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Related Clinical Coverage Policies

Refer to http://dma.ncdhhs.gov/ for the related coverage policies listed below:
1E-7, Family Planning Services
2A-3, Out-of-State Services

Information

Refer to the following web sites for information:
DMA Provider Services: http://dma.ncdhhs.gov/
OEMS Website: https://www.ncdhhs.gov/divisions/dhsr
Provider Policies, Manuals and Guidelines:
https://www.nctracks.nc.gov/content/public/providers/provider-manuals.html

1.0 Description of the Procedure, Product, or Service

Ambulance services provide medically necessary treatment for NC Medicaid Program or NC Health Choice beneficiaries. Transport is provided only if the beneficiary's medical condition is such that the use of any other means of transportation is contraindicated. Ambulance services include emergency and non-emergency ambulance transport via ground and air medical ambulance for a Medicaid beneficiary. Ambulance services include only emergency transport via ground and air medical ambulance for a NCHC beneficiary. Refer to **Subsection 4.0**.

1.1 Definitions

1.1.1 Ground and Air Medical Ambulances

A **ground ambulance** is the same as defined in 10A NCAC 13P .0102(29). In this policy, ambulance transport by either land or water vehicles may be referred to as "ground transportation." Vehicle and equipment requirements are located at 10A NCAC 13P .0207, .0208, and .0210.

An **air medical ambulance** is the same as defined in 10A NCAC 13P .0102(5). Vehicle and equipment requirements are located at 10A NCAC 13P .0209.

1.1.2 Emergency Services

1.1.2.1 Emergency Medical Condition

An **emergency medical condition** is defined in 42 C.F.R. 489.24(b).

1.1.2.2 Emergency and Immediate Responses

An **emergency response** means responding immediately at the Basic Life Support (BLS) or Advanced Life Support Level 1 (ALS1) service to a 911 call or the equivalent in areas without a 911 call system.

An **immediate response** is one in which the ambulance service begins as quickly as possible to take the steps necessary to respond to a 911 call.

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1.1.2.3 Emergency Ground Transport

Emergency ground transport is medically necessary ground transportation to the nearest appropriate facility where prompt medical services are provided in an emergency situation such as accident, acute illness, or injury. Emergency ground transport includes both BLS and ALS services.

1.1.2.4 Basic Life Support

BLS is transportation by a ground ambulance vehicle and the provision of medically necessary supplies and services, including BLS ambulance services as defined by the State Office of Emergency Medical Services (OEMS). The ambulance shall be staffed by an individual who is credentialed in accordance with 10A NCAC 13P .0502 and G.S. 131E-159 as an Emergency Medical Technician (EMT).

1.1.2.5 Advanced Life Support

ALS services include BLS plus invasive procedures and techniques provided by Emergency Medical Technicians–Intermediate (EMT–I) or Emergency Medical Technicians–Paramedic (EMT–P) who are credentialed in accordance with 10A NCAC 13P .0502. An EMT–I is credentialed to perform essential advanced techniques and to administer a limited number of medications in addition to the skills of the EMT. An EMT–P is credentialed to administer additional medications and interventions in addition to the skills of the EMT and EMT-I.

An **ALS assessment** must be a medically necessary procedure performed by an ALS crew as part of an emergency response and necessary because the beneficiary's reported condition at the time of dispatch is such that only an ALS crew is qualified to perform the assessment. An ALS assessment does not necessarily result in a determination that the beneficiary requires an ALS level of service.

An **ALS intervention** is a procedure that is, in accordance with state and local laws, rendered by ALS personnel. If local protocols require an ALS response for all calls, N.C. Medicaid only covers the level of service actually provided. ALS level of service must include ALS assessment, ALS intervention, or both, and then only when the service is medically necessary.

ALS Level 1 (ALS1) is the transportation by ground ambulance vehicle and the provision of an ALS assessment or at least one ALS intervention.

ALS Level 2 (ALS2) is the transportation by ground ambulance vehicle and the provision of medically necessary supplies and services, including at least one of the following:

a. At least three separate administrations of one or more medications by intravenous push or bolus or by continuous infusion, excluding

crystalloid, hypotonic, isotonic, and hypertonic solutions (Dextrose, Normal Saline, or Ringer's Lactate); or

b. At least one of the ALS2 procedures listed below:
   1. Manual defibrillation or cardioversion;
   2. Cardiac pacing;
   3. Endotracheal intubation insertion;
   4. Central venous line;
   5. Intraosseous line;
   6. Chest decompression;
   7. Surgical airway;
   8. 12 Lead electrocardiogram (ECG) for Segment Elevation Myocardial Infarction [STEMI];
   9. Continuous Positive Airway Pressure (CPAP);
   10. Ventilator Operation; or
   11. Femoral Line.

