# AMBULANCE

**CSHCN SERVICES PROGRAM PROVIDER MANUAL**

**MARCH 2026**

TEXAS
Health and Human
Services

# AMBULANCE

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## 9.1 Enrollment

To enroll in the CSHCN Services Program, ambulance providers must be actively enrolled in Texas Medicaid, have a valid Provider Agreement with the CSHCN Services Program, have completed the CSHCN Services Program enrollment process, and comply with all applicable state laws and requirements. Providers may enroll online or download enrollment forms at www.tmhp.com.

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

Out-of-state ambulance and air ambulance providers must meet all these conditions and be located in the United States within 50 miles of the Texas state border.

Ambulance and air ambulance providers must submit a copy of their permit or license from the Department of State Health Services (DSHS).

***Important:*** *CSHCN Services Program providers are responsible for knowing, understanding, and complying with the laws, administrative rules, and policies of the CSHCN Services Program and Texas Medicaid.*

By enrolling in the CSHCN Services Program, providers are charged not only with knowledge of the adopted CSHCN Services Program agency rules published in Title 26 Texas Administrative Code (TAC), but also with knowledge of the adopted Medicaid agency rules published in 1 TAC, Part 15, and specifically including the fraud and abuse provisions contained in Chapter 371.

CSHCN Services Program providers also are required to comply with all applicable laws, administrative rules, and policies that apply to their professions or to their facilities. Specifically, it is a violation of program rules when a provider fails to provide health-care services or items to recipients in accordance with accepted medical community standards and standards that govern occupations, as explained in 1 TAC §371.1659 for Medicaid providers, which also applies to CSHCN Services Program providers as set forth in 26 TAC §351.6(b)(1). Accordingly, CSHCN Services Program providers can be subject to sanctions for failure to deliver, at all times, health-care items and services to recipients in full accordance with all applicable licensure and certification requirements. These include, without limitation, requirements related to documentation and record maintenance, such that a CSHCN Services Program provider can be subject to sanctions for failure to create and maintain all records required by his or her profession or their facility, as well as those required by the CSHCN Services Program and Texas Medicaid.

***Refer to:*** Section 2.1, "Provider Enrollment" in Chapter 2, "Provider Enrollment and Responsibilities" for more detailed information about CSHCN Services Program provider enrollment procedures.

## 9.2 General Information

The CSHCN Services Program may reimburse emergency and nonemergency ambulance transports (ground, air, or specialized emergency medical services vehicle) when the client meets the definition of emergency medical condition or meets the requirements for nonemergency transport.

The following ambulance services procedure codes are a benefit of the CSHCN Services Program:

| Procedure Codes | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| A0382 | A0398 | A0420 | A0422 | A0424 | A0425 | A0426 | A0427 | A0428 | A0429 |
| A0430 | A0431 | A0433 | A0434 | A0435 | A0436 | A0999 | Q3014 | | |

Procedure codes A0398, A0433, A0434 and A0999 may be reimbursed as emergency or nonemergency services.

- Claims for emergency services must be submitted with the ET modifier.

- Nonemergency services must be prior authorized.

Ground and air mileage (procedure codes A0425, A0435, and A0436) is reimbursed the lower of the billed amount or the amount allowed by Texas Medicaid.

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 hospital 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.

### 9.2.1 Origin and Destination Modifiers

The following are the origin and destination codes accepted by the CSHCN Services Program:

| Origin and Destination Code | Description |
|---|---|
| D | Diagnostic or therapeutic site, or freestanding facility (e.g., radiation therapy center) other than H or P |
| E | Residential, domiciliary, or custodial facility (unskilled facility) |
| G | Hospital-based dialysis facility (hospital or hospital-related) |
| H | Hospital (inpatient or outpatient) |
| I | Site of transfer (e.g., airport or helicopter pad) between modes of ambulance transport |
| J | Nonhospital-based dialysis facility |
| N | Skilled nursing facility |
| P | Physician's office |
| 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) |

The following are emergency Triage, Treat, and Transport (ET3) alternative destination and treatment in place (TIP) destination codes:

| Destination | Description |
|---|---|
| C | Community mental health center (including substance use disorder center) |
| F | Federally qualified health center |
| O | Physician's office |
| U | Urgent care facility |
| W | Treatment in place (in person or via telehealth) |

All ambulance claims must include the origin and destination modifiers on each procedure code submitted. Any procedure code submitted without the origin and destination modifiers will be denied.

### 9.2.2 Place of Service

All claims submitted must include a Place of Service (POS) code in block 24b of the CMS-1500 paper claim form.

