

	<p><b>Ambulance Provider Specific Policy</b></p> <p><b>Revision Table</b></p>
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<b>Effective Date of Revision</b>	<b>Sections Revised</b>	<b>Description</b>
7/1/02	All	Complete manual revision to reflect changes related to the MMIS and HIPAA compliance.
10/1/02	Multiple	DMAP utilized a broker system to provide ALL non-emergency medical transportation (including non-emergency ambulance transportation) to eligible Medicaid clients. Sections of the Ambulance Provider Specific Policy Manual, specifically those sections regarding non-emergency transportation services, are updated to reflect the new broker system.

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## Ambulance Provider Specific Policy Manual

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## Ambulance Provider Specific Policy Manual

This manual reflects the policies as they relate to Medicaid clients who are exempt from managed care coverage (see list of those exempt from managed care coverage in the Managed Care section of the General Policy).

Emergency ambulance transportation services are included in the MCO benefits package. All Medicaid clients who are enrolled with an MCO must receive emergency ambulance services through the MCO.

### 1.0 Overview

#### 1.1 General Information

- 1.1.1 The Delaware Medical Assistance Program (DMAP) will reimburse a ground ambulance provider for medically necessary transportation services that are an emergency as defined by the “federal prudent layperson definition” if:
  - 1.1.1.1 The provider is properly licensed and certified by the State in which the provider is located.
  - 1.1.1.2 The provider has an effective agreement on file with the DMAP.
  - 1.1.1.3 Transportation by ground ambulance is medically necessary and meets the criteria in this policy manual.
  - 1.1.1.4 The transportation is to and/or from a medical service covered by the DMAP (see General Policy - Covered Services segment).
- 1.1.2 The DMAP will reimburse an air ambulance provider for medically necessary transportation services that are of a life-threatening nature and if the air ambulance is:
  - 1.1.2.1 Licensed, certified, operated and equipped according to federal, state and local statutes, ordinances, and regulations in which the provider is located;
  - 1.1.2.2 Staffed and operated by appropriately trained and certified personnel and if;
  - 1.1.2.3 The provider has an effective agreement with the DMAP and;
  - 1.1.2.4 The air transport is a hospital-to-hospital transport OR a transport serving as a back up to the State Police Aviation Section and meets the criteria for air ambulance as stated in this Ambulance Provider Specific Policy manual.

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## 2.0 Coverage

### Ground Ambulance

Ground ambulance providers should submit only claims that are believed by the provider to meet the criteria for covered services. The DMAP will monitor claims retrospective to payment to determine if the provider is adhering to the policies in this manual. Prepayment review will not be conducted unless retrospective review or other conditions warrant such action.

### 2.1 Criteria for Emergency Ground Ambulance Transports

2.1.1 The ground ambulance provider must maintain documentation of the medical necessity of each transport being submitted to the DMAP for payment. The required documentation consists of the following:

2.1.1.1 The “from” place of transport

2.1.1.2 The “to” place of transport; and

2.1.1.3 A detailed description of the patient’s current condition or complaint at time of transport.

2.1.2 Past histories of illnesses as well as diagnoses that rule out illnesses are not acceptable. Further, opinions of transport personnel regarding diagnoses are not considered valid documentation. NOTE: Determination of whether a transport is an emergency is NOT based on the call received by the provider, but upon the patient’s condition at the time of transport.

2.1.3 When billing the DMAP the ground ambulance provider is required to use ICD-9 CM diagnoses codes to identify the patient’s condition.

2.1.4 Medical necessity is established when the patient’s condition at the time of transport indicates one of the following conditions or a condition of equal severity:

2.1.4.1 Present life threatening condition or significant trauma that may endanger life or limb.

2.1.4.2 Seizures--patient should have had a recent onset of active seizure

2.1.4.3 Comatose or shock

2.1.4.4 Patient must remain immobile because of the nature of certain injuries to the neck, spine, head or long bones

- 2.1.4.5 Patient is experiencing severe hemorrhage
- 2.1.4.6 Requires tracheotomy suction
- 2.1.4.7 Sickle cell crisis
- 2.1.4.8 Immediate postpartum care (within one (1) hour of home delivery)
- 2.1.4.9 Burn victims--significant second degree burns in children or third degree burns in any individual
- 2.1.4.10 Severe chest pains indicative of a heart attack
- 2.1.4.11 Significant respiratory distress
- 2.1.4.12 Poisoning or drug overdose
- 2.1.5 Ground ambulance transportation that requires the patient to be transported, either across a state boundary line or, from/to a medical service within a state other than Delaware, must meet the emergency or non-emergency criteria addressed in this policy manual.