1.1.3 Non-emergency Medically Necessary Ambulance Transport

Non-emergency ambulance transport is a medically necessary transport for a **Medicaid beneficiary** to obtain medical services that cannot be provided when needed at the beneficiary's location, such as computed tomography (CT) scans, magnetic resonance imaging (MRI), endoscopies, radiation therapy, and dialysis.

1.1.4 Air Medical Ambulance

Air medical ambulance applies to both rotary-wing and fixed-wing aircraft. Rotary-wing air medical ambulance, is transport by a helicopter that has been inspected and issued a permit by the State OEMS as a rotary-wing ambulance, and the provision of medically necessary supplies and services. Fixed-wing air medical ambulance, is transport by a fixed-wing aircraft that has been inspected and issued a permit by the State OEMS as a fixed-wing air medical ambulance, and the provision of medically necessary supplies and services. Vehicle and equipment requirements are located at 10A NCAC 13P .0209.

1.1.5 Loaded Mileage

Loaded mileage is the number of miles for which the beneficiary is transported in the ambulance vehicle.

For air medical ambulance (fixed wing and rotary wing), the point of origin includes-the beneficiary's loading point and runway taxiing until the beneficiary is offloaded from the air medical ambulance. Air mileage is based on loaded miles flown, as expressed in statute miles, and is reimbursable.

For ground ambulance, loaded mileage is from the point of origin to the nearest appropriate facility. Mileage to a facility that does not meet this criterion is not covered. Ground ambulance loaded mileage is reimbursable **only** for out-of-county transport. In-county loaded ground mileage is not reimbursable.

Out of county transport is a transport by ambulance in which the final destination of the beneficiary is outside the limits of the county in which the transport originated.

1.1.6 Locality

Locality means the service area surrounding the institution to which beneficiaries normally travel or are expected to travel to receive hospital or skilled nursing services.

If two or more facilities that meet the destination requirements can treat the beneficiary appropriately, and the locality of each facility encompasses the place where the ambulance transportation of the beneficiary began, then the out of county mileage (if applicable) to any one of the facilities to which the beneficiary is taken is covered.

1.1.7 Nearest Appropriate Facility

The nearest appropriate facility for emergency transport is the nearest institution or medical facility that is capable, under federal and state laws, of furnishing the required type of care for the beneficiary's illness or injury.

1.1.8 Round Trip and One-Way Trip

A **round trip** is non-emergency transportation by ambulance from the point of pickup to destination and return to point of pickup. The ambulance remains in the vicinity of the destination, does not return to base, and does not respond to other calls for transport. This service is covered for **Medicaid beneficiaries only**. Refer to **Subsection 4.0.**

A **one-way trip** is emergency or non-emergency transportation from point of pickup to destination. Delivery of the beneficiary at the destination discharges the ambulance provider's responsibility. The ambulance service is then available to transport other beneficiaries.

1.1.9 Date of Service

The date of service of an ambulance service is the date that the loaded ambulance vehicle departs the point of pick-up. In the case of a ground transport, if the beneficiary is pronounced dead after the vehicle is dispatched but before the (now deceased) beneficiary is loaded into the vehicle, the date of service is the date of the vehicle's dispatch.

1.1.10 Point of Pick-up

The point of pick-up is the location of the beneficiary at the time placed on board the ambulance.

2.0 Eligibility Requirements

2.1 Provisions

2.1.1 General

(***The term "General" found throughout this policy applies to all Medicaid and NCHC policies***)

a. An eligible beneficiary shall be enrolled in either:
   1. the NC Medicaid Program; or
   2. the NC Health Choice Program on the date of service and shall meet the criteria in **Section 3.0 of this policy**.

b. Provider(s) shall verify each Medicaid or NCHC beneficiary's eligibility each time a service is rendered.
c. The Medicaid beneficiary may have service restrictions due to their eligibility category that would make them ineligible for this service.
d. Following is only one of the eligibility and other requirements for participation in the NCHC Program under GS 108A-70.21(a): Children must be between the ages of 6 through 18.

2.1.2 Specific

a. **Medicaid**
   None Apply.
b. **NCHC**
   None Apply.

2.2 Special Provisions

2.2.1 EPSDT Special Provision: Exception to Policy Limitations for a Medicaid Beneficiary under 21 Years of Age

a. **42 U.S.C. § 1396d(r) [1905(r) of the Social Security Act]**

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) is a federal Medicaid requirement that requires the state Medicaid agency to cover services, products, or procedures for Medicaid beneficiary under 21 years of age **if** the service is **medically necessary health care** to correct or ameliorate a defect, physical or mental illness, or a condition [health problem] identified through a screening examination** (includes any evaluation by a physician or other licensed clinician).