The POS identifies where services are performed. Indicate the POS by using the appropriate numeric code for each service listed on the claim. The following POS codes must be used:

| Place of Service | Two-Digit Numeric Codes (Electronic Billers) | One-Digit Numeric Codes (Paper Billers) |
|---|---|---|
| Office | 11, 65, 71, 72 | 1 |
| Home | 12, 27 | 2 |
| Inpatient hospital | 21, 51, 52, 56, 61 | 3 |
| Outpatient hospital | 22, 23, 24, 55, 62 | 5 |
| Other location | 26, 34, 53, 99 | 9 |
| Independent lab | 81 | 6 |
| Destination of ambulance | Indicate destination using above codes | Indicate destination using above codes |

### 9.2.3 Diagnosis Coding

Medical necessity and coverage of ambulance transport services are not based solely on the presence of a specific diagnosis. The CSHCN Services Program reimbursement for ambulance transports may be made only for those clients whose condition at the time of transport is such that ambulance transport is medically necessary. For example, it is insufficient that a client merely has a diagnosis such as pneumonia, stroke, or fracture to justify ambulance transport. In each of those instances, the condition of the client must be such that transport by any other means is medically contraindicated. In the case of ambulance transport, the condition necessitating transport is often that an accident or injury has occurred that gives 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 (facility, physician, or ambulance) responsibility to supply the CSHCN Services Program contract administrator with information that describes the condition of the client that necessitated the ambulance transport. Because many ambulance personnel have only a limited ability to establish a diagnosis, the CSHCN Services Program recognizes that coding of a client's condition using International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) diagnosis codes by ambulance transport services may be less specific than those determined by other health-care providers.

Ambulance services providers who submit ICD-10-CM diagnosis codes should choose the code that best describes the client's condition at the time of transport. When a diagnosis is not confirmed, it is better to use a symptom, finding, or injury code. Providers of ambulance services should avoid using ICD-10-CM codes to report "rule out" or "suspected" diagnoses.

When there are two responders to an emergency, the company that transports the client will be reimbursed for their services. The CSHCN Services Program does not reimburse for the return trip of an empty ambulance.

The ambulance provider does not have to submit the run sheet with the claim. This documentation may be requested upon retrospective review. A Medicare ambulance claim that has been denied must go through the appropriate Medicare claims appeal process with a decision by the administrative law judge before TMHP will process the ambulance claim.

### 9.2.4 General Documentation Requirements

Supporting documentation is required to be maintained by both the ambulance provider and the requesting provider, including a physician, health-care provider, or other responsible party.

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

Physicians, health-care providers, or other responsible parties who request ambulance transport are required to maintain physician orders and the Texas Medicaid and Children with Special Health Care Needs (CSHCN) Services Program Non-Emergency Ambulance Prior Authorization Request form in the client's medical record. Requesting providers must also maintain documentation of medical necessity for the ambulance transport.

## 9.3 Emergency Ambulance Transports

Emergency transports are to be to the nearest medical facility. An appropriate facility includes the equipment, personnel, and capability to provide the services necessary to support the required medical care. When an emergency transport is made to a facility other than the nearest appropriate facility and the type of transport is medically necessary, reimbursement for mileage is limited to the amount that would be reimbursed to transport to the nearest appropriate facility.

Facility-to-facility transports may be considered an emergency if the emergency treatment is not available at the first facility. All other facility-to-facility transports are considered nonemergent and prior authorization will be required.

The CSHCN Services Program coverage for emergency air ambulance transport services is limited to instances in which the client's pickup point is inaccessible by ground transport or when great distance interferes with the immediate admission to a medical treatment facility appropriate for their condition.

Claims for emergency transport services, must include the following:

- ET modifier for each procedure code.
- One or more emergency medical condition codes in the Emergency Medical Condition Code table below.

Claims for emergency ambulance transport services that are submitted without an emergency medical condition code may be appealed with documentation of medical necessity that supports the definition of an emergency medical condition.

An emergency ambulance transport that is denied will not be accepted on appeal as a nonemergency transport.

### 9.3.1 Emergency Triage, Treat, and Transport (ET3)

Emergency Triage Treat and Transport (ET3) services are designed to allow greater flexibility for enrolled ambulance providers to address clients' health care needs following a 9-1-1, fire, police, or other locally established system for emergency calls. ET3 permits emergency transportation (ground ambulance) providers to:

- Transport a client to an alternative destination, other than an emergency department; or
- Initiate and facilitate appropriate treatment in place (TIP) at the scene; or
- Initiate and facilitate appropriate TIP via telemedicine or telehealth.

#### 9.3.1.1 Transport to an Alternative Destination

An ambulance provider may transport a client to an alternative destination (such as an urgent care clinic, mental health center, FQHC, etc.) when upon evaluation:

- The client's condition is determined to be non-emergent but requires medical attention.

- An alternative destination will meet the client's level of care more appropriately than an emergency department.
- There is no other appropriate transportation available.

The alternative destination must be within or near the responding emergency transportation provider's service area. Prior to initiating ET3 transport to an alternative destination, the provider must have pre-established arrangements with alternative destination partners within their region, and have knowledge of the alternative destination's:

- Hours of operation.
- Clinical staff available.
- Services provided.

HHSC expects ambulance providers to use best practices and exercise their normal standard of care to determine the nearest most appropriate alternative destination for a client.

#### 9.3.1.2 Treatment in Place

Upon the emergency response team's arrival on the scene and their evaluation of the client, if the services required at that time are determined to be medically necessary, but not emergent, the emergency transportation provider may provide treatment to the client in accordance with the provider's scope of practice, their emergency transport service's medical direction and established protocols.

