required, EMS should be re-contacted via 911 dispatches and the reason documented.

The following inclusion criteria must be met in order for the transport to qualify as an alternative destination transport.

For a Facility:

A facility is identified as a crisis stabilization unit, evaluation and treatment facility, or triage facility that provides substance use disorder treatment services and mental health services. RCW 71.05 applies to substance use disorder centers, and treatment centers, include sobering centers, and acute and subacute detox centers as well as mental health facilities.

For a Patient:

- Voluntary patients with a mental health and/or substance use disorder chief complaint willing to go to an alternative destination.
- Patients with a mental health and/or substance use disorder chief complaint referred by a peace officer.
- The patient's current condition cannot be not explained by another medical issue and traumatic injury is not suspected.
- The EMS agency was dispatched via 911 or police request.
- Age 18-55 is the recommended age for this service, based on a review of research during the development of the Department of Health guideline. MPDs may adjust this parameter.
- Cooperative and noncombative.
- Normal level of consciousness, no medical issues suspected.
- Suicidal patients may accept voluntary care or may be detained by a peace officer or DCR.
- Heart rate between 50-110.
- Blood pressure systolic 100-190, diastolic less than 110.
- Respiratory rate between 12-24.
- Temperature 97-100.3.
- Room air O2 saturation greater than 92.
- If indicated check blood sugar, 70-300 is acceptable.
- Patient has the ability to care for self.

If any of the following exclusion criteria occur, the transport does not qualify as an alternative destination transport.

For a Facility:

- No bed availability.
- Intake staff identifies concerns that exceed the ability of the facility to provide adequate care to the patient, requiring local hospital emergency department -physician evaluation.
- Facilities may test for blood alcohol level and establish a cutoff level for acceptance that should not be below 300.

For a Patient:

- Intentional or accidental overdose.
- Any acute trauma other than minor wounds not in need of treatment beyond bandaging.
- Loss of consciousness or seizure within the past 24 hours by patient history.
- Pregnancy.
- Anticoagulation.
- Blood sugar out of control over past 24 hours by patient history.
- Indwelling tubes, lines or catheters currently being utilized.
- New onset of mental health or substance use disorder problems. MH and/or SUD problems are.
- Any evidence for acute medical or traumatic problem.
- Patients with a mental health and/or substance use disorder chief complaint detained under the Involuntary Treatment Act (ITA) by a designated crisis responder (DCR). The proper documents must be completed and signed by the appropriate medical professional for reimbursement.

Behavioral Health Transportation for Treatment under the Involuntary Treatment Act and Ricky Garcia Act

What are the Involuntary Treatment Act (ITA) and the Ricky Garcia Act?

The Involuntary Treatment Act (ITA)/Ricky Garcia Act, Chapter 71.05 RCW (adults age 18 and older) and Chapter 71.34 RCW (minors age 13 to 17), provide for the involuntary detention of people evaluated by a DCR and assessed as one of the following:

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

Who is eligible for ITA services?

The Involuntary Treatment Act (ITA) and the Ricky Garcia Act apply to all people within the borders of the state of Washington, including people who are not Medicaid-eligible.

See the agency's ProviderOne Billing and Resource Guide for instructions to verify client eligibility. If the detained person is not currently eligible for agency-covered ambulance services, providers must submit the claim with the *Authorization of Secure Ambulance Transportation to/from Behavioral Health Services* (HCA 42-0003) form, signed by a DCR, following Superior Court Mental Proceedings Rule 2.2.

The authorization form must contain all of the following information:

- Be dated within 20 days of providing transportation services
- Name of the person taken into custody
- Attest the transport was for a person found to be a danger to themselves, a danger to others, or gravely disabled when assessed by a DCR
- State the agent who undertakes the involuntary detention is authorized to take custody of the person according to RCW 71.05.
- State the person was taken into custody for the purpose of delivering that person to a secure detoxification facility, evaluation & treatment (E&T) facility, or a crisis response center for a period of up to 72 hours excluding Saturdays, Sundays, and holidays as provided in RCW 71.05.180
- Specify the name and location of the evaluation and treatment facility where the person will be detained

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

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

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

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

Who decides what transportation is necessary under ITA?

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

- Local police or sheriff
- Ambulance

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

Who authorizes and pays for ITA services?

HCA will pay the ITA transportation costs for a person when a DCR determines the services are noncovered by insurance or Medicare (e.g., when an ambulance must be used to transport the person to a court hearing for ITA purposes) **and** one of the following applies:

- There is no other third party liability (TPL) payment source and the involuntarily detained person does not have the resources to pay
- Requiring the person to pay would result in a substantial hardship upon the person or the person's family
- The services are noncovered by insurance or Medicare (e.g., ITA court hearings or persons detained in public institutions)

Who pays for ITA transportation of managed care enrollees?

Authorization for the ITA ambulance transportation of a managed care enrollee to an evaluation and treatment (E&T) facility is the responsibility of a DCR.

When does the agency pay for ITA transportation?

ITA ambulance transportation

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

ITA transportation provided by law enforcement

Law enforcement is the only non-ambulance provider allowed to provide ITA transportation. ITA transportation provided by law enforcement is paid only for the mileage, not the base rate.

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

> **Note:** The agency payment is payment in full. The agency allows no additional charge to the involuntarily detained person, in accordance with 42 C.F.R. § 447.15.

When are transportation services covered under ITA?

