

Texas Medicaid

Provider Procedures Manual

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Provider Handbooks

Ambulance Services Handbook

The Texas Medicaid & Healthcare Partnership (TMHP) is the claims administrator for Texas Medicaid under contract with the Texas Health and Human Services Commission.

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 NPI and taxonomy code, not the hospital NPI and taxonomy code.

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

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

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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.

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 Emergency Triage, Treat, and Transport (ET3) and Treatment in Place (TIP) services. Ambulance providers must include TIP destination modifier W in the destination position of the origin/destination modifier combination.

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.

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2.2.1 Emergency Ambulance Transport Services

Emergency ambulance transport is covered in emergent situations in which specially equipped ambulance transportation is required to safely manage the client's medical condition. Emergency transportation may be initiated by an emergency response system 9-1-1 call, fire, police, or other locally established system for medical emergency calls. At the time of the call, emergency teams are required to respond; however, upon arrival on the scene, the services required at that time (based on field evaluation by the emergency team) may be determined to be:

- Emergent, or
- Non-emergent but medically necessary.

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.

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 himself, or herself or others, or that renders the client incapable of controlling, knowing, or understanding the consequences of his or her actions.

Emergency transports are to be to the nearest medical facility that is equipped to provide medical care for the illness or injury of the client. An appropriate facility includes the equipment, personnel, and capability to provide the services necessary to support the required medical care.

Facility-to-facility transports may be considered an emergency if emergency treatment is not available at the first facility and the client still requires emergency 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 an appropriate facility.

All other facility-to-facility transport is considered nonemergent and will require prior authorization.

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.

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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 Emergency Triage, Treat, and Transport (ET3)

Emergency Triage, Treat, and Transport (ET3) services are designed to allow greater flexibility for Medicaid-enrolled ambulance providers to address clients' health-care needs following a 9-1-1 call, 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 through telemedicine or telehealth.

2.2.2.1 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 following requirements apply:

- 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.

2.2.2.2 Treatment in Place (TIP)

Upon the emergency response team's arrival to the scene and their evaluation of the client, if the services required at that time are determined to be medically necessary but not emergent, ambulance staff may provide treatment to the client under the supervision of a physician, such as the medical director of the ambulance company, or under the supervision of a qualified health care professional, such as a physician assistant or advanced practice registered nurse contracted by the ambulance company. Ambulance staff must provide TIP in accordance with their emergency transport service's medical direction and established protocols.

Treatment on scene may also be performed, when medically necessary, through a telemedicine or telehealth visit performed in accordance with telemedicine and telehealth services requirements outlined in the *Telecommunication Services Handbook (Vol. 2, Provider Handbooks)*.

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Refer to: The *Telecommunication Services Handbook* (*Vol. 2, Provider Handbooks*) for telehealth and telemedicine services requirements.

2.2.3 Nonemergency Ambulance Transport Services

According to 1 TAC §354.1111, nonemergency transport is defined as a transport provided by an ambulance provider for a Medicaid recipient to or from a scheduled medical appointment, to or from another licensed facility for treatment, or to the recipient's home after discharge from a hospital. Non-emergency transport is appropriate when the Medicaid recipient's medical condition is such that the use of an ambulance is medically required, e.g., bed confinement, and alternate means of transport 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 reviews 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 nonemergency 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, 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.

2.2.4 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.

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- 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 administrations 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.

2.2.5 Oxygen

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

2.2.6 Types of Transport

2.2.6.1 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*).

2.2.6.2 Air or Water Specialized Emergency Medical Services 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. Specialized emergency medical services vehicles (i.e., boat or airboat) must be billed using unlisted ambulance service (procedure code A0999).

2.2.6.3 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.

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2.2.6.4 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.

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

Nonemergency ambulance transports between a client's home and a PPECC are not covered.

2.2.6.6 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.

2.2.6.7 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.

Claims submitted with a GY modifier indicating no medical necessity existed for transport will automatically deny and will not be suspended for additional documentation. The ambulance provider must maintain a waiver, signed by the client, indicating that the client was instructed prior to the transport that there was no medical necessity for the transport and that the client agreed to provide reimbursement for the services if reimbursement for the transport is denied by Texas Medicaid. A signed waiver from the client is subject to retrospective review.

Refer to: Subsection 1.7.12.1, "Client Acknowledgment Statement" in "Section 1: Provider Enrollment and Responsibilities" (*Vol. 1, General Information*).

2.2.6.8 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 Non-emergency 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) is 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).

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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 to outpatient departments or to physicians' offices for recertification or examinations for rehabilitative treatment (i.e., physical therapy) are not reimbursable ambulance services. The cost of such transportation is included in the nursing facility vendor rate.

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.

2.2.6.9 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

2.2.6.10 No Transport

Texas Medicaid reimburses ambulance 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 is 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 provider should have the client sign an acknowledgment 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.

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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 Non-emergency 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.

