



Texas Medicaid Provider Procedures Manual

April 2019

Volume
2

Provider Handbooks

Ambulance Services Handbook

AMBULANCE SERVICES HANDBOOK

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1 General Information

The information in this handbook is intended for Texas Medicaid ambulance providers. The handbook provides information about Texas Medicaid's benefits, policies, and procedures applicable to emergency and nonemergency ambulance transports.

Important: *All providers are required to read and comply with “Section 1: Provider Enrollment and Responsibilities” (Vol. 1, General Information). In addition to required compliance with all requirements specific to Texas Medicaid, it is a violation of Texas Medicaid rules when a provider fails to provide health-care services or items to Medicaid clients in accordance with accepted medical community standards and standards that govern occupations, as explained in Title 1 Texas Administrative Code (TAC) §371.1659. Accordingly, in addition to being subject to sanctions for failure to comply with the requirements that are specific to Texas Medicaid, providers can also be subject to Texas Medicaid sanctions for failure, at all times, to deliver health-care items and services to Medicaid clients in full accordance with all applicable licensure and certification requirements including, without limitation, those related to documentation and record maintenance.*

Refer to: “Section 1: Provider Enrollment and Responsibilities” (Vol. 1, General Information) for more information about enrollment procedures.

The *Medicaid Managed Care Handbook (Vol. 2, Provider Handbooks)*.

Subsection 5.1.8, “Prior Authorization for Nonemergency Ambulance Transport” in “Section 5: Fee-for-Service Prior Authorizations” (Vol. 1, General Information) for more information about nonemergency ambulance transport.

2 Ambulance Services

2.1 Enrollment

To enroll in Texas Medicaid, ambulance providers must operate according to the laws, regulations, and guidelines governing ambulance services under Medicare Part B; equip and operate under the appropriate rules, licensing, and regulations of the state in which they operate; acquire a license from the Texas Department of State Health Services (DSHS) approving equipment and training levels of the crew; and enroll in Medicare.

A hospital-operated ambulance provider must be enrolled as an ambulance provider and submit claims using the ambulance provider identifier, not the hospital provider identifier.

Refer to: Subsection 2.4.3, “Medicare and Medicaid Coverage” in this handbook.

Note: *Air ambulance providers are not required to enroll with Medicare.*

Reminder: *When ambulance providers enroll in Texas Medicaid, they accept Medicaid payment as payment in full. They cannot bill clients for Texas Medicaid-covered benefits.*

2.1.1 Subscription Plans

The Texas Insurance Code does not apply to ambulance providers who finance, in part or in whole, an ambulance service by subscription plan. DSHS's license requirements do not permit providers of membership or subscription programs to enroll Medicaid clients. Emergency Medical Services (EMS)

Subscription Programs are regulated by the DSHS-EMS Compliance Group. An EMS provider must have specific approval to operate a subscription program.

For more information, providers should contact the DSHS Office of EMS/Trauma Systems Coordination at 1-512-834-6700. A list of EMS office and contact information is available at <http://dshs.texas.gov/emstraumasystems/contact.shtm>.

2.2 Services, Benefits, Limitations, and Prior Authorization

Emergency and nonemergency ambulance transport services are a benefit of Texas Medicaid when the client meets the definition of emergency medical condition or meets the requirements for nonemergency transport.

Cardiopulmonary resuscitation (CPR) is included in ambulance transport when needed and is not a separately billable service. Claims for CPR during transport will be denied. If CPR is performed during a nonemergency transport, the advanced life support (ALS) procedure code must be billed.

Reimbursement for disposable supplies is separate from the established global fee for ambulance transports and is limited to one billable code per trip.

Providers must calculate the number of miles traveled by using the ambulance vehicle odometer reading or an Internet mapping tool. Mileage reported on the claim must be the actual number of miles traveled.

Claims for ground ambulance transports (procedure codes A0426, A0427, A0428, A0429, A0433, A0434, and A0999) must be submitted with mileage procedure code A0425.

Medical necessity and coverage of ambulance services are not based solely on the presence of a specific diagnosis. Medicaid payment for ambulance transportation may be made only for those clients whose condition at the time of transport is such that ambulance transportation is medically necessary. For example, it is insufficient that a client merely has a diagnosis such as pneumonia, stroke, or fracture to justify ambulance transportation. In each of those instances, the condition of the client must be such that transportation by any other means is medically contraindicated. In the case of ambulance transportation, the condition necessitating transportation is often an accident or injury that has occurred giving rise to a clinical suspicion that a specific condition exists (for instance, fractures may be strongly suspected based on clinical examination and history of a specific injury).