This means EPSDT covers most of the medical or remedial care a child needs to improve or maintain his or her health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

Medically necessary services will be provided in the most economic mode, as long as the treatment made available is similarly efficacious to the service requested by the beneficiary's physician, therapist, or other licensed practitioner; the determination process does not delay the delivery of the needed service; and the determination does not limit the beneficiary's right to a free choice of providers.

EPSDT does not require the state Medicaid agency to provide any service, product or procedure:

1. that is unsafe, ineffective, or experimental or investigational.
2. that is not medical in nature or not generally recognized as an accepted method of medical practice or treatment.

Service limitations on scope, amount, duration, frequency, location of service, and other specific criteria described in clinical coverage policies may be exceeded or may not apply as long as the provider's documentation shows that the requested service is medically necessary "to correct or ameliorate a defect, physical or mental illness, or a condition" [health problem]; that is, provider documentation shows how the service, product, or procedure meets

all EPSDT criteria, including to correct or improve or maintain the beneficiary's health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

b. **EPSDT and Prior Approval Requirements**

1. If the service, product, or procedure requires prior approval, the fact that the beneficiary is under 21 years of age does **NOT** eliminate the requirement for prior approval.
2. **IMPORTANT ADDITIONAL INFORMATION** about EPSDT and prior approval is found in the *NCTracks Provider Claims and Billing Assistance Guide,* and on the EPSDT provider page. The Web addresses are specified below.

   NCTracks Provider Claims and Billing Assistance Guide: https://www.nctracks.nc.gov/content/public/providers/provider-manuals.html
3. EPSDT provider page**:** http://dma.ncdhhs.gov/

2.2.2 EPSDT does not apply to NCHC beneficiaries

2.2.3 Health Choice Special Provision for a Health Choice Beneficiary age 6 through 18 years of age

The Division of Medical Assistance (DMA) shall deny the claim for coverage for a NCHC beneficiary who does not meet the criteria within **Section 3.0** of this policy. Only services included under the NCHC State Plan and the DMA clinical coverage policies, service definitions, or billing codes are covered for a NCHC beneficiary.

3.0 When the Procedure, Product, or Service Is Covered

Note: Refer to Subsection 2.2.1 regarding EPSDT Exception to Policy Limitations for a Medicaid Beneficiary under 21 Years of Age.

3.1 General Criteria Covered

Medicaid and NCHC shall cover procedures, products, and services related to this policy when they are medically necessary, and:

a. the procedure, product, or service is individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the beneficiary's needs;
b. the procedure, product, or service can be safely furnished, and no equally effective and more conservative or less costly treatment is available statewide; and
c. the procedure, product, or service is furnished in a manner not primarily intended for the convenience of the beneficiary, the beneficiary's caretaker, or the provider.

3.2 Specific Criteria Covered

3.2.1 Specific criteria covered by both Medicaid and NCHC

3.2.1.1 Air Medical Ambulance

For air medical ambulance, the point of origin is the beneficiary's loading point and runway taxiing, until the beneficiary is offloaded from the air medical ambulance.

Air medical ambulance is covered in any one of the following situations:

a. the beneficiary's medical condition requires immediate and rapid ambulance transport that cannot be provided by ground ambulance;
b. the point of pickup is inaccessible by ground vehicle; or
c. the beneficiary's condition is such that the time needed to transport the beneficiary by land, or the instability of transport by land, to the nearest appropriate facility poses a threat to the beneficiary's survival or endangers the beneficiary's health.

Some conditions requiring emergency air medical ambulance transportation are:

a. intracranial bleeding requiring neurosurgical intervention;
b. shock;
c. major burns requiring treatment in a burn center;
d. conditions requiring immediate treatment in a hyperbaric oxygen unit;
e. multiple severe injuries;
f. life-threatening trauma;
g. ST Segment Elevation Myocardial Infarction (STEMI); and
h. cardiovascular Accident (CVA).

3.2.1.2 Ambulance Transport of Deceased Beneficiaries

Ambulance transport of a deceased beneficiary is covered in either one of the following situations:

a. The beneficiary is pronounced dead by a legally authorized individual after the dispatch of the ambulance, but before the beneficiary is loaded on board the ambulance. The provider is reimbursed for the BLS base rate. No mileage is reimbursed. The date of service is the date of the dispatch of the ambulance. Use QL modifier, "Patient pronounced dead after ambulance called," on the claim; or
b. The beneficiary is pronounced dead by a legally authorized individual after pick-up but prior to arrival at the receiving facility. The same reimbursement rules apply as if the beneficiary were alive.

3.2.1.3 Out-of-State (Non-Contiguous) Transport of Beneficiaries

Hospitals, acute medical care, and ambulance services are out-of-state services when they are provided more than 40 miles outside of the N.C. border.

