UnitedHealthcare Community Plan

UnitedHealthcare® Community Plan
Medical Policy

Ambulance Services (for Louisiana Only)

Guideline Number: CS003LA.M
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➲ Instructions for Use

Content mandated by Louisiana Department of Health

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Application

This Medical Policy only applies to the state of Louisiana. The coverage rationale contained in this policy represents Louisiana Medicaid coverage policy and is set forth below in accordance with state requirements.

Coverage Rationale

Indications for Coverage

Ambulance transportation is emergency or non-emergency medical transportation provided to Medicaid beneficiaries to and/or from a Medicaid provider for a medically necessary Medicaid covered service when the beneficiary's condition is such that use of any other method of transportation is contraindicated or would make the beneficiary susceptible to injury.

To participate in the Medicaid program, ambulance providers must meet the requirements of La. R.S. 40:1135.3. Licensing by the Louisiana Department of Health (LDH) Bureau of Emergency Medical Services is also required. Services must be provided in accordance with state law and regulations governing the administration of these services. Additionally, licensure is required for the medical technicians and other ambulance personnel by the LDH Bureau of Emergency Medical Services.

Coverage information by enrollment type is provided in the following matrix:

Enrollment	Non-Emergency Ambulance	Emergency Ambulance
Adults in ICF-IIDs†	FFS Medicaid	FFS Medicaid
Children in ICF-IIDs†	MCO	FFS Medicaid
Excluded populations	FFS Medicaid	FFS Medicaid
Managed care for behavioral health only	MCO	FFS Medicaid
Managed care for physical and behavioral health	MCO	MCO
Managed care for physical health only (CSoC children)	MCO	MCO
Nursing home residents	MCO	MCO for month of admission*; FFS Medicaid for subsequent months

†Intermediate Care Facility for Individuals with Intellectual Disabilities
^Southeastrans is currently authorizing and reimbursing for these transportation services covered by FFS Medicaid.
*During the single transitional month where an enrollee is both in a P-linkage and certified in LTC, the MCO will remain responsible for all transportation services that are not the responsibility of the nursing facility.

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Reimbursement to ambulance providers shall be no less than the published Medicaid FFS rate in effect on the date of service, unless mutually agreed upon by the transportation broker and the transportation provider in the provider agreement.

Terms utilized in the published Medicaid fee schedule are defined as follows:

- Basic Life Support (BLS): The provision of medically necessary supplies and services by EMS practitioners who are licensed at least to the level of an emergency medical technician.
- Advanced Life Support (ALS): The provision of medically necessary supplies and services by EMS practitioners who are licensed at least to the level of an advanced emergency technician or equivalent.
- Specialty Care Transport: Interfacility transportation of a critically injured or ill beneficiary by a ground ambulance vehicle, including medically necessary supplies and services, at a level of service beyond the scope of the EMT-Paramedic.

Ambulance providers may bill for mileage to the nearest appropriate facility. Reimbursement for mileage will vary depending on whether the transport is for an emergency or non-emergency event.

Reimbursement for mileage will be limited to actual mileage from point of pick up to point of delivery. Mileage can only be billed for miles traveled with the beneficiary in the ambulance.

Hospital-Based Ambulance Services

Inpatient Hospital-Based Ambulance Services

If a hospital admits an inpatient that is transported by its own hospital-based ambulance (ground or air), the MCO shall cover the ambulance charges, which must be billed as part of inpatient hospital services.

It may be necessary to transport an inpatient temporarily to another hospital for specialized care while the enrollee maintains inpatient status. These services are not billable ambulance services.

If a hospital-based ambulance transports an enrollee for inpatient admission to any other hospital, the ambulance service is not part of the hospital service and may be covered under the independent ambulance provider number.

Hospital-based ambulances must meet equipment and personnel standards set by the Bureau of Emergency Services (EMS). Hospitals must submit a copy of the EMS certification to Provider Enrollment for recognition to bill ambulance services.

Outpatient Hospital-Based Ambulance Services

The MCO shall cover emergency transports by a hospital’s own hospital-based ambulance (ground only) for enrollees treated and released as an outpatient. These must be billed as part of outpatient hospital services.