It is the requesting provider's responsibility to supply the contractor with information describing the condition of the client that necessitated ambulance transportation. Medicaid recognizes the limitations of ambulance personnel in establishing a diagnosis, and recognizes therefore, that diagnosis coding of a client's condition using *International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM)* codes when reporting ambulance services may be less specific than those reported by other professional providers. Providers who submit diagnosis codes must choose the code that best describes the client's condition at the time of transport. As a reminder to providers of ambulance services, "rule out" or "suspected" diagnoses must not be reported using specific ICD-10-CM codes. In such instances where a diagnosis is not confirmed, it is correct to use a symptom, finding, or injury code.

The ambulance provider may be sanctioned, including nonparticipation in the Medicaid Title XIX programs, for completing or signing a claim form that includes false or misleading representations of the client's condition or the medical necessity of the transport.

The inpatient hospital stay benefit includes medically necessary emergency and nonemergency ambulance transportation of the client during an inpatient hospital stay.

Ambulance transport during a client's inpatient stay will not be reimbursed to the ambulance provider. One-time ambulance transports that occur immediately after the client's discharge may be considered for reimbursement.

2.2.1 Emergency Ambulance Transport Services

An emergency ambulance transport service is a benefit when the client has an emergency medical condition. An emergency medical condition is defined, according to 1 TAC §354.1111, as a medical condition (including emergency labor and delivery) manifesting itself by acute symptoms of sufficient severity (including severe pain, psychiatric disturbances, or symptoms of substance use) such that a prudent layperson with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in one of the following:

- Placing the client's health (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy
- Serious impairment to bodily functions
- Serious dysfunction of any bodily organ or part

Facility-to-facility transport may be considered an emergency if emergency treatment is not available at the first facility and the client still requires emergency care. The transport must be to an appropriate facility, meaning the nearest medical facility equipped in terms of equipment, personnel, and the capacity to provide medical care for the illness or injury of the client involved.

Transports to out-of-locality providers (one-way transfers of 50 or more miles from the point of pickup to the point of destination) are covered if a local facility is not adequately equipped to treat the condition. Transports may be cut back to the closest appropriate facility.

When there are two responders to an emergency, the company that transports the client will be reimbursed for their services.

2.2.1.1 Prior Authorization for Emergency Out-of-State Transport

All emergency out-of-state (air, ground, and water) transports require authorization before the transport is considered for payment.

Prior authorization for emergency transport is required for out-of-state providers with the exception of those providers located within 200 miles of the Texas border.

Refer to: Subsection 2.6, "Out-of-State Medicaid Providers" in "Section 2: Texas Medicaid Fee-for-Service Reimbursement" (*Vol. 1, General Information*) for additional information on providers who are not considered out-of-state providers.

To initiate the prior authorization process, providers must call 1-800-540-0694.

Texas Medicaid & Healthcare Partnership (TMHP) is responsible for processing prior authorization requests for all Medicaid clients.

2.2.2 Nonemergency Ambulance Transport Services

According to 1 TAC §354.1111, nonemergency transport is defined as ambulance transport provided for a Medicaid client to or from a scheduled medical appointment, to or from a licensed facility for treatment, or to the client's home after discharge from a hospital when the client has a medical condition such that the use of an ambulance is the only appropriate means of transportation (i.e., alternate means of transportation are medically contraindicated).

Note: *In this circumstance, contraindicated means that the client cannot be transported by any other means from the origin to the destination without endangering the individual's health.*

According to Human Resource Code (HRC) §32.024 (t), a Medicaid-enrolled physician, nursing facility, health-care provider, or other responsible party is required to obtain authorization before an ambulance is used to transport a client in circumstances not involving an emergency.

Providers requesting prior authorization must document whether the client is currently an inpatient in a hospital when requesting prior authorization. Prior authorization will not be approved if the provider indicates the client is currently an inpatient in a hospital, except for one-time transports immediately after the client's discharge from the hospital.

Prior authorization requests may be submitted to the TMHP Prior Authorization Department by mail, fax, or the electronic portal. Prescribing or ordering providers, dispensing providers, clients' responsible adults, and clients may sign prior authorization forms and supporting documentation using electronic or wet signatures.

Medical necessity must be established through prior authorization for all nonemergency ambulance transports. Retrospective review may be performed to ensure that documentation supports the medical necessity of the transport.

Clients who do not meet medical necessity requirements for nonemergency ambulance transport may be able to receive transport through the Medical Transportation Program (MTP).

Transports must be limited to those situations where the transportation of the client is less costly than bringing the service to the client.

For non-emergency ambulance transportation services rendered to a client, ambulance providers may coordinate the nonemergency ambulance prior authorization request between the requesting provider, which may include a physician, nursing facility, healthcare provider, or other responsible party. Ambulance providers may assist in providing necessary information such as their National Provider Identifier (NPI) number, fax number, and business address to the requesting provider. However, the Non-emergency Ambulance Prior Authorization Request form must be signed and dated and submitted by the Medicaid-enrolled requesting provider, not the ambulance provider.