Hospitals, acute medical care, and ambulance services provided *within* 40 miles of the N.C. border in the contiguous states of Georgia, South Carolina, Tennessee, and Virginia will be covered to the same extent and under the same conditions as services provided in North Carolina. These facilities and providers shall obtain Medicaid provider numbers. Contact DMA Provider Services (http://dma.ncdhhs.gov/) for information on obtaining a Medicaid Provider number.

Refer to clinical coverage policy, 2A-3, *Out-of-State Services***,** located at http://dma.ncdhhs.gov/.

3.2.1.4 Out-of-County Transport of Beneficiaries

Ground ambulance loaded mileage is reimbursable only for out-of-county transport.

3.2.2 Medicaid Additional Criteria Covered

3.2.2.1 Origin and Destination

Medicaid shall cover ambulance transports (that meet all other program requirements for coverage) only to the following destinations:

a. hospital;
b. critical access hospital;
c. skilled nursing facility;
d. adult care home;
e. intermediate care facility for individuals with intellectual disabilities (ICF-IID);
f. beneficiary's primary private residence;
g. dialysis facility for end-stage renal disease if the beneficiary's condition requires ambulance services;
h. transfer site (airport or helipad);
i. physician's office;
    1. Non-emergency transport to a physician's office shall meet the criteria in **Subsection 3.2.2.2, Non-Emergency Medically Necessary Ambulance Transport.**
    2. Emergency transportation to a physician's office shall meet the following conditions:
        A. the beneficiary is en route to a hospital;
        B. there is medical need for a professional to stabilize the beneficiary's condition; and
        C. the ambulance continues the trip to the hospital immediately after stabilization.
j. emergency transport from hospital to hospital is appropriate when the transferring facility does not have adequate facilities to provide needed care. Coverage is available only if the beneficiary is transferred to the nearest appropriate facility such as, transportation between burn centers, neonatal care centers, trauma units, primary cardiac intervention centers, and stroke centers; and
k. emergency transport of a beneficiary residing in a nursing home shall meet medical necessity criteria for an emergency, and the services needed shall be unavailable at the facility.

3.2.2.2 Non-emergency Medically Necessary Ambulance Transport

Non-emergency medically necessary ambulance transport is covered for Medicaid beneficiaries only in the following situations:

a. medical necessity is indicated when the use of other means of transportation is medically contraindicated. This refers to beneficiaries whose medical condition requires transport by stretcher;
b. the beneficiary is in need of medical services that cannot be provided in the place of residence; or
c. return transportation is provided from a facility that can provide total care for every aspect of an injury or disease to a facility that has fewer resources to offer highly specialized care.

Non-emergency medically necessary ambulance transport is appropriate in either of the following situations:

a. the beneficiary is bed confined and it is documented that the beneficiary's medical condition is such that a stretcher is the only safe mode of transportation; or
b. the beneficiary's medical condition, regardless of bed confinement, is such that transportation by ambulance is medically required.

A beneficiary is bed confined when all of the following criteria are met. The beneficiary is:

a. unable to get up from bed without assistance;
b. unable to ambulate; and
c. unable to sit in a chair or wheelchair.

A provider shall move a bed-confined beneficiary by stretcher for:

a. contractures creating non-ambulatory status and the beneficiary cannot sit;
b. immobility of lower extremities (spica cast, fixed hip joints) and unable to be moved by wheelchair; or
c. return (back) transport, such as when a newborn is transported to a tertiary hospital for necessary care and services and, when stabilized, is transported back to the referring hospital to receive a lower level of services.

3.2.2.3 Ambulance Services during Pregnancy

Ambulance services for pregnant beneficiaries must be medically necessary. Medical necessity may be present if one of the following conditions occur:

a. Crowning;
b. Hemorrhage;
c. Preterm labor (prior to 37 weeks);
d. Premature rupture of membranes;
e. Abruptio placenta;
f. Placenta Previa;
g. Pre-eclampsia or Eclampsia; or

h. Transport from a small hospital to tertiary hospital when beneficiary is in preterm labor.

3.2.3 NCHC Additional Criteria Covered

3.2.3.1 Origin and Destination

NCHC shall cover **only emergency** ambulance transports that meet all other program requirements for coverage and only to the following destinations:

a. Transportation to and from a hospital for inpatient care or outpatient emergency care;
b. Transportation from a hospital to the nearest facility which is prepared to accept the beneficiary AND is able to provide needed service(s) which is (are) not available at the hospital where the beneficiary is presently confined;
c. Critical access hospital;
d. Transfer site (airport/helipad);
e. Emergency transportation to a physician's office shall meet the following conditions:
   1. the beneficiary is en route to a hospital;
   2. there is medical need for a professional to stabilize the beneficiary's condition; and
   3. the ambulance continues the trip to the hospital immediately after stabilization.
f. Emergency transport from hospital to hospital is appropriate when the transferring facility does not have adequate facilities to provide needed care. Coverage is available only if the beneficiary is transferred to the nearest appropriate facility such as~~,~~ transportation between burn centers, trauma units, primary cardiac intervention centers, and stroke centers.