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

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

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

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 transferring hospital. Providers are not required to fax medical documentation to TMHP; however, in certain circumstances, TMHP may request that the transferring 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.

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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 NPI 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.

Claims submitted for BLS supplies (procedure code A0382) will be denied unless a corresponding BLS transport is billed on the same claim.

Claims for ALS supplies (procedure code A0398) will be denied unless a corresponding ALS transport is billed on the same claim.

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.

2.4.2.2 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.

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Refer to: Subsection 3.7.4.17, "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.

Ambulance providers can include copayment amounts as coinsurance for non-contracted Medicare Part C clients on dual eligible claims submitted to TMHP. Providers do not have to bill Medicare copay procedure codes to TMHP for ambulance services.

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 NPI and taxonomy code, 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 NPI and taxonomy code 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.*

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2.4.4 Ambulance Claims Coding

Providers must submit claims for emergency and ET3 transports with the ET modifier on each procedure code submitted. Any procedure code submitted on the claim for emergency and ET3 transports 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
R	Residence (client's home or any residence)
S	Scene of accident or acute event
X	Intermediate stop at physician's office in route to the hospital (destination code only)

The following are the ET3 Alternative Destinations and Treatment in Place Codes codes accepted by Texas Medicaid:

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)

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 NPI of the facility in Block 32.

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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.

2.4.5 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 (i.e., boat and airboat). 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 2.2.6.2, "Air or Water Specialized Emergency Medical Services 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	G2022	Q3014				
***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	D75A	D8130	D8131	D8132	D8139	E869
F068	F10929	F19939	F29	G4489	G8929	H579	H814
I2693	I2694	I4811	I4819	I4820	I4821	I469	I499

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Emergency Medical Condition Codes							
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	T25739S	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	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 Emergency Triage Services Billing

To bill for ET3 services, a provider must:

- Be enrolled in Texas-Medicaid 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 require medical attention.
- Follow all requirements as outlined in section 2.2, Services, Benefits, Limitations, and Prior Authorization.

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2.4.7.1 Transport to an Alternative Destination Billing

For transport to an alternative destination reimbursement, providers must bill using the most clinically appropriate emergency transport code (A0427 or A0429), the ET modifier, and the appropriate destination modifier. Providers may 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.*

2.4.7.2 Treatment in Place 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 include 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.

The medical services provided under the supervision of a physician, such as the medical director of the ambulance company or a health care professional, must be billed separately with the appropriate codes by the physician or health care professional who provides supervision of care on the scene. Ambulance providers may only bill for initiating or facilitating TIP using the corresponding emergency ground transport code (A0427 or A0429).

Supplies (procedure codes A0382 and A0398) and oxygen (procedure code A0422) are payable, but mileage (procedure code A0425) and other ambulance transportation services are not payable for TIP services. Claims billed with non-payable ambulance TIP services will be denied.

The following are valid Treatment in Place Ambulance Claim Origin/Destination Modifiers:

Codes	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	Nonhospital-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 the clinical condition necessitating immediate transport to an emergency department, the ambulance provider must not bill for both treatment in place ambulance service and the transport to the emergency room. In this case, the ambulance provider must bill only for the emergency department transport.

For informational purposes, ambulance providers may include procedure code 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 procedure code Q3014. Procedure code Q3014 will be informational only and used by Medicaid to identify TIP through telemedicine or telehealth services.

Multiple TIP and transport claims rendered on the same date of service for the same client will suspend for review.

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2.4.8 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.**									

2.4.9 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 must be certified by DSHS to provide emergency medical services.

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 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).

2.4.9.1 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.

2.4.9.2 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. Reimbursement for an extra attendant will be based on prior authorization requirements.

2.4.10 Night Call

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

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2.4.11 Waiting Time

Procedure code A0420 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.*

2.4.12 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.

2.4.13 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 in route to the destination, Texas Medicaid covers the transport. If a physician pronounces a 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.

2.5 Claims Resources

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

Resource	Location
Acronym Dictionary	"Appendix C: Acronym Dictionary" (*Vol. 1, General Information*)
Automated Inquiry System (AIS)	Subsection A.10, "TMHP Telephone and Fax Communication" in "Appendix A: State, Federal, and TMHP Contact Information" (*Vol. 1, General Information*)
CMS-1500 Paper Claim Filing Instructions	Subsection 6.5, "CMS-1500 Paper Claim Filing Instructions" in "Section 6: Claims Filing" (*Vol. 1, General Information*)

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Resource	Location
State, federal, and TMHP contact information	"Appendix A: State, Federal, and TMHP Contact Information" (*Vol. 1, General Information*)
TMHP Electronic Data Interchange (EDI) information	"Section 3: TMHP Electronic Data Interchange (EDI)" (*Vol. 1, General Information*)

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
Ambulance Emergency Transport from Residence to Hospital
Ambulance Emergency Transport from Scene of Accident to Hospital

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