Refer to: Subsection 5.1.8, "Prior Authorization for Nonemergency Ambulance Transport" in "Section 5: Fee-for-Service Prior Authorizations" (*Vol. 1, General Information*) for more information about nonemergency ambulance transport prior authorization requests and appeals.

The *Medical Transportation Program Handbook (Vol. 2, Provider Handbooks)* for more information about the Medical Transportation Program.

2.2.3 Levels of Service

Levels of services as defined by Texas Medicaid:

- Basic Life Support (BLS) is emergency care that uses noninvasive medical acts and, if allowed by licensing jurisdiction, may include the establishment of a peripheral intravenous (IV) line.
- Advanced Life Support (ALS) is emergency care that uses invasive medical acts. For Medicaid purposes only, ALS services are divided into two categories, Level 1 and Level 2.
- Level 1 ALS includes an ALS assessment or at least an ALS intervention.
- Level 2 ALS includes either of the following:
- At least three separate administration of one or more medications by intravenous push/bolus or by continuous infusion (excluding crystalloid fluids); or

- At least one of the ALS 2 procedures: manual defibrillation/cardioversion; endotracheal intubation; central venous line; cardiac pacing; chest decompression; surgical airway; or intra-osseous line.

2.2.4 Oxygen

Reimbursement for oxygen (procedure code A0422) is limited to one billable code per transport.

2.2.5 Types of Transport

2.2.5.1 Multiple Client Transports

Multiple client transports occur when more than one client with Medicaid coverage is transported simultaneously in the same vehicle. A claim for each client must be billed with the transport procedure code and the mileage procedure code with the GM modifier that indicates multiple client transport.

Claims must include the names and Medicaid numbers of other Texas Medicaid clients who shared the transfer, or indicate “Not a Medicaid client” in Block 19 of the CMS 1500 paper form. Providers must enter charges on a separate claim for each client. TMHP adjusts the payment to 80 percent of the allowable base rate for each claim and divides mileage equally among the clients who share the ambulance.

Refer to: Subsection 6.4, “Claims Filing Instructions” in “Section 6: Claims Filing” (*Vol. 1, General Information*).

2.2.5.2 Air or Specialized Vehicle Transports

Air ambulance transport services, by means of either fixed or rotary wing aircraft, and other specialized emergency medical services vehicles may be covered only if one of the following conditions exists:

- The client’s medical condition requires immediate and rapid ambulance transportation that could not have been provided by standard automotive ground ambulance.
- The point of client pick up is inaccessible by standard automotive ground vehicle.
- Great distances or other obstacles are involved in transporting the client to the nearest appropriate facility.

Claims for air ambulance transports procedure codes A0430 and A0431 must be submitted with the corresponding air mileage procedure code A0435 or A0436.

2.2.5.3 Specialty Care Transport (SCT)

SCT (procedure code A0434) is the interfacility transport of a critically injured or ill client by a ground ambulance vehicle, including the provision of medically necessary supplies and services, at a level of service beyond the scope of the emergency medical technician (EMT) or paramedic. SCT is necessary when a client’s condition requires ongoing care that must be furnished by one or more health professionals in an appropriate specialty area, for example, emergency or critical-care nursing, emergency medicine, respiratory care, cardiovascular care, or a paramedic with additional training.

2.2.5.4 Transports for Pregnancies

Transporting a pregnant woman may be covered as an emergency transfer if the client’s condition is documented as an emergency situation at the time of transfer.

Claims documenting an emergency home delivery or delivery en route are considered emergency transfers. Premature labor and early onset of delivery (less than 37 weeks gestation) may also be

considered an emergency. Active labor without more documentation of an emergency situation is not payable as an emergency transport.

If the pregnant client is transported in an ambulance for a nonemergency situation, all criteria for nonemergency prior authorization must be met.

2.2.5.5 Transports to or from Prescribed Pediatric Extended Care Centers (PPECC)

Non-emergency ambulance transports between a client's home and a PPECC are not covered.

2.2.5.6 Transports to or from State Institutions

Ambulance transports to or from a state-funded hospital for admission or following discharge are covered when nonemergency transfer criteria are met. Ambulance transfers of clients while they are inpatients of the institution are not covered. The institution is responsible for routine nonemergency transportation.

2.2.5.7 Not Medically Necessary Transports

Providers must use the GY modifier to submit claims for instances when the provider is aware no medical necessity existed. When billing for this type of transportation, ambulance providers must maintain a signed Client Acknowledgment Statement indicating that the client was aware, prior to service rendered, that the transport was not medically necessary. The Client Acknowledgment Statement is subject to retrospective review.