Treatment on scene may also be performed, when medically necessary, via a telemedicine or telehealth visit performed in accordance with telemedicine and telehealth services requirements outlined in the *Telecommunications Handbook*.

***Refer to:*** *Chapter 38, "Telecommunication Services"* for telemedicine and telehealth requirements.

### 9.3.2 Emergency Prior Authorization

Emergency transports within the state of Texas do not require authorization. Transports within 50 miles of the Texas state border do not require authorization.

The inpatient hospital stay benefit includes medically necessary emergency and nonemergency ambulance transport of the client during an inpatient hospital stay. Ambulance transports during an inpatient hospital stay will not be authorized unless the transport is immediately after the client's discharge from the hospital.

Out-of-state (air, ground, and water) emergency transports require authorization. All out-of-state emergency transport requests will be reviewed by the CSHCN Services Program Medical Director.

### 9.3.3 Levels of Service

Ambulance services for basic life support and advanced life support are benefits of the CSHCN Services Program. The following CMS and the Texas Health and Safety Code definitions apply for basic and advanced levels of service:

- Basic life support (BLS) is emergency care that uses noninvasive medical acts, and if allowed by the licensing jurisdiction, may include the establishment of a peripheral intravenous (IV) line.
- Advanced life support, level 1 (ALS 1) is emergency care that uses invasive medical acts that include an ALS assessment or at least one ALS intervention.
- Advanced life support, level 2 (ALS 2) is emergency care that uses invasive medical acts including one of the following:
    - At least three separate administrations of one or more medications (excluding crystalloid fluids) by intravenous push/bolus or by continuous infusion

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

### 9.3.4 Emergency Medical Conditions

An emergency is defined as a medical condition that manifests acute symptoms of sufficient severity (including severe pain) 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 in serious jeopardy
- Serious impairment to bodily functions
- Serious dysfunction of any bodily organ or part

An emergency behavioral health condition is defined as any condition that, in the opinion of a prudent layperson with an average knowledge of health and medicine, requires immediate intervention or medical attention regardless of the nature, without which the client would present an immediate danger to themselves or others or that renders the client incapable of controlling, knowing, or understanding the consequences of their actions.

The following table includes the valid emergency medical condition codes for emergency ambulance services:

| Emergency Medical Condition Codes | | | | | | | |
|---|---|---|---|---|---|---|---|
| B9689 | B999 | D75A | D8130 | D8131 | D8132 | D8139 | E869 |
| F068 | F10929 | F19939 | F29 | G4489 | G8929 | H579 | H814 |
| I2693 | I2694 | I469 | I4811 | I4819 | I4820 | I4821 | I499 |
| I80241 | I80242 | I80243 | I80249 | I80251 | I80252 | I80253 | I80259 |
| I82451 | I82452 | I82453 | I82459 | I82461 | I82462 | I82463 | I82469 |
| J9600 | J984 | M549 | O2690 | Q7960 | Q7961 | Q7962 | Q7963 |
| Q7969 | R002 | R0602 | R0603 | R0689 | R079 | R092 | R0989 |
| R100 | R109 | R238 | R4182 | R4189 | R4589 | R509 | R52 |
| R55 | R569 | R58 | R6889 | R7309 | S02121A | S02121B | S02121S |
| S02122A | S02122B | S02122S | S02129A | S02129B | S02129S | S02831A | S02831B |
| S02831S | S02832A | S02832B | S02832S | S02839A | S02839B | S02839S | S02841A |
| S02841B | S02841S | S02842A | S02842B | S02842S | S02849A | S02849B | S02849S |
| S0285XA | S0285XB | S0285XS | S0590XA | T07XXXA | T148XXA | T1490XA | T1491XA |
| T17300A | T300 | T50904A | T50911A | T50911S | T50912A | T50912S | T50913A |
| T50913S | T50914A | T50914S | T50915A | T50915S | T50916A | T50916S | T59891A |
| T5994XA | T6701XA | T6701XS | T6702XA | T6702XS | T6709XA | T6709XS | T672XXA |
| T675XXA | T68XXXA | T699XXA | T7500XA | T751XXA | T754XXA | T782XXA | T7840XA |
| T8189XA | T82519A | T887XXA | Y35009A | Y35009S | Y35019A | Y35019S | Y35029A |
| Y35029S | Y35039A | Y35039S | Y35049A | Y35049S | Y35099A | Y35099S | Y35109A |
| Y35109S | Y35119A | Y35119S | Y35129A | Y35129S | Y35199A | Y35199S | Y35209A |
| Y35209S | Y35219A | Y35219S | Y35299A | Y35299S | Y35309A | Y35309S | Y35319A |
| Y35319S | Y35399A | Y35399S | Y35409A | Y35409S | Y35419A | Y35419S | Y35499A |
| Y35499S | Y35819A | Y35819S | Y35831A | Y35831S | Y35832A | Y35832S | Y35833A |
| Y35833S | Y35839A | Y35839S | Y3599XA | Y3599XS | Y710 | Y828 | Z209 |

| Emergency Medical Condition Codes | | | | |
|---|---|---|---|---|
| Z7401 | Z779 | Z9181 | Z9981 | Z9989 |

## 9.4 Nonemergency Ambulance Transports

Nonemergency transports are provided by an ambulance provider for a client to or from a scheduled medical appointment, to or from another licensed facility for treatment, or to the client's home after discharge from a hospital. Nonemergency ambulance transports may be considered a benefit of CSHCN Services Program when alternate means of transport is contraindicated due to the client's medical or mental health condition.

