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:

- 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;
- Serious impairment to bodily functions; or
- 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 nonemergency service and must be coded and billed as such.

Prior review or authorization is not permitted for emergency ambulance transportation.

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

Treatment-in-Place

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:

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

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, 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 to prevent payment of treatment-in-place ambulance claims and emergency ambulance transportation claims for the same occurrence.

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, 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.