Refer to: Subsection 1.6.9.1, "Client Acknowledgment Statement" in "Section 1: Provider Enrollment and Responsibilities" (*Vol. 1, General Information*).

2.2.5.8 Transports for Nursing Facility Residents

Nursing facilities are responsible for providing or arranging transportation for their residents. Arranging transportation for Medicaid clients includes obtaining prior authorizations for nonemergency ambulance transports. The Nonemergency Ambulance Prior Authorization Request form must be filled out and submitted to TMHP by the facility or the physician's staff that is most familiar with the client's condition. The ambulance provider must not assist in completing or submitting any portion of this form.

Transports from a nursing facility to a hospital are covered if the client's condition meets emergency criteria.

A return trip to a nursing facility following an emergency transport is not considered routine; therefore, transport back to the facility must be requested by the discharging hospital. Nonemergency transport for the purpose of required diagnostic or treatment procedures that are not available in the nursing facility (such as dialysis treatments at a freestanding facility) are also allowable only for clients whose medical condition is such that the use of an ambulance is the only appropriate means of transport (e.g., alternate means of transport are medically contraindicated).

The cost of routine nonemergency transportation is included in the nursing facility vendor rate. This nonemergency transport requires the nursing facility to request and obtain a Prior Authorization Number (PAN) from the TMHP Ambulance Unit before contacting the ambulance company for the transport.

Transports of nursing facility residents for rehabilitative treatment (e.g., physical therapy) to outpatient departments or physicians' offices for recertification examinations for nursing facility care are not reimbursable ambulance services.

Claims for services to nursing facility residents must indicate the medical diagnosis or problem requiring treatment, the medical necessity for use of an ambulance for the transport, and the type of treatment rendered at the destination (e.g., admission or X-ray).

If a client is returned by ambulance to a nursing facility following inpatient hospitalization, the acute condition requiring hospitalization must be noted on the ambulance claim form. This transport is considered for payment only if the client’s medical condition is appropriate for transport by ambulance. This nonemergency transport requires the nursing facility to request and obtain a PAN from the TMHP Ambulance Unit before contacting the ambulance company for the transport.

Ambulance providers may bill a nursing facility or client for a nonemergency ambulance transport only under the following circumstances:

- *Providers may bill the nursing facility* when the nursing facility requests the nonemergency ambulance transport without a PAN.
- *Providers may bill the client* only when the client requests transport that is not an emergency and the client does not have a medical condition such that the use of an ambulance is the only appropriate means of transport (i.e., alternate means of transport are medically contraindicated). The provider must advise the client of acceptance as a private pay patient at the time the service is provided, and the client is responsible for payment of all services. Providers are encouraged to have the client sign the Private Pay Agreement.

Providers may refer questions about a nursing facility’s responsibility for payment of a transport to the TMHP Contact Center at 1-800-925-9126 or TMHP provider relations representatives.

2.2.5.9 Emergency Transports Involving a Hospital

Hospital-to-hospital transports that meet the definition of an emergency transport do not require prior authorization.

Providers must use modifier ET and one of the facility-to-facility transfer modifiers (HH, HI, or IH) on each procedure code listed on the claim.

Modifier	Transport Type
HH	From hospital to hospital
HI	From hospital to site of transfer
IH	From site of transfer to hospital

2.2.5.10 No Transport

Texas Medicaid does not reimburse ambulance providers for services that do not result in a transport to a facility, regardless of whether any medical care was rendered. If a client contacts an ambulance provider, but the call does not result in a transport, the provider should have the client sign an acknowledgement statement and may bill the client for services rendered.

Texas Medicaid will not reimburse for the return trip of an empty ambulance. Texas Medicaid will not reimburse air or ground mileage when the client is not on board the ambulance.

2.3 Documentation Requirements

The requesting provider, which may include a physician, nursing facility, health-care provider, or other responsible party, is required to maintain the supporting documentation, physician’s orders, the Non-emergency Ambulance Prior Authorization Request form and if applicable, the Nonemergency Ambulance Exception form.

The requesting provider (i.e., physician, nursing facility, healthcare provider, or other responsible party) must contact the transporting ambulance provider with the PAN and the dates of service that were approved. The transporting ambulance provider will submit claims for the nonemergency ambulance transportation services, using the approved PAN provided by the requesting provider.

An ambulance provider is required to maintain documentation that represents the client's medical condition and other clinical information to substantiate medical necessity, the level of service, and the mode of transportation requested. This supporting documentation is limited to documents developed or maintained by the ambulance provider.

Physicians, nursing facilities, health-care providers, or other responsible parties are required to maintain physician orders related to requests for prior authorization of nonemergency and out-of-state ambulance services. These providers must also maintain documentation of medical necessity for the ambulance transport.