> ***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.*

Medical necessity must be established through prior authorization for all nonemergency ambulance transports.

Nonemergency transports of clients with conditions that do not meet medical necessity criteria are not a benefit of the CSHCN Services Program. Transports must be limited to trips in which the client not only meets the medical necessity requirements, but the transport of the client is the least costly service available.

A provider may appeal denied prior authorization requests by submitting a request for an administrative review to the CSHCN Services Program.

Providers may appeal denied payment for services when prior authorization was not obtained before the service was provided by submitting a request for an administrative review to the CSHCN Services Program.

A provider that is denied payment for rendered ambulance transport services is entitled to payment from the health-care provider or other responsible party that requested the services if:

- Payment is denied because the requesting provider did not obtain prior authorization.
- The performing provider submits a copy of the bill for which payment was denied to the health-care provider or other responsible party for payment.

Clients and/or providers may contact the Medical Transportation Program (MTP) for assistance when non-emergent transports are not approved. MTP may be contacted toll free at 1-877-633-8747 to request transportation services.

### 9.4.1 Nonemergency Prior Authorizations

Prior authorization will be required for all nonemergency ambulance transports, regardless of the type of transport (e.g., air or specialized emergency medical services vehicle). To obtain prior authorization, a completed Texas Medicaid and Children with Special Health Care Needs (CSHCN) Services Program Non-Emergency Ambulance Prior Authorization Request form must be submitted. The Texas Medicaid and Children with Special Health Care Needs (CSHCN) Services Program Non-Emergency Ambulance Prior Authorization Request form must not be modified (i.e., changing of the sequence). If altered in any way, the request may be denied.

The following nonemergency transports require prior authorization:

- Hospital to hospital
- Hospital to outpatient facilities
- Round-trip transport from the client's home to a scheduled medical appointment

A physician, health-care provider, or facility must obtain prior authorization from the TMHP/CSHCN Services Program Ambulance Department or a person authorized to act on behalf of the prior authorization department on the same day or the next business day following the day of transport when an ambulance is used to transport a client in circumstances not involving an emergency, and the request is for the authorization of the provision of transportation for only one day. If transportation occurs over the weekend or a holiday, the responsible party must obtain authorization on the following business day.

If the request is for the provision of transportation for more than one day, the prior authorization department shall require a physician, health-care provider, or other responsible party to obtain a single prior authorization before an ambulance is used to transport a client in circumstances that do not involve an emergency.

For nonemergency ambulance transportation services rendered to a client, ambulance providers may coordinate the nonemergency ambulance prior authorization request with the requesting provider, which may include a physician, nursing facility, health-care 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 Texas Medicaid and Children with Special Health Care Needs (CSHCN) Services Program Non-Emergency Ambulance Prior Authorization Request form form must be signed, dated, and submitted by the CSHCN Services Program-enrolled requesting provider, not the ambulance provider.

The following rules apply to all nonemergency transports:

- Authorization must be evaluated based on the client's medical needs and may be granted for a length of time appropriate to the client's medical condition.
- A response to a request for authorization will be made no later than 48 hours after receipt of the request.
- A request for authorization will be immediately granted and will be effective for a period of not more than 60 days from the date of issuance if the request includes a written statement from a physician that includes both of the following:
  - A statement that alternative means of transporting the client are contraindicated.
  - A submission date that is no earlier than 60 days before the requested date of service.

Authorization can be obtained by telephone at 1-800-540-0694 for hospital-to-hospital or hospital-to-outpatient-facilities transports. Telephone requests will be accepted only from the transferring facility. Hospital-to-hospital or hospital-to-outpatient-facilities transport information and prior authorization requests may also be faxed or mailed. The requesting hospital should fax or mail supporting documentation to the TMHP/CSHCN Ambulance Unit when requested, to assist in determining medical necessity. Requests may be faxed or mailed to:

Texas Medicaid & Healthcare Partnership
Ambulance Prior Authorizations
PO Box 200735
Austin, TX 78727-0735
Fax: 1-512-514-4205

The requesting provider must select from the following prior authorization periods on the Texas Medicaid and Children with Special Health Care Needs (CSHCN) Services Program Non-Emergency Ambulance Prior Authorization Request form:

- **One-time, nonrepeating (1 day)**. One-time requests are for those clients who require only a one-time transport.

- The request must be signed and dated by a physician, physician assistant (PA), nurse practitioner (NP), clinical nurse specialist (CNS), or discharge planner with knowledge of the client's condition. Stamped signatures and dates are not accepted. Without a signature and date, the form will be considered incomplete.