## **2.2 Non-Emergency Ground Ambulance Transports**

- 2.2.1 Effective October 1, 2002, DMAP utilized a "broker" system to facilitate all non-emergency transportation (NET) services. Under the new system, the Broker is responsible for verifying client eligibility for DMAP services, assessing the client's need for NET services, selecting the most appropriate transportation to meet the client's needs, and educating clients about NET services. The Broker serves as a single point of contact for ALL NET services.

## **2.3 Reserved**

## **2.4 Additional Ground Ambulance Crew(s)**

- 2.4.1 The DMAP may reimburse ground ambulance providers for additional ambulance crew(s) when it is necessary to lift extraordinarily overweight non-ambulatory patients. The ambulance provider must maintain documentation that explains the circumstances requiring the additional ambulance crew(s). Documentation must include:
  - 2.4.1.1 Transport destination

- 2.4.1.2 Diagnosis of patient (must include a diagnosis that indicates why the patient is non-ambulatory); and
- 2.4.1.3 Weight of patient.
- 2.4.1.4 The appropriate HCPCS procedure code must to be used when billing for additional ambulance crew(s).

## **2.5 Reserved**

### **Air Ambulance**

Air ambulance providers should submit only claims that are believed by the provider to meet the criteria for covered services. The DMAP will monitor claims retrospective to payment to determine if the provider is adhering to the policies in this manual. Prepayment review will not be conducted unless retrospective review or other conditions warrant such action.

## **2.6 Criteria for Emergency Air Ambulance Transports**

- 2.6.1 The air ambulance transport must be a hospital-to-hospital transport or a transport servicing as a back up to the State Police Aviation Section that provides emergency air ambulance service to the general public.
- 2.6.2 The client must have a potentially life-threatening condition that does not permit the use of another form of transportation. Examples of life-threatening conditions are, but not limited to:
- Amputation (traumatic above the wrists or ankle)
  - Asphyxia (severe birth asphyxia with one minute APGAR score 0-3)
  - Bleeding (uncontrolled or internal)
  - Burns (major, 3rd degree)
  - Drowning, near drowning
  - Flail chest injury (ribs broken off at sternum)
  - Major trauma or “polytrauma”
  - Neonatal respiratory distress
  - Respiratory/pulmonary insufficiency
- 2.6.3 When billing the DMAP the air ambulance provider is required to use ICD-9 CM diagnoses codes to identify the patient’s condition.

- 2.6.4 Providers must maintain documentation for hospital-to-hospital trips being submitted to the DMAP for payment. Air ambulance documentation must be completed by the referring hospital, and must include:
  - 2.6.4.1 The reason the physician at the referring hospital ordered air ambulance transportation;
  - 2.6.4.2 Why air ambulance transportation, rather than ground ambulance, was medically necessary; and
  - 2.6.4.3 The name of the referring physician or agency.
- 2.6.5 Providers must maintain documentation for all air transports when serving as a back up to the State Police Aviation Section and being submitted to the DMAP for payment. The documentation must include:
  - 2.6.5.1 The reason why back-up transport was required
  - 2.6.5.2 Why air ambulance transportation, rather than ground ambulance, was medically necessary
  - 2.6.5.3 The patient's condition/diagnoses
  - 2.6.5.4 Name and address of the hospital to which the patient was transported.
- 2.6.6 Air ambulance transportation that requires the patient to be transported, either across a state boundary line or, from/to a medical service within a state other than Delaware, must meet the emergency criteria addressed in this policy manual.

## **3.0 Non-Covered Services**

### **3.1 Ground Ambulance**

The DMAP does not reimburse ground ambulance providers for the following services. These services include, but are not limited to:

- Non-emergency ambulance transportation (unless provided by the Broker)
- Transportation of an inpatient hospital patient to physician's office
- Inter-hospital transportation
- Oxygen (unless it is a life sustaining situation)
- Waiting time
- Non-loaded mileage
- Receiving services not covered by DMAP

### **3.2 Air Ambulance**

The DMAP does not reimburse air ambulance providers for the following services. These services include, but are not limited, to:

- When travel by ground ambulance is appropriate
- Non loaded mileage
- Waiting time
- Transport is to a destination other than an acute care hospital

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## **4.0 Reimbursement**

### **4.1 Ground Ambulance**

- 4.1.1 The DMAP reimburses a base rate plus mileage.
- 4.1.2 Ground ambulance providers are required to use the appropriate HCPCS procedure code(s) when billing the DMAP for ground ambulance transports. Refer to Appendix A or Appendix B for appropriate HCPCS procedure codes.
- 4.1.3 Medicaid will reimburse an ambulance provider a flat fee, per transport, for oxygen and oxygen supplies in a life-sustaining situation. Refer to Appendix A or Appendix B for appropriate HCPCS procedure code.