In hospital-to-hospital transports or hospital-to-outpatient medical facility transports, the TMHP Ambulance Unit considers information by telephone from the hospital. Providers are not required to fax medical documentation to TMHP; however, in certain circumstances, TMHP may request that the hospital fax the supporting documentation. Hospitals are allowed to release a client's protected health information (PHI) to a transporting emergency medical services provider for treatment, payment, and health-care operations.

Providers must document whether the client is currently an inpatient in a hospital when requesting prior authorization. Prior authorization will not be approved if the provider indicates the client is currently an inpatient in a hospital, except for one-time transports immediately after the client's discharge from the hospital.

The hospital must maintain documentation of medical necessity, including a copy of the authorization from TMHP in the client's medical record for any item or service that requires prior authorization. The services provided must be clearly documented in the medical record with all pertinent information regarding the client's condition to substantiate the need and medical necessity for the services.

2.3.1 Medicaid Surety Bond Requirements

Ambulance providers attempting to renew their Emergency Medical Services (EMS) license must submit a surety bond to TMHP for each license they are attempting to renew. A copy of the surety bond must also be attached to an application for renewal of an EMS license when submitted to DSHS. **Refer to:** Subsection 1.1.6, "Surety Bond Enrollment Requirement" in "Section 1: Provider Enrollment and Responsibilities" (*Vol. 1, General Information*) for more information.

2.4 Claims Filing and Reimbursement

2.4.1 Claims Information

Emergency and nonemergency claims may be billed electronically. For electronic billers, the hospital's provider identifier must be entered in the Facility ID field. Providers should consult their software vendor for the location of this field on the electronic claim form.

The Healthcare Common Procedure Coding System (HCPCS)/Current Procedural Terminology (CPT) codes included in policy are subject to National Correct Coding Initiative (NCCI) relationships. Exceptions to NCCI code relationships that may be noted in the Texas Medicaid medical policy are no longer valid.

The CMS NCCI and MUE guidelines can be found in the [NCCI web page](#), which are available on the CMS website. Providers should refer to the CMS NCCI web page for correct coding guidelines and specific applicable code combinations.

In instances when Texas Medicaid medical policy quantity limitations are more restrictive than NCCI Medically Unlikely Edits (MUE) guidance, medical policy prevails.

2.4.2 Reimbursement

Ground and air ambulance providers are reimbursed based on the lesser of a provider's billed charges or the maximum fee established by the Texas Health and Human Services Commission (HHSC) in accordance with 1 TAC §355.8600. Providers can refer to the [Online Fee Lookup \(OFL\)](#) or the applicable fee schedule on the TMHP website at www.tmhp.com.

Refer to: Subsection 2.2, "Fee-for-Service Reimbursement Methodology" in "Section 2: Texas Medicaid Fee-for-Service Reimbursement" (*Vol. 1, General Information*) for more information about reimbursement methodologies.

Subsection 1.11, "Texas Medicaid Limitations and Exclusions" in "Section 1: Provider Enrollment and Responsibilities" (*Vol. 1, General Information*) for information on Medicaid exclusions.

2.4.2.1 Ambulance Disposable Supplies

Ambulance disposable supplies are included in the global fee for specialty care transport and must not be billed separately.

Reimbursement for BLS or ALS disposable supplies (procedure codes A0382 and A0398 respectively) is separate from the established fee for ALS and BLS ambulance transports and is limited to one billable procedure code per transport.

2.4.2.2 Payment Window Reimbursement Guidelines for Services Preceding an Inpatient Admission

The three-day and one-day payment window reimbursement guidelines do not apply for ambulance services.

Refer to: Subsection 3.7.3.14, "Payment Window Reimbursement Guidelines" in the *Inpatient and Outpatient Hospital Services Handbook (Vol. 2, Provider Handbooks)* for additional information about the payment window reimbursement guidelines.

2.4.3 Medicare and Medicaid Coverage

All ambulance claims are exempt from Medicare equalization, which pays the lesser of the coinsurance and deductible or the remainder of the amount that Medicaid would have paid for the same service minus what Medicare has already paid on Medicare crossover claims.

All claims for ambulance services provided to dual-eligible clients are reimbursed the full amount of the

Medicare coinsurance and deductible for Part B claims and Part C claims from non-contracted Medicare Advantage Plans.

Medicaid prior authorization is not required for ambulance services for Qualified Medicare Beneficiary (QMB) clients because QMB clients are not eligible for Medicaid benefits. Providers can contact Medicare for the Medicare prior authorization guidelines.

Medicaid Qualified Medicare Beneficiary (MQMB) clients are eligible for all Medicaid benefits; therefore, the provider should simultaneously request prior authorization for the nonemergency transport from TMHP for the MQMB client in the event the service requested is denied by Medicare as a non-covered service.