4.0 When the Procedure, Product, or Service Is Not Covered

Note: Refer to Subsection 2.2.1 regarding EPSDT Exception to Policy Limitations for a Medicaid Beneficiary under 21 Years of Age.

4.1 General Criteria Not Covered

Medicaid and NCHC shall not cover procedures, products, and services related to this policy when:

a. the beneficiary does not meet the eligibility requirements listed in **Section 2.0;**
b. the beneficiary does not meet the criteria listed in **Section 3.0;**
c. the procedure, product, or service duplicates another provider's procedure, product, or service; or
d. the procedure, product, or service is experimental, investigational, or part of a clinical trial.

4.2 Specific Criteria Not Covered

4.2.1 Specific Criteria Not Covered by both Medicaid and NCHC

Medicaid and NCHC shall not cover the following:

4.2.1.1 Nearest Appropriate Facility

a. The beneficiary is to be transferred to the nearest appropriate facility. Loaded mileage to a facility that does not meet this criterion is not reimbursed.
b. The fact that a physician does or does not have staff privileges in a hospital is not a consideration in determining whether the hospital has appropriate facilities.
c. A facility is not deemed appropriate or inappropriate based on a beneficiary's preference.

4.2.1.2 Transport of Deceased Beneficiaries

Ambulance transport of a deceased beneficiary is not covered if the beneficiary is pronounced dead by a legally authorized individual before the ambulance is called.

4.2.1.3 Air Medical Ambulance

Air medical ambulance transport to a facility that is not an acute-care hospital is not a covered service.

4.2.1.4 Other Non-covered Ambulance Services

a. An ambulance is called and no treatment is needed.
b. The ambulance responds to a false alarm call.
c. The beneficiary refuses all medical services.
d. Ambulance transport is for a medical service that is not a Medicaid or NCHC covered service.
e. Commercial airline tickets are not reimbursable
f. Airstrip fees are not covered.
g. Charges for taxes (local, state, federal, etc.) are not covered.
h. Separate additional charges for nursing personnel who are employees of a facility or ambulance service are not covered.
i. Waiting fees are not covered.
j. Costs for oxygen and other items and supplies provided are included in the base rate and not separately reimbursable.
k. Services other than those listed in **Subsection 3.2** are not covered.

4.2.2 Medicaid Additional Criteria Not Covered

4.2.2.1 Maternity Transport

Ambulance transport of beneficiaries with routine pregnancies is not covered. Beneficiaries without complications that would endanger the life of the mother, the child, or both do not meet medical necessity criteria.

Beneficiaries with Medicaid coverage through Family Planning are not covered to receive ambulance services.

4.2.2.2 Nursing Facility Non-Ambulance Transportation

Non-ambulance transportation of Medicaid-eligible beneficiaries to receive medical care that cannot be provided in the nursing facility is covered in the per diem that is reimbursed to the facility. The facility may contract with a service (including county-coordinated transportation systems) to provide transportation or may provide transportation services using its own vehicles.

Note: The nursing facility cannot charge the beneficiary or the beneficiary's family for the cost of this transportation.

4.2.3 NCHC Additional Criteria Not Covered

a. In addition to the specific criteria not covered in **Subsection 4.2.1** of this policy, NCHC shall not cover prenatal or childbirth services.
b. NCGS § 108A-70.21(b) "Except as otherwise provided for eligibility, fees, deductibles, copayments, and other cost sharing charges, health benefits coverage provided to children eligible under the Program shall be equivalent to coverage provided for dependents under North Carolina Medicaid Program except for the following:
   1. No services for long-term care.
   2. No nonemergency medical transportation.
   3. No EPSDT.
   4. Dental services shall be provided on a restricted basis in accordance with criteria adopted by the Department to implement this subsection."

5.0 Requirements for and Limitations on Coverage

Note: Refer to Subsection 2.2.1 regarding EPSDT Exception to Policy Limitations for a Medicaid Beneficiary under 21 Years of Age.

5.1 Prior Approval

Prior approval (PA) is required for non-emergency ambulance services for a Medicaid beneficiary by ground or air from North Carolina to another state, from one state to another, or from another state back to North Carolina. Medical necessity determination is based on the documentation submitted by the provider. PA must be obtained **before** rendering out-of-state non-emergency ambulance services. PA for ambulance service is separate from PA for a medical procedure or treatment provided out of state.