### **4.2 Air Ambulance**

- 4.2.1 The DMAP will reimburse air ambulance providers a base rate that includes no miles. Each loaded mile will be reimbursed at a rate per mile.
- 4.2.2 Air ambulance providers are required to use the appropriate HCPCS procedure code(s) when billing the DMAP for air ambulance transports. Refer to Appendix A or Appendix B for the appropriate HCPCS procedure codes.

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## HCPCS Procedure Codes for Ambulance

### 5.0 Appendix A – HCPCS Procedure Codes Prior to 7/1/02

When billing the DMAP for ambulance transport services provided prior to 7/1/02, the transportation provider must use the appropriate HCPCS procedure codes listed below.

Code	Description
WW104	Transportation Co-pay. Attach a copy of the payment voucher if it is available. Refer to the Billing Instructions of this manual, Completion of the CMS-1500 section, Field #'s 24D, 24F, and 29 for specific billing information.
A0422	Ambulance (ALS or BLS) oxygen and oxygen supplies, life-sustaining situation. This code may be used with emergency transports (YY506, YY507, YY513, and YY514) or with non-emergency transports (YY509 and YY510). The ambulance provider may bill one (1) unit of code A0422 per transport.
YY506	Ambulance, emergency transport, one way, up to 10 miles
YY507	Ambulance, emergency transport, one way, each mile over 10
YY509	Ambulance, non-emergency transport, one way, up to 10 miles
YY510	Ambulance, non-emergency transport, one way each mile over 10
YY511	Additional ambulance crew(s) necessary to lift extraordinary overweight non-ambulatory patients (This code is used in addition to a transport code)
YY513	Ambulance, neonatal emergency transport, one way, up to 10 miles
YY514	Ambulance, neonatal emergency transport, one way each mile over 10
A0431	Ambulance service, conventional air services, transport, one way (rotary wing)
A0436	Rotary wing air mileage, per statute mile

When billing the DMAP for ambulance services provided prior to 7/1/02, the following modifiers are used in addition to HCPCS procedure codes A0422, YY509, YY510 and YY511:

- X1 Return Trip
- X2 Second Trip, same day, outbound
- X3 Second Trip, same day, return

When billing, be sure that you are using the codes authorized by the DMAP. The use of unauthorized codes will result in the denial of your claims.



## HCPCS Procedure Codes for Ambulance

### 6.0 Appendix B – HCPCS Procedure Codes on or after 7/1/02

When billing the DMAP for ambulance transport services provided on and after 7/1/02, the transportation provider must use the following HCPCS procedure code(s). These codes (in the “new code” column) are based on Medicare’s National Level II HCPCS 2002 Codes. It is the responsibility of the ambulance transportation provider to use these codes or their future equivalence.

Old Code	New Code	Description
A0422	A0422	Ambulance (ALS or BLS) oxygen and oxygen supplies, life sustaining situation
YY506	A0427	Ambulance service, advanced life support, emergency transport, level 1 (ALS 1 emergency)
	A0429	Ambulance service, basic life support, emergency transport (BLS-emergency)
YY507	A0380	BLS mileage (per mile)
	A0390	ALS mileage (per mile)
YY509	A0426	Ambulance service, advanced life support, non-emergency transport, level 1 (ALS 1)
	A0428	Ambulance service, basic life support, non-emergency transport (BLS)
YY510	A0380	BLS mileage (per mile)
	A0390	ALS mileage (per mile)
YY511	A0424+PA	Extra ambulance attendant, ALS or BLS (requires medical review)
YY513	A0225	Ambulance service, neonatal transport, base rate, emergency transport, one way
YY514	A0380	BLS mileage (per mile)
	A0390	ALS mileage (per mile)
A0431	A0431	Ambulance service, conventional air services, transport, one way (rotary wing)
A0436	A0436	Rotary wing air mileage, per statute mile

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