- **Recurring (up to 60 days)**. Prior authorization requests are reserved for recurring transports are for those clients whose transportation needs are anticipated to last as long as 60 days.
  - The request must be signed and dated by a physician, PA, NP, or CNS. Stamped signatures and dates are not accepted. Without a signature and date, the form will be considered incomplete.
  - The request must include the approximate number of visits needed for the repetitive transport (i.e. dialysis, radiation therapy).
  - If a prior authorization request has been approved and additional procedure codes are needed because the client's condition has deteriorated or the need for equipment has changed, the requesting provider must submit a new Texas Medicaid and Children with Special Health Care Needs (CSHCN) Services Program Non-Emergency Ambulance Prior Authorization Request form.

The TMHP Ambulance Unit no longer issues nonemergency long-term (61-180 day) approvals effective February 15, 2013. Existing prior authorization approvals by the CSHCN Services Program are not affected by this change.

Long-term prior authorization requests submitted after February 15, 2013 are still processed; however, the approval criteria is issued for only up to 60 days if the client meets the criteria.

The prior authorization department will render a decision within 48 hours for prior authorization requests that are 60 days duration or less. If for any reason, the client's condition deteriorates or the need for equipment changes requiring additional procedure codes to be submitted for the transport after a previous prior authorization request has been approved, the requesting provider must submit a new Texas Medicaid and Children with Special Health Care Needs (CSHCN) Services Program Non-Emergency Ambulance Prior Authorization Request form.

### 9.4.2 Nonemergency Ambulance Exception Request

Clients whose physician has documented a debilitating condition and require recurring trips that will extend longer than 60 days may qualify for an exception to the 60 day prior authorization request.

To request an exception, the provider must submit all the following documentation:

- A completed Non-emergency Ambulance Exception form that is signed and dated by a physician.

  ***Note:*** *Stamped signatures and dates are not accepted. Without a physician's signature and date, the form is considered incomplete.*

- A completed Texas Medicaid and Children with Special Health Care Needs (CSHCN) Services Program Non-Emergency Ambulance Prior Authorization Request form
- Medical records that support the client's debilitating condition which may include, but not limited to:
  - Discharge information
  - Diagonstic images (i.e. MRI, CT, X-rays)
  - Care Plan

  ***Note:*** *Documentation submitted with the statement "client has a debilitating condition" is insufficient.*

### 9.4.3 Documentation of Medical Necessity

Providers may be asked to supply additional documentation to support the client's condition. Retrospective review may be performed to ensure documentation supports the medical necessity of the transport.

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 requesting provider which may include a physician, healthcare provider, or other responsible party is required to maintain the supporting documentation, physician's orders, the Texas Medicaid and Children with Special Health Care Needs (CSHCN) Services Program Non-Emergency Ambulance Prior Authorization Request form and, if applicable, the Non-emergency Ambulance Exception form.

The requesting provider (i.e., physician, nursing facility, health-care provider, or other responsible party) must contact the transporting ambulance provider with the prior authorization number (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.

Documentation supporting medical necessity must include either:

- The client is bed-confined before, during and after the trip and alternate means of transport is medically contraindicated and would endanger the client's health (i.e. injury, surgery, or use of respiratory equipment); or
- The client's functional physical and/or mental limitations that have rendered him/her bed-confined must be documented.

  ***Note:*** *Bed-confined is defined as a client who is unable to stand, ambulate, and sit in a chair or wheelchair.*
- The client's medical or mental health condition is such that alternate means of the transport is medically contraindicated and would endanger the client's health (i.e., injury, surgery, or the use of respiratory equipment); or
- The client is a direct threat to his/her self or others requiring the use of restraints (chemical or physical) or trained medical personnel during transport for client and staff safety (i.e., suicidal)

When physical restraints are needed, documentation must include, but not limited to:

- Type of restraint
- Time frame of use of the restraint
- Client's condition

  ***Note:*** *The standard straps used in ambulance transport are not considered a restraint.*

#### 9.4.3.1 Run Sheets

The run sheet is used as a medical record for ambulance services and may serve as a legal document to verify the care provided, if necessary. The ambulance provider does not have to submit the run sheet with the claim.

The ambulance provider must have documentation to support the claim. Without documentation that would establish the medical necessity of a nonemergency ambulance transport, the transport may not be covered by the CSHCN Services Program.

It is the responsibility of the ambulance provider to maintain (and to furnish to the CSHCN Services Program upon request) concise and accurate documentation. The run sheet must include the client's physical assessment that explains why the client requires ambulance transportation and cannot be safely transported by an alternate mode of transport.

Coverage will not be allowed if the trip record contains an insufficient description of the client's condition at the time of transfer for the CSHCN Services Program to reasonably determine that other means of transportation are contraindicated. Coverage will not be allowed if the description of the client's condition is limited to statements and/or opinions, such as the following:

- "Patient is non-ambulatory."
- "Patient moved by drawsheet."
- "Patient could only be moved by stretcher."
- "Patient is bed-confined."
- "Patient is unable to sit, stand, or walk."

The run sheet should detail the client's condition and must be consistent with documentation found in other supporting medical record documentation (including the nonemergency prior authorization request).