Refer to: Subsection 4.9, "Medicare and Medicaid Dual Eligibility" in "Section 4: Client Eligibility" (*Vol. 1, General Information*).

Subsection 2.7, “Medicare Crossover Claim Reimbursement” in “Section 2: Texas Medicaid Fee-for-Service Reimbursement” (*Vol. 1, General Information*) for additional information about Medicare coinsurance and deductible payments and exceptions.

2.4.3.1 Medicare Services Paid

Assigned claims filed with and paid by Medicare should automatically transfer to TMHP for payment of the deductible and coinsurance liability. According to current guidelines, providers must submit Medicare-paid claims that do not cross over to TMHP for the coinsurance and deductible. Providers must send the Medicare Remittance Advice Notice (MRAN) with the client information circled in black ink.

2.4.3.2 Medicare Services Denied

A Medicare ambulance claim that has been denied must go through the appropriate Medicare claim appeals process with a decision by the administrative law judge before TMHP will process the ambulance claim. MQMB ambulance claims that have exhausted the Medicare third level of appeal by the administrative law judge (ALJ) must be submitted to TMHP with the disposition letter from the ALJ along with all other required documents for an appeal.

An assigned claim that was denied by Medicare because the client has no Part B benefits or because the transport destination is not allowed can be submitted to TMHP for consideration. Providers must send claims to TMHP on a CMS-1500 paper claim form with the ambulance provider identifier, unless they are a hospital-based provider. Hospital-based ambulance providers must send Medicare denied claims to TMHP on a CMS-1500 paper claim form with the ambulance provider identifier and a copy of the MRAN.

***Note:** All claims for STAR+PLUS clients with Medicare and Medicaid must follow the same requirements used for obtaining prior authorization for Medicaid-only services from TMHP. The STAR+PLUS HMO is not responsible for reimbursement of these services.*

2.4.4 Ambulance Claims Coding

Providers must submit claims for emergency transport with the ET modifier on each procedure code submitted. Any procedure code submitted on the claim for emergency transport without the ET modifier will be subject to prior authorization requirements.

2.4.4.1 Place of Service Codes

The place of service (POS) for all ambulance transports is considered the destination.

POS codes 41 and 42 (other) are national POS codes that are accepted by Texas Medicaid only for electronic claims. POS code 9 is accepted by Texas Medicaid for ambulance claims submitted on paper.

2.4.4.2 Origin and Destination Codes

All claims submitted on paper or electronically must include the two-character origin and destination codes for every claim line. The origin is the first character, and the destination is the second character.

The following are the origin and destination codes accepted by Texas Medicaid:

Origin and Destination Code	Description
D	Diagnostic or therapeutic site/freestanding facility (e.g., radiation therapy center) other than P or H
E	Residential/domiciliary/custodial facility (e.g., nonskilled facility)

G	Hospital-based dialysis facility (hospital or hospital-related)
H	Hospital (e.g., inpatient or outpatient)
I	Site of transfer (e.g., airport or helicopter pad) between modes of ambulance transport
J	Non-hospital-based dialysis facility
N	Skilled Nursing Facility (SNF) (swingbed is considered an SNF)
P	Physician’s office (includes HMO and nonhospital facility)
R	Residence (client’s home or any residence)
S	Scene of accident or acute event
X	Intermediate stop at physician’s office en route to the hospital (destination code only)

Nonemergency claims filed electronically must include the PAN in the appropriate field. For nonemergency hospital-to-hospital transfers, indicate the services required from the second facility and unavailable at the first facility in Block 19 of the CMS-1500 paper claim form. If the destination is a hospital, enter the name and address and the provider identifier of the facility in Block 32.

For nonemergency transports, ambulance providers must enter the ICD-10-CM diagnosis code to the highest level of specificity available for each diagnosis observed in Block 21 of the claim form.

Reminder: *Providers must submit multiple transports for the same client on the same date of service through one claim submission. Additional claims information can be found within individual topics in this section.*

Providers should consult their software vendor for the location of the field on the electronic claim form. Providers must submit ambulance services to TMHP on a CMS-1500 paper claim form. Providers may purchase CMS-1500 paper claim forms from a vendor of their choice. TMHP does not supply the forms.

When completing a CMS-1500 paper claim form, all required information must be included on the claim, as TMHP does not key information from claim attachments. Superbills, or itemized statements, are not accepted as claim supplements.

Refer to: “Section 3: TMHP Electronic Data Interchange (EDI)” (*Vol. 1, General Information*) for information on electronic claims submissions.

“Section 6: Claims Filing” (*Vol. 1, General Information*) for general information about claims filing.