Obtaining PA does not guarantee payment, ensure beneficiary eligibility on the date of service, or guarantee a post-payment review to verify that the service was appropriate and medically necessary will not be conducted. A beneficiary must be eligible for Medicaid coverage on the date the procedure is performed or the service rendered. In accordance with 10A NCAC 22J.0106 (d), the provider cannot bill beneficiaries when he fails to follow program regulations or when the claim denies on the basis of a lack of medical necessity.

A provider requesting PA for state-to-state ambulance transport shall submit both the State-to-State Ambulance Transportation Addendum (Form 372-118A) and the Medicaid

Prior Approval Form (Form 372-118) to DMA's designee. The request may be made by the transferring facility or the receiving facility. Forms are available at http://dma.ncdhhs.gov/.

NCHC does not cover non-emergency medical transportation.

Services must be provided in compliance with all applicable rules, regulations, laws, and current standards of practice. When requesting authorization for payment of services, the provider shall submit the beneficiary's face sheet and any other relevant information that demonstrates the beneficiary had an emergency medical condition as defined in 42 C.F.R. 489.24(c)(3).

PA is *not* required for in-state emergency ambulance services, ground or air, for Medicaid or NCHC beneficiaries.

5.2 Prior Approval Requirements

5.2.1 General

The provider(s) shall submit to the Department of Health and Human Services (DHHS) Utilization Review Contractor the following:

a. the prior approval request; and
b. all health records and any other records that support the beneficiary has met the specific criteria in **Subsection 3.2** of this policy.

5.2.2 Specific

a. Each trip requires a separate PA process and PA number
b. For non-emergency medically necessary ambulance transport, PA shall be obtained before service is rendered for a Medicaid beneficiary.
c. The PA is active for 30 calendar days.

5.3 Limitations or Requirements

The provider shall bill only one ambulance procedure code for the same date of service, the same hour or time of pick-up, and the same or a different provider.

The provider shall not bill a round-trip ambulance transport and a one-way-trip ambulance transport on the same date of service. If this situation occurs, the provider shall submit an adjustment request with documentation that substantiates a round trip and an additional one-way trip on the same date of service.

6.0 Provider(s) Eligible to Bill for the Procedure, Product, or Service

To be eligible to bill for procedures, products, and services related to this policy, the provider(s) shall:

a. meet Medicaid or NCHC qualifications for participation;
b. have a current and signed Department of Health and Human Services (DHHS) Provider Administrative Participation Agreement; and
c. bill only for procedures, products, and services that are within the scope of their clinical practice, as defined by the appropriate licensing entity.

6.1 Provider Qualifications and Occupational Licensing Entity Regulations

None Apply.

6.2 Provider Certifications

None Apply.

6.3 Licensure and Vehicles

Ambulance providers shall comply with licensure and credentialing requirements of the State Office of Emergency Medical Services (OEMS) in the Division of Health Service Regulation (DHSR) and G.S. 131E-155.1. The beneficiary shall be transported in an appropriately equipped vehicle that has been inspected and issued a permit by the State OEMS and the ambulance provider shall comply with G.S. 131E-156 and 131E-157. Staffing shall be in accordance with G.S. 151E-158 and 10A NCAC 13P and appropriate for the level of care provided to the Medicaid or NCHC beneficiary. The OEMS Website is located at https://www.ncdhhs.gov/divisions/dhsr.

6.4 In-State Ambulance Service Requirements

In-state ambulance service providers shall meet each of the following requirements:

a. Have a valid license from the State OEMS;
b. Hold a current permit issued by OEMS on the vehicle(s) used for transport;
c. Participate as an ambulance provider in the Medicare program; and
d. Staff the ambulance in accordance with State and local laws, including staff credentialing in accordance with OEMS.

6.5 Out-of-State Ambulance Service Requirements

Out-of-state ambulance service providers shall meet all of the following requirements:

a. A valid license as an ambulance provider under the laws of the state in which the provider operates;
b. An enrolled Medicaid ambulance provider in the state in which the provider operates;
c. An enrolled Medicare ambulance provider; and
d. Enrolled with an N.C. Medicaid provider number.

7.0 Additional Requirements

Note: Refer to Subsection 2.2.1 regarding EPSDT Exception to Policy Limitations for a Medicaid Beneficiary under 21 Years of Age.

7.1 Compliance

Provider(s) shall comply with the following in effect at the time the service is rendered:

a. All applicable agreements, federal, state and local laws and regulations including the Health Insurance Portability and Accountability Act (HIPAA) and record retention requirements; and
b. All DMA's clinical (medical) coverage policies, guidelines, policies, provider manuals, implementation updates, and bulletins published by the Centers for Medicare and Medicaid Services (CMS), DHHS, its divisions or its fiscal agent.