***Note:*** *The ambulance provider may decline the transport if the client's medical or mental health condition does not meet the medical necessity requirements.*

## 9.5 Types of Transport

### 9.5.1 Multiple Client Transport

Multiple client transports are those in which more than one client is transported in the same vehicle at the same time. Claims for CSHCN Services Program clients must be submitted 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 CSHCN Services Program numbers of other CSHCN Services Program clients who shared the transfer or must indicate "Not a CSHCN Services Program client."

Payment for multiple client transports are adjusted to 80-percent reimbursement of the allowable base rate for the transport for each claim and mileage is divided equally among the clients who share the ambulance.

### 9.5.2 Specialty Care Transport

Specialty care transport (SCT) is the interfacility transportation 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) paramedic. SCT is necessary when a client's condition requires ongoing care that must be furnished by one or more health-care 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.

### 9.5.3 Air or Water Specialized Medical Services Vehicle Transport

Helicopter, fixed-wing aircraft, or specialized emergency medical services vehicle ambulance transport services (procedure codes A0430, A0431, A0435, A0436, and A0999) will be reviewed by the CSHCN Services Program Medical Director and may be reimbursed if one or more of the following conditions are met:

- The client's medical condition requires immediate and rapid ambulance transport that could not have been provided by ground ambulance.
- The point of client pick-up is inaccessible by ground vehicle.

- Great distance or other obstacles are involved in transporting the client to the nearest appropriate facility.

Emergency air or specialized emergency medical services vehicle transports that do not meet the emergency air criteria, but do meet the ground criteria, will be reimbursed at the appropriate ground rate.

Prior authorization is required for all nonemergency ambulance transports, regardless of the type of transport (e.g., air or specialized emergency medical services vehicle). All ambulance transport services that include helicopter, fixed-wing aircraft, or specialized emergency medical services vehicles will be reviewed by the Medical Director. Claims for specialized emergency medical services vehicles (i.e., boat or airboat) must be submitted using procedure code A0999.

All air ambulance transports (procedure codes A0430 and A0431) must be billed with the corresponding air mileage procedure code A0435 or A0436.

### 9.5.4 Out-of- Locality Transport

Out-of-locality transports may be reimbursed if a local facility is not adequately equipped to treat the condition. "Out-of-locality" refers to one-way transfers of 50 or more miles from point of pickup to point of destination.

### 9.5.5 Extra Attendant

The use of an additional attendant must be related to extraordinary circumstances that prevent the basic crew from transporting a client safely. The extra attendant must be certified by the Department of State Health Services (DSHS) to provide emergency medical services.

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

- Necessity of additional special medical equipment or treatment en route to destination (Providers must describe what special treatment and equipment is required and why it requires an attendant.)
- Client behavior that may be a danger to the client or ambulance crew or requires or may require restraints
- Extreme obesity (Providers must specify the client's weight and functional limitations.)

The CSHCN Services Program does not reimburse for an extra attendant based solely on an ambulance provider's internal policy.

The use of an extra attendant for air transport is not a benefit of the CSHCN Services Program. Reimbursement for an extra attendant (procedure code A0424) will be denied if billed with air transport (procedure codes A0430 or A0431).

#### 9.5.5.1 Extra Attendant - Emergency Ambulance Transports

Emergency transports that use an extra attendant do not require prior authorization.

The billing provider's medical documentation must clearly indicate the services the attendant performed along with rationale for the services to indicate medical necessity of the attendant. The information that supports medical necessity must be kept in the billing provider's medical record and is 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 being transported requires medical attention and close monitoring.

#### 9.5.5.2 Extra Attendant - Nonemergency Ambulance Transports

Prior authorization is required when an extra attendant is needed for any nonemergency transport. When an extra attendant is needed for subsequent transports, the prior authorization must be updated.

The requesting provider must prove medical necessity on the prior authorization request by identifying attendant services that could not be provided by the basic crew. The information that supports medical necessity must be kept in the requesting provider's medical record and is subject to retrospective review.

### 9.5.6 Oxygen

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

Oxygen (procedure code A0422) is reimbursed the lower of the billed amount or the amount allowed by Texas Medicaid.

### 9.5.7 Ambulance Disposable Supplies

Ambulance disposable supplies are included in the global fee for SCT transports and must not be billed separately.

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

Claims submitted for BLS or ALS supplies will be denied unless a corresponding ALS or BLS transport is billed on the same claim.

### 9.5.8 Mileage

The CSHCN Services Program does not reimburse air or ground mileage when the client is not on board the ambulance.

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.

Procedure codes for ground ambulance transports (A0426, A0428, A0433, A0434, and A0999) must be submitted with mileage procedure code A0425. Emergency ground ambulance transports (procedure codes A0427 and A0429) may be billed without mileage code A0425 for ET3 TIP services. Providers must include TIP destination code W in the destination position of the origin/destination modifier combination.

A transport and mileage procedure code must be billed on the same claim to be considered for reimbursement. Transport and mileage procedure codes should never be reported as stand-alone services.