Subsection 6.5, “CMS-1500 Paper Claim Filing Instructions” in “Section 6: Claims Filing” (*Vol. 1, General Information*). Blocks that are not referenced are not required for processing by TMHP and may be left blank.

2.4.4.3 Transports Billed Without Mileage

Ambulance transport claims with a billed mileage amount of \$0.00 will be reimbursed. To qualify for reimbursement, the transport claim must include a mileage quantity that is greater than zero.

Providers may not include a mileage charge as part of the transport charge or as part of any other charges on the claim.

Payments for ambulance transports are only made if the client is actually transported and the mileage quantity billed is greater than zero. Mileage charges greater than zero will be considered for reimbursement when a transport procedure code is included on the claim.

2.4.5 Air or Specialized Vehicle Transports

Procedure codes A0430 and A0435, or A0431 and A0436 are used to bill air transport. Procedure code A0999 is used to bill for specialized vehicle transports. Transport claims may be submitted electronically with a short description of the client’s physical condition in the comment field. If the client’s condition cannot be documented, providers must file a paper claim with supporting documentation. **Refer to:** Subsection 2.2.5.2, “Air or Specialized Vehicle Transports” in this handbook for more information about how to meet the specific criteria for reimbursement consideration for air or specialized transport claims.

2.4.6 Emergency Transport Billing

Emergency transport is a benefit when billed with the ET modifier and the most appropriate emergency medical condition codes. The ET modifier is required for every detail on an emergency transport claim, but is not required to be listed in the first position on the claim line.

The following procedure codes are for emergency transport:

Procedure Codes									
A0382	A0398	A0422	A0424	A0425*	A0427	A0429	A0430	A0431	A0433
A0434	A0435	A0436	A0999						
*A0425 is denied if it is billed without procedure code A0427, A0429, A0433, or A0434.									

One of the following emergency medical condition code is required on all emergency ambulance claims and must be listed in Box 21 of the CMS-1500 claim form:

Emergency Medical Condition Codes							
B9689	B999	E869	F068	F10929	F19939	F29	G4489
Emergency Medical Condition Codes							
G8929	H579	I469	I499	J9600	J984	M549	O2690
R002	R0602	R0603	R0689	R079	R092	R0989	R100
R109	R238	R4182	R4189	R4589	R509	R52	R55
R569	R58	R6889	R7309	S0590XA	T07XXXA	T148XXA	T1490XA
T1491XA	T17300A	T300	T50904A	T59891A	T5994XA	T672XXA	T675XXA
T68XXXA	T699XXA	T7500XA	T751XXA	T754XXA	T782XXA	T7840XA	T8189XA
T82519A	T887XXA	Y710	Y828	Z209	Z7401	Z779	Z9181
Z9981	Z9989						

While ICD-10-CM codes are not precluded from use on ambulance claims, they are currently not required (per the Health Insurance Portability and Accountability Act [HIPAA] of 1996) on most ambulance claims and the use of these codes generally does not trigger a payment or a denial of a claim.

Claims for emergency transports that are denied for not meeting the emergency criteria will be considered on appeal with additional documentation to support the emergency nature of the transport. Claims that have denied for not meeting emergency transport criteria cannot be appealed for reimbursement as a nonemergency claim.

Refer to: Subsection 2.2.1, “Emergency Ambulance Transport Services” in this handbook.

2.4.7 Nonemergency Transport Billing

The following procedure codes are used when billing for nonemergency ambulance services:

Procedure Codes									
A0382	A0398	A0420	A0422	A0424	A0425*	A0426	A0428	A0430	A0431
A0433	A0434	A0435	A0436						
*A0425 is denied if it is billed without procedure code A0426, A0428, A0433, or A0434.									

2.4.8 Extra Attendant

The use of additional attendants (procedure code A0424) must be related to extraordinary circumstances when the basic crew is unable to transport the client safely.

An extra attendant on a nonemergency transport must be prior authorized. On an emergency transport, the billing provider’s medical documentation must clearly indicate the services the attendant performs along with a rationale for the services to indicate medical necessity of the attendant.

The information supporting medical necessity must be kept in the billing provider’s medical record and is subject to retrospective review.

Situations when an extra attendant may be required beyond the basic crew include, but are not limited to:

- Necessity of additional special medical equipment or treatment en route to destination (describe what special treatment and equipment is required and why it requires an attendant).
- Client behavior that may be a danger to self or ambulance crew or that requires, or may require, restraints.
- Extreme obesity of client (provide weight and client’s functional limitations).
- The extra attendant must be certified by DSHS to provide emergency medical services.
- The use of an extra attendant for air transport is not a benefit of Texas Medicaid. Claims submitted with procedure code A0424 will be denied if billed with air transports (procedure code A0430 or A0431).

2.4.8.1 Emergency Transports

Emergency transports that use an extra attendant do not require prior authorization. Modifier ET must be billed with the extra attendant procedure code A0424.