7.2 Call Reports

The ambulance provider shall maintain all call reports, PA forms, documentation to support the miles billed, and any other records prepared or received in regard to the service rendered to Medicaid and NCHC beneficiaries and claimed for reimbursement. The provider shall retain the records for a minimum of six years from the date of service, unless a longer retention period is required, and shall be made available to DMA or its DMA's designee upon request.

Submission of call reports is not required when filing ambulance claims.

A call report shall be legible, complete, and accurate and:

a. Include a complete description of the beneficiary at the scene and in transit:
    1. Detail the condition necessitating the ambulance service;
    2. Include a physical description of the beneficiary's position, location, and status during the initial encounter (for example, lying on the floor or sitting in a wheelchair);
    3. Include data on how, when, and where the beneficiary was found; all vital signs; level of consciousness; and other relevant information;
    4. Document all treatments rendered and the beneficiary's response to treatment;
    5. Use sufficient detail to justify that the beneficiary's health and safety would be endangered if transported other than by stretcher; and
    6. Use sufficient detail to support the medical necessity of the transport, the condition codes billed, and the level of care provided. If the ambulance service does not meet medical necessity and coverage criteria, the provider shall document this information on the call report to ensure a complete and accurate record of the beneficiary's condition.
b. Include the time in the range of 00–23 hours, the point of pickup, the destination, and the number of loaded miles;
c. Document that the transport is to the nearest appropriate facility; and
d. Document one-way or round-trip ambulance transport.

7.3 Physician Certification and Order for Non-Emergency Medicaid Ambulance Services

The ambulance provider shall obtain the signed written order and certification with the appropriate signatures before billing for the following services:

7.3.1 Non-Emergency, Scheduled, Repetitive Ambulance Services

For all non-emergency, scheduled, repetitive ambulance services, ambulance providers shall obtain from the Medicaid beneficiary's attending physician a written order certifying the medical necessity of the ambulance services. The physician's order shall be dated no earlier than 60 calendar days before the date the service is furnished.

7.3.2 Non-Emergency Ambulance Services That Are Either Unscheduled or That Are Scheduled on a Non-Repetitive Basis

For a Medicaid beneficiary who is under the care of a physician, the ambulance provider shall obtain a written order certifying the medical necessity from the beneficiary's attending physician within 48 hours after the transport.

If the ambulance provider cannot obtain the written order and certification with appropriate signatures within 21 calendar days following the date of service, the provider shall document the attempts to obtain the requested order and certification and may then submit the claim to DMA's designee.

If the ambulance provider cannot obtain a signed physician certification statement from the beneficiary's attending physician, he shall obtain a signed certification statement from either the physician assistant (PA), nurse practitioner (NP), clinical nurse specialist (CNS), registered nurse (RN), or discharge planner who has personal knowledge of the beneficiary's condition at the time the ambulance transport is ordered, or the service is furnished.

This individual shall be employed by the beneficiary's attending physician or by the hospital or facility where the beneficiary is being treated and from which the beneficiary is transported.

A physician order is not required for a Medicaid beneficiary who resides at home or in a facility and is not under the direct care of a physician.

The presence of the signed physician certification statement does not necessarily demonstrate that the transport was medically necessary and that it met coverage criteria. The ambulance provider shall meet all coverage criteria, including call report criteria, in order for reimbursement to be made.

8.0 Policy Implementation and History

Original Effective Date: February 1, 2016

History:

Date	Section or subsection Revised	Change
02/01/2016	All sections and attachment(s)	New policy documenting current coverage and services

Attachment A: Claims-Related Information

Provider(s) shall comply with the, *NCTracks Provider Claims and Billing Assistance Guide*, Medicaid bulletins, fee schedules, DMA's clinical coverage policies and any other relevant documents for specific coverage and reimbursement for Medicaid and NCHC:

A. Claim Type

Institution-based ambulance providers bill institutional (UB-04/837I)

Independent/private ambulance providers bill professional (CMS-1500/837P)

B. International Classification of Diseases, Tenth Revisions, Clinical Modification (ICD-10-CM) and Procedural Coding System (PCS)

Provider(s) shall report the ICD-10-CM and Procedural Coding System (PCS) to the highest level of specificity that supports medical necessity. Provider(s) shall use the current ICD-10 edition and any subsequent editions in effect at the time of service. Provider(s) shall refer to the applicable edition for code description, as it is no longer documented in the policy.