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

### 9.5.9 Waiting Time

Waiting time (procedure code A0420) is reimbursed up to one hour. Waiting time may be submitted when it is the general billing practice of local ambulance companies to charge for unusual waiting time (over 30 minutes) based on the following:

- Separate charges must be billed for unusual wait times.
- The circumstances that necessitate a wait time and the exact time involved must be documented.

The amount charged for waiting time must not exceed the charge for a one-way transfer.

## 9.6 Relation of Service to Time of Death

The CSHCN Services Program may reimburse an ambulance provider in the following circumstances related to a deceased client:

- The client dies in the ambulance while en route to the destination.

- The ambulance services to the point of pickup for the client who is pronounced dead by the physician after the ambulance is called.

## 9.7 Ambulance Transport Services That Are Not Benefits

The CSHCN Services Program does not reimburse providers for the following:

- An extra charge for a night call.
- Ambulance services performed in the skilled nursing facility (SNF), intermediate care facility (ICF), or extended care facility settings.

The CSHCN Services Program reimburses providers for ground emergency transports (procedure codes A0427 and A0429) that do not result in a transport to a facility, only as part of ET3 services when the destination modifier W indicating TIP is included on the claim. For all other transports, if a client contacts an ambulance provider, but the call does not result in a transport, the CSHCN Services Program will not reimburse the provider and the provider should have the client sign an acknowledgment statement and bill the client for services rendered.

## 9.8 Claims Filing and Reimbursement

### 9.8.1 Claims Filing

Ambulance claims must be submitted to TMHP in an approved electronic format or on the CMS-1500 paper claim form. Providers may purchase CMS-1500 paper claim forms from the 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 information is not keyed from attachments. Superbills, or itemized statements, are not accepted as claim supplements.

Ambulance claims must be submitted to TMHP in an approved electronic format or on the CMS-1500 paper claim form. Providers may purchase CMS-1500 paper claim forms from the vendor of their choice. TMHP does not supply the forms.

Run sheets, medical records, or emergency room records are not required to be submitted with the claim submission. If, however, documentation is submitted with the claim, an emergency medical technicians signature is required on all of the documents.

***Note:*** *Providers must maintain any documentation that substantiates the medical need for the transport and must ensure that the documentation is available to the CSHCN Services Program or its designee upon request.*

The ambulance provider is responsible for the integrity of the information about the client's condition necessitating the transport and the medical necessity of the transport. The ambulance provider may be sanctioned, including exclusion from the CSHCN Services Program, for completing or signing a claim form that includes a false or misleading representation of the client's condition or of the medical necessity of the transport.

***Refer to:*** Chapter 41, "TMHP Electronic Data Interchange (EDI)" for information on electronic claims submissions.

Chapter 5, "Claims Filing, Third-Party Resources, and Reimbursement" for general information about claims.

Section 5.7.2.4, "CMS-1500 Paper Claim Form Instructions" in Chapter 5, "Claims Filing, Third-Party Resources, and Reimbursement" for instructions on completing paper claims. Blocks that are not referenced are not required for processing by TMHP and may be left blank.

All claims submitted on paper or electronically must include the 2-letter origin and destination codes on every line detail. The origin is the first letter, and the destination is the second letter. For example, modifiers HR would indicate a hospital origin with a residence destination.

Providers must not bill CSHCN Services Program clients for ambulance services.

### 9.8.1.1 Emergency Ambulance Claims

Emergency air ambulance claims must include the appropriate procedure code(s) and all of the following additional information to be considered for reimbursement:

- Distance of transport
- Time of transport
- Acuity of client, origin or destination modifier, and relevant vital signs

Ambulance providers must use an appropriate ICD-10-CM diagnosis code in Block 21 of the CMS-1500 paper claim form or electronic equivalent to document the client's condition and the reason for the transport. If a diagnosis is not known at the time of the transport, providers must use the diagnosis code that most closely represents the client's physical signs and symptoms at the time of the transport. If the above documentation does not indicate an emergency, the claim is denied.

Providers billing electronically can enter the data supporting the necessity for the emergency transport in the Comments field or the Purpose of Stretcher field of the electronic claim. Providers using the CMS-1500 paper claim form can enter relevant vital signs and detailed narrative in Block 19 or 21 of the claim form. For ambulance transfers where the destination is a hospital, enter the name and address of the facility in Block 32.

#### 9.8.1.1.1 Emergency Triage Services Billing

To bill for ET3 services, a provider must:

- Be enrolled in the CSHCN Services Program as an ambulance provider.
- Be responding to a call initiated by an emergency response system (9-1-1 call, fire, police, or other locally established system for medical emergency calls).
- Upon arrival at the scene, the emergency team's field evaluation determines the client's needs are non-emergent but requires medical attention.
- Follow all requirements as outlined in section 9.1 Enrollment.

#### 9.8.1.1.2 Transport to an Alternative Destination Billing

When billing for transport to an alternative destination, providers shall bill using the most clinically appropriate emergency transport code (A0427 or A0429), the ET modifier, and the appropriate destination modifier to indicate ET3 services. Providers should also include the mileage code (A0425) in the claim as appropriate.