The billing provider’s medical documentation must clearly indicate the services the attendant performed along with rationale for the services to indicate the medical necessity of having the attendant. The billing provider must keep the information that supports medical necessity in the client’s medical record, which will be subject to retrospective review.

When more than one client is transported at the same time in the same vehicle, the use of an extra attendant may be required when each client who is being transported requires medical attention or close monitoring.

2.4.8.2 Nonemergency Transports

Prior authorization is required when an extra attendant is needed for any nonemergency transport. When a client's condition changes, such as a need for oxygen or an extra attendant for transport, the prior authorization request must be updated.

To receive prior authorization, the requesting provider must prove medical necessity and identify attendant services that could not be provided by the basic crew. The information supporting medical necessity must be kept in the requesting provider's medical record and is subject to retrospective review.

Texas Medicaid does not reimburse for an extra attendant based only on an ambulance provider's internal policy.

2.4.9 Night Call

Texas Medicaid does not reimburse an extra charge for a night call.

2.4.10 Waiting Time

Procedure code A0420 for nonemergency ambulance transportation services requires prior authorization and may be billed when it is the general billing practice of local ambulance companies to charge for unusual waiting time (longer than 30 minutes). Providers must use the following procedures:

- Separate charges must be billed for all clients, Medicaid and non-Medicaid, for unusual waiting time.
- The circumstances requiring waiting time and the exact time involved must be documented in Block 24 of the CMS-1500 paper claim form.
- The amount charged for waiting time must not exceed the charge for a one-way transfer.

Important: *Waiting time is reimbursed up to one hour.*

2.4.11 Appeals

Only a denial of prior authorization may be appealed. Clients may appeal prior authorization request denials by contacting TMHP Client Notification at 1-800-414-3406. The Non-emergency Ambulance Prior Authorization Request form is not considered to be documentation after the service has been rendered.

Claims denied due to an inappropriate emergency medical condition code may be resubmitted with the appropriate emergency medical condition code.

On appeal, supporting documentation is critical for determining the client's condition at the time of transport. Ambulance providers who file paper claims must include all information that supports the reason for the transport and attach a copy of the run sheet to the claim. The EMT who transported the client must sign the documentation.

Refer to: Subsection 2.3, "Documentation Requirements" in this handbook.

Medicaid clients have the right to request a Fair Hearing within 90 days of the date of the denial action.

2.4.12 Relation of Service to Time of Death

Medicaid benefits cease at the time of the client’s death. However, if the client dies in the ambulance while en route to the destination, Texas Medicaid covers the transport. If a physician pronounces the client dead after the ambulance is called, Texas Medicaid covers the ambulance service (base rate plus mileage) to the point of pick up. Providers must indicate the date and time the client died in Block 19 of the CMS-1500 paper claim form. If a physician or coroner pronounces the client dead before the ambulance is called, the service is not covered.

Equipment and nondisposable supplies are included in the base rate. These items are not separately reimbursable and are considered part of another procedure. Therefore, equipment and supplies cannot be billed to the client.

2.5 Claims Resources

Providers may refer to the following sections or forms when filing claims:

Resource	Location
Acronym Dictionary	“Appendix D: Acronym Dictionary” (<i>Vol. 1, General Information</i>)
Automated Inquiry System (AIS)	Subsection A.10, “TMHP Telephone and Fax Communication” in “Appendix A: State, Federal, and TMHP Contact Information” (<i>Vol. 1, General Information</i>)
CMS-1500 Paper Claim Filing Instructions	Subsection 6.5, “CMS-1500 Paper Claim Filing Instructions” in “Section 6: Claims Filing” (<i>Vol. 1, General Information</i>)
State, federal, and TMHP contact information	“Appendix A: State, Federal, and TMHP Contact Information” (<i>Vol. 1, General Information</i>)
TMHP Electronic Data Interchange (EDI) information	“Section 3: TMHP Electronic Data Interchange (EDI)” (<i>Vol. 1, General Information</i>)

2.6 Contact TMHP

The TMHP Contact Center at 1-800-925-9126 is available Monday through Friday from 7 a.m. to 7 p.m., Central Time.

3 Forms

The following linked forms can also be found on the [Forms](#) page of the Provider section of the TMHP website at www.tmhp.com:

Forms
Non-emergency Ambulance Prior Authorization Request

4 Claim Form Examples

The following linked claim form examples can also be found on the [Claim Form Examples](#) page of the Provider section of the TMHP website at www.tmhp.com:

Claim Form Examples
Ambulance Non-emergency Transport

<u>Ambulance Emergency Transport from Residence to Hospital</u>
<u>Ambulance Emergency Transport from Scene of Accident to Hospital</u>