- The agency covers fee-for-service (FFS) ITA transportation services when provided from one of the following:

  - ✓ The site of the initial detention
  - ✓ A court hearing
  - ✓ A local emergency room department
  - ✓ An evaluation and treatment facility
  - ✓ A state hospital or long-term civil commitment bed

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

  - ✓ A state hospital or long-term civil commitment bed
  - ✓ A less restrictive alternative setting (except home)
  - ✓ A court hearing
  - ✓ A local emergency room department
  - ✓ An evaluation and treatment facility

When are transportation services not covered under ITA/Ricky Garcia?

The agency does not reimburse providers for non-ITA transportation such as the transporting of people to and from outpatient mental health services.

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

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

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

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

Who pays for transportation to and from court hearings?

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

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

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

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

There are four CLIP facilities in the State of Washington:

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

The CLIP coordinator is responsible for facilitating placement of clients and making the necessary CLIP transportation arrangements.

What is the parent initiated treatment (PIT) program?

Washington State law related to PIT specifies that a parent may bring or authorize bringing their minor child to:

- An evaluation and treatment facility or an inpatient facility licensed under chapter 70.41, 71.12 or 72.23 RCW and request that the behavioral health professional assess the minor to determine whether the minor has a mental disorder and is in need of inpatient treatment; or

- A secure withdrawal management and stabilization facility or approved substance use disorder treatment program and request that a substance use disorder assessment be conducted by a professional person to determine whether the minor has a substance use disorder and is in need of inpatient treatment.

The consent of a minor child (age 17 and younger) is not required for parent-initiated admission, evaluation, and treatment if the parent brings the minor child to the facility.

An appropriately trained professional may evaluate whether the minor has a behavioral health disorder. The evaluation is completed within twenty-four hours from the time the minor was brought to the facility unless the professional determines that the condition of the minor necessitates additional time for evaluation. If, in the judgement of the professional, it is determined it is medically necessary for the minor to receive inpatient treatment, the minor may be held for treatment.

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

No provider may refuse to treat a minor solely on the basis that the minor has not consented to the treatment.

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

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

Laws pertaining to PIT:

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

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

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

Yes. The only non-ambulance provider eligible to receive payment for ITA transportation services is law enforcement. Law enforcement is paid mileage only without a base rate.

ITA vehicle standards and maintenance

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

Driver training

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

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

Billing

How can I submit voluntary behavioral health or ITA transport claims electronically?

Providers must submit either voluntary or involuntary behavioral health transport claims electronically. This helps with continuity of claims processing and creates better data for tracking and reporting.

Voluntary or involuntary behavioral health transport electronic claims 3-step process:

Step 1

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

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

Step 2

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

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

If the provider has not received a response to a help ticket within 72 hours, request a status update by responding to the original email or submitting a new Medicaid Management Information System (MMIS) email. Reference the original help ticket number in the status update.

Step 3

Electronically submit the voluntary or involuntary transport claim with all required documentation.

Once the new ProviderOne client identification number is received, the provider must electronically submit the claim using the number received. Electronic submission can be done via DDE – Direct Data Entry (web submission) or 837P HIPAA batch. The provider must key the appropriate special claims indicator followed by an additional note stating supporting documentation to follow via fax.

If the provider has not received a response to the help ticket within 72 hours, contact our Customer Service Center at (800) 562-3022 and follow the prompts.

Voluntary/ITA documentation requirements

Mental Health (MH) Voluntary/ITA Transports

Claim Submission – Must have ALL of the following:

- Ambulance provider trip report/run sheet

AND

- HCA 42-0003 Form

Or, the trip report must be accompanied by a PCS/NPCS AND one of the following documents (this excludes voluntary BH services):

- Authorization for Emergency Apprehension and Detention
- Notice of Emergency Detention
- Petition for Emergency Detention under RCW 71.05/71.34

Substance Use (SUD) Voluntary/ITA Transports

Claim Submission – Must have ALL of the following:

- Ambulance provider trip report/run sheet

AND

- HCA 42-0003 Form

Or, the trip report must be accompanied by a PCS/NPCS AND one of the following documents (this excludes voluntary BH services):

- Authorization for Emergency Apprehension and Detention
- Notice of Emergency Detention
- Petition for Emergency Detention under RCW 70.96A

Note: The agency has updated the voluntary services attestation section of the *Authorization of Secure Ambulance Transportation to/from Behavioral Health Services* (HCA 42-0003) form. The agency no longer requires an assessment, conducted by a designated crisis responder (DCR), to be performed for individuals seeking voluntary behavioral health services.

Example: If an individual is assessed by an emergency department (ED) physician/attending physician, and is determined to meet the criteria for voluntary services, the physician would be the medical professional signing the voluntary attestation section of the form.

How do providers bill for mileage?

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

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

- If an air ambulance provider transports more than one client on a single trip, the agency will pay the lift-off rate for each client. Document the pick-up point and destination, for each client. The number of air miles associated with the trip must be divided equally by the number of clients transported. Modifier GM is required to indicate multiple patients on one ambulance trip. Modifier GM must be used **in addition** to the origin and destination modifier pair.

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

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

Audits

(Chapter 182-502A WAC)

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

Post-payment reviews

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

Recoupment of improper payments

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

As a result of post-pay audits/reviews, the agency may consider a range of options. Foremost, the agency will recoup improper payments for claims.

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

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

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

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

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

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

Quality of care audits and reviews

The agency expects providers to provide high quality care. The agency conducts reviews and/or audits to monitor and enforce community standards of care.

Ambulance Transportation Matrix

Ambulance transportation providers can now use the new HCA Ambulance Transportation Matrix.

This matrix serves as a quick reference to determine documentation requirements for electronically submitting claims. The matrix addresses both emergent and nonemergent transportation services.