> ***Note:*** *If an emergency transportation provider transports a client to an alternative destination and determines at the time that the site is either closed, or unable to provide the needed level of care, then the emergency transportation provider shall transport the client to the nearest emergency department. In these cases, the provider may not bill for two transports.*

#### 9.8.1.1.3 Treatment in Place (TIP) Billing

Treatment in place (TIP) is classified as an emergency transportation service and must be billed using the most clinically appropriate emergency transport code (A0427 or A0429), the ET modifier, and the W destination modifier to indicate TIP.

Claims must indicate TIP destination modifier W in the destination position of the origin/destination modifier combination. TIP claims without modifier W in the emergency indicator field will be denied.

Supplies (procedure codes A0382 and A0398) and oxygen (procedure code A04220) are payable, but mileage (procedure code A0425) and other ambulance transportation services (A0426 and A0428) are not payable for TIP services. Claims billed with non-payable ambulance TIP services will be denied.

The following are TIP ambulance claim modifiers:

| Modifier | Origination Site | Destination |
|---|---|---|
| DW | Diagnostic or therapeutic site, or freestanding facility (e.g., radiation therapy center) other than H or P | TIP |
| EW | Residential, domiciliary, or custodial facility (unskilled facility) | TIP |
| JW | Non-hospital-based dialysis facility | TIP |
| PW | Physician's office | TIP |
| RW | Residence (client's home or any residence) | TIP |
| SW | Scene of accident or acute event | TIP |

If a client being treated in place has a real-time deterioration in their clinical condition necessitating immediate transport to an emergency department, the ambulance provider cannot bill for both treatment in place ambulance service and the transport to the emergency room. In this case, the ambulance provider shall bill only the emergency department transport.

For informational purposes, ambulance providers may include G2022 on ambulance transportation claims to an emergency department that met ET3 requirements, but the client refused TIP or transportation to an alternative destination.

When billing for TIP via telemedicine or telehealth, providers must bill using the most clinically appropriate emergency transport code (A0427 or A0429), the ET modifier, the W destination modifier to indicate TIP, and in addition, procedure code Q3014. The Q3014 code will be informational only used to identify TIP via telemedicine or telehealth services.

Ambulance TIP with telemedicine or telehealth encounters without a corresponding telemedicine or telehealth encounter will be denied. Claims for multiple TIP and transport claims rendered on the same date of service for the same recipient will be denied.

#### 9.8.1.2 Nonemergency Ambulance Claims

All nonemergency ambulance claims must include the appropriate procedure codes and all of the following additional information to be considered for reimbursement:

- Detailed description of the client's medical condition necessitating the transport
- Distance of transport
- Time of transport
- Acuity of client, origin and destination modifier, and relevant vital signs

Providers billing electronically can enter the data supporting the necessity for the nonemergency transport in the Comments field or the Purpose of Stretcher field of the electronic claim. Providers using the CMS-1500 paper claim form can enter relevant vital signs and detailed narrative in Block 19 or 21 of the claim form. For ambulance transfers where the destination is a hospital, enter the name and address of the facility in Block 32. For transfers from hospital-to-hospital, indicate in Block 19 the services needed at the second facility that were unavailable at the first facility.

#### 9.8.1.3 Billing Mileage with $0.00

If the appropriate transport procedure code is submitted for reimbursement, claims with a billed mileage amount of $0.00 may be reimbursed. To qualify for reimbursement, the transport claim must include a mileage quantity that is greater than zero.

#### 9.8.1.4 National Correct Coding Initiative (NCCI) Guidelines

The HCPCS/CPT codes included in policy are subject to NCCI relationships. Exceptions to NCCI code relationships that may be noted in CSHCN Services Program medical policy are no longer valid. Providers should refer to the Centers for Medicare & Medicaid Services (CMS) NCCI web page for correct coding guidelines and specific applicable code combinations. In instances when CSHCN Services Program medical policy quantity limitations are more restrictive than NCCI MUE guidance, medical policy prevails.

### 9.8.2 Reimbursement

Ambulance procedure codes are reimbursed at a reasonable charge, which is the lesser of the billed amount or the amount allowed by Texas Medicaid.

For fee information, providers can refer to the Online Fee Lookup (OFL) on the TMHP website at www.tmhp.com.

The CSHCN Services Program implemented rate reductions for certain services. The OFL includes a column titled "Adjusted Fee" to display the individual fees with all percentage reductions applied. Additional information about rate changes is available on the TMHP website at www.tmhp.com/resources/rate-and-code-updates/rate-changes.

***Note:*** *Certain rate reductions including, but not limited to, reductions by place of service, client type program, or provider specialty may not be reflected in the Adjusted Fee column.*

#### 9.8.2.1 One-day Payment Window Reimbursement Guidelines

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

***Refer to:*** Section 24.3.7, "Payment Window Reimbursement Guidelines" in Chapter 24, "Hospital" for additional information about the one-day payment window reimbursement guidelines for services related to an inpatient hospital stay.

## 9.9 TMHP-CSHCN Services Program Contact Center

The TMHP-CSHCN Services Program Contact Center at 1-800-568-2413 is available Monday through Friday from 7 a.m. to 7 p.m., Central Time, and is the main point of contact for the CSHCN Services Program provider community.