EMERGENCY AMBULANCE TRANSPORTATION

Emergency ambulance transportation is provided for a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in any of the following:

1. Placing the health of the beneficiary (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;

2. Serious impairment to bodily functions; or

3. Serious dysfunction of any bodily organ or part.

A beneficiary may also require emergency ambulance transportation if he or she is psychiatrically unmanageable or needs restraint.

Ambulance providers must retain documentation that appropriately supports that at least one of these criteria was met and that the beneficiary would be susceptible to injury using any other method of transportation. An ambulance trip that does not meet at least one of these criteria would be considered a non-emergency service and must be coded and billed as such.

Prior review or authorization is not permitted for emergency ambulance transportation. The fiscal intermediary may conduct a post-payment review after service delivery. Claims for payment of emergency ambulance transportation services is received and reviewed retrospectively. Clinical documentation to support emergency ambulance transportation services shall not be required for submission concurrent with the claim. If required, clinical documentation shall be required post claim submission.

Separate reimbursement for oxygen and disposable supplies will be made when medically necessary.

Treatment-in-Place

A physician directed treatment-in-place service is the facilitation of a telehealth visit by an ambulance provider.

Each paid treatment-in-place ambulance claim must have a separate and corresponding paid treatment-in-place telehealth claim, and each paid treatment-in-place telehealth claim must have a separate and corresponding paid treatment-in-place ambulance claim or a separate and corresponding paid ambulance transportation claim. Reimbursement for both an emergency transport to a hospital and an ambulance treatment-in-place service for the same incident is not permitted.

Treatment-in-Place Ambulance Services

Payment of treatment-in-place ambulance services is restricted to those identified on the Physician Directed Ambulance Treatment-in-Place Fee Schedule and edit claims for non-payable procedure codes as follows:

1. If a treatment-in-place ambulance claim is billed with mileage, the entire claim document shall be denied;

2. If an unpayable procedure code, that is not mileage, is billed on a treatment-in-place ambulance claim, only the line with the unpayable code will be denied;

3. Claims for allowable telehealth procedure codes must be billed with procedure code G2021. The G2021 code shall be accepted, paid at $0.00, and used by the transportation provider to identify treatment-in-place telehealth services; and

4. As with all telehealth claims, providers must include POS identifier “02” or “10” and modifier "95" with their claim to identify the claim as a telehealth service. Providers must follow CPT guidance relative to the definition of a new patient versus an established patient.

The following table contains valid treatment-in-place ambulance claim modifiers:

Modifier	**Origination Site**	**Destination**
DW	Diagnostic or therapeutic site other than P or H when these are used as origin codes	Tx-in-Place
EW	Residential, domiciliary, custodial facility (other than 1819 facility)	Tx-in-Place
GW	Hospital based ESRD facility	Tx-in-Place
HW	Hospital	Tx-in-Place
IW	Site of transfer (e.g., airport or helicopter pad) between modes of ambulance transport	Tx-in-Place
JW	Freestanding ESRD facility	Tx-in-Place

NW	Skilled nursing facility	Tx-in-Place
PW	Physician's office	Tx-in-Place
RW	Residence	Tx-in-Place
SW	Scene of accident or acute event	Tx-in-Place

If the beneficiary being treated-in-place has a real-time deterioration in his or her clinical condition necessitating immediate transport to an emergency department, as determined by the ambulance provider (i.e., EMT or paramedic), telehealth provider, or beneficiary, the ambulance provider cannot bill for both the treatment-in-place ambulance service and the transport to the emergency department. In this situation, **the ambulance provider shall bill for the transport to the emergency department only.** The transportation broker shall require ambulance providers to submit pre-hospital care summary reports when ambulance treatment-in-place and ambulance transportation claims are billed for the same beneficiary with the same date of service.

If a beneficiary is offered treatment-in-place services declines the services, ambulance providers should include procedure code G2022 on claims for ambulance transportation to an emergency department. Use of this informational procedure code is optional and does not affect the establishment of medical necessity of the service or reimbursement of the ambulance transportation claim. The G2022 code shall be accepted, paid at $0.00, and used by the transportation provider to identify beneficiary refusal of treatment-in-place services.

Treatment-in-Place Telehealth Services

Payment of the treatment-in-place services is restricted to those identified on the Treatment-in-Place Telehealth Services Fee Schedule.

Valid rendering providers are licensed physicians, advanced practice registered nurses, and physician assistants.

Ambulance Service Exclusions

Medicaid does not cover "Ambulance 911-Non-emergency" services. If the beneficiary's medical condition does not present itself as an emergency in accordance with the criteria in this manual chapter, the service may be considered a non-covered service by Medicaid.

Ambulance providers shall code and bill such non-emergency services using modifiers GY, QL, or TQ to indicate that the services performed were non-covered Medicaid services.

Ambulance providers may bill beneficiaries for non-covered services only if the beneficiary was informed prior to transportation, verbally and in writing that the service would not be covered by Medicaid and if the beneficiary then agreed to accept the responsibility for payment. The transportation provider must obtain a signed statement or form which documents that the beneficiary was verbally informed of the out-of-pocket expense.

Emergency Action Procedure

If a medical emergency arises while transporting a beneficiary, the ambulance driver must immediately assess the situation and determine whether to proceed immediately to the closest, most appropriate healthcare facility. If the beneficiary is taken to an emergency medical facility, the ambulance driver must immediately notify the transportation broker within 48 hours of the transport.