C. Code(s)

Provider(s) shall report the most specific billing code that accurately and completely describes the procedure, product or service provided. Provider(s) shall use the Current Procedural Terminology (CPT), Health Care Procedure Coding System (HCPCS), and UB-04 Data Specifications Manual (for a complete listing of valid revenue codes) and any subsequent editions in effect at the time of service. Provider(s) shall refer to the applicable edition for the code description, as it is no longer documented in the policy.

If no such specific CPT or HCPCS code exists, then the provider(s) shall report the procedure, product or service using the appropriate unlisted procedure or service code.

HCPCS Codes

Institutional and professional providers use the following HCPCS code(s) to identify the service being rendered.

HCPCS Code(s)	
A0425	A0430
A0426 *	A0431
A0427	A0433
A0428 *	A0435
A0429	A0436
	T2003*

* This code is not covered under the NCHC program. NCHC does not cover non-emergency ambulance transportation.

Revenue Codes

Institutional providers must report revenue code (RC) 540 and one of the HCPCS codes listed above for each ambulance trip provided. Institutional providers must report RC 540 and a mileage code, when applicable, on a separate detail line.

Revenue Code
RC540

Condition Codes

Institutional providers must report one of the condition codes listed below:

Condition Code	
AK	Air Ambulance Required
AL	Specialized Treatment/Bed Unavailable (transported to alternate facility)
AM	Non-Emergency Medically Necessary Stretcher Transport Required

Medical Conditions List

Refer to the Medicare Claims Processing Manual, Chapter 15-Ambulance, Section 40-Medical Conditions List and Instructions located at http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c15.pdf.

Unlisted Procedure or Service

CPT: The provider(s) shall refer to and comply with the Instructions for Use of the CPT Codebook, Unlisted Procedure or Service, and Special Report as documented in the current CPT in effect at the time of service.

HCPCS: The provider(s) shall refer to and comply with the Instructions For Use of HCPCS National Level II codes, Unlisted Procedure or Service and Special Report as documented in the current HCPCS edition in effect at the time of service.

D. Modifiers

Provider(s) shall follow applicable modifier guidelines.

Providers must report an origin and destination modifier for each ambulance trip provided. Origin and destination modifiers used for ambulance services are created by combining two alpha characters. Each alpha character, with the exception of "x," represents an origin code or a destination code. The pair of alpha codes creates one modifier. The first position alpha code equals origin; the second position alpha code equals destination. The modifier description is listed in the Health Care Procedure Coding System (HCPCS). Provider(s) shall refer to the applicable edition for the code description as it is no longer documented in the policy.

Alpha Codes		
D	I	R
E	J	S
G	N	X
H	P	

Providers must report QL modifier if the time of death pronouncement is made after dispatch but before the beneficiary is loaded onboard the ambulance.

E. Billing Units

Provider(s) shall report the appropriate code(s) used which determines the billing unit(s).

The time of pick-up, in the range of 00–23 hours, is required on the claim form.

When multiple units respond to a call for services, the provider that transports the beneficiary is the only provider that may bill for the service. If both ground and air medical ambulances are involved, then each submits its own claim and each claim is processed and reimbursed independently of the other.

F. Place of Service

Ambulance

G. Co-payments

For Medicaid refer to Medicaid State Plan, Attachment 4.18-A, page 1, located at http://dma.ncdhhs.gov/.
For NCHC refer to G.S. 108A-70.21(d), located at http://www.ncleg.net/EnactedLegislation/Statutes/HTML/BySection/Chapter_108A/GS_108A-70.21.html

Co-payments are not required for ambulance services.

H. Reimbursement

Provider(s) shall bill their usual and customary charges.
For a schedule of rates, see: http://dma.ncdhhs.gov/

Reimbursement is based on the level of service rendered, not the type of vehicle. The level of service is determined by medical necessity and qualifying criteria.

Reimbursement includes both the transport of the Medicaid or NCHC beneficiary to the nearest appropriate facility and all supplies (disposable and nondisposable, including oxygen) associated with such transport.

Reimbursement is allowed for a round trip only if the ambulance remained in the vicinity of the destination, did not return to base, and did not respond to other calls for transport. Otherwise, the provider should bill for two one-way trips. Medicaid and NCHC providers shall not bill for additional reimbursement for waiting time on round trips. Waiting time is included in the round-trip reimbursement. Medicaid and NCHC providers shall not bill a beneficiary for waiting time on round trips.

If a beneficiary is transported and returned to the point of pick-up or other delivery point by a different provider on the same date of service, each provider is allowed a one-way trip. The level of reimbursement is determined by medical necessity and qualifying criteria.

Ambulance transport of a Medicaid or NCHC hospice beneficiary for any service related to the terminal illness is the responsibility of the hospice provider. The ambulance provider shall contact the hospice provider prior to transport to arrange for payment. The ambulance provider shall not bill Medicaid or NCHC.