If a hospital-based ambulance transports a patient for emergency outpatient treatment to any other hospital, the ambulance service is not part of the hospital service and may be covered under the independent ambulance provider number.

Hospital-based ambulances may be used only to transport enrollees to the hospital in an emergency so they may be stabilized.

The MCO shall not cover non-emergency transport by a hospital-based ambulance as a hospital service.

Note: Air ambulance is not covered as an outpatient service.

Hospital-based ambulances must meet equipment and personnel standards set by the Bureau of Emergency Medical Services (EMS). Hospitals must submit a copy of EMS certification to Provider Enrollment for recognition to bill ambulance charges.

Air Ambulance

Air ambulances may be used for emergency and non-emergency ambulance transportation when medically necessary. Licensure by the LDH Bureau of Emergency Medical Services is required. Licensure for air ambulance services is governed by La. R.S. 40:1135.8. Rotor winged (helicopters) and fixed winged emergency aircraft must be certified by the Bureau of Health Services Financing in order to receive Medicaid reimbursement.

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All air ambulance services must comply with state laws and regulations governing the personnel certifications of the emergency medical technicians, registered nurses, respiratory care technicians, physicians, and pilots as administered by the appropriate agency of competent jurisdiction.

Air ambulance services are covered only if:

- Speedy admission of the beneficiary is essential and the point of pick-up of the beneficiary is inaccessible by a land vehicle; or
- Great distances or other obstacles are involved in getting the beneficiary to the nearest hospital with appropriate services.

If both ground and air ambulance transport are necessary during the same trip, each type of provider will be reimbursed separately according to regulations for that type of provider.

Return Trips and Transfers

Return Trips

When a beneficiary is transported to a hospital by ambulance on an emergency basis and is not admitted, the hospital shall request an NEMT return trip with the transportation broker unless the beneficiary meets the medical necessity requirements for NEAT.

Transfers

An ambulance transfer is the transport of a beneficiary by ambulance from one hospital to another. It must be medically necessary for the beneficiary to be transported by ambulance. The beneficiary must be transported to the most appropriate hospital that can meet his/her needs.

If the physician makes the decision that the level of care required by the beneficiary cannot be provided by the hospital, and the beneficiary has to be transported by the provider to another hospital, the transportation provider shall be reimbursed for both transfers once clean claims are submitted for the transfers.

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.

The MCO may not require prior review or authorization for emergency ambulance transportation. The MCO 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 by the MCO, clinical documentation shall be required post claim submission.

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

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.

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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:

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

Ambulance Service Exclusions

Medicaid does not cover “Ambulance 911-Non-emergency” services (i.e., procedure code A0226). If the beneficiary’s medical condition does not present itself as an emergency in accordance with the criteria in this policy, the service may be considered a non-covered service by Medicaid.

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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.

Non-Emergency Ambulance Transportation

Non-emergency ambulance transportation (NEAT) is transportation provided by ground or air ambulance to a Medicaid beneficiary to and/or from a Medicaid covered service, including carved-out services, or value-added benefits (VAB), when no other means of transportation is available and the beneficiary's condition is such that use of any other method of transportation is contraindicated or would make the beneficiary susceptible to injury. The nature of the trip is not an emergency, but the beneficiary requires the use of an ambulance.

Coverage Requirements

The beneficiary's treating physician, a registered nurse, the director of nursing at a nursing facility, a nurse practitioner, a physician's assistant, or a clinical nurse specialist must certify on the Certification of Ambulance Transportation (CAT) that the transport is medically necessary and describe the medical condition which necessitates ambulance services. The certifying authority shall complete the date range on the CAT, which shall be no more than 180 days. A single CAT should be utilized by the transportation broker for all of the beneficiary's transports within the specified date range. A new CAT form from the certifying authority may not be required for the same beneficiary during this date range.

NEAT must be scheduled by the beneficiary or a medical facility through the transportation broker or the ambulance provider, following the criteria below:

- If transportation is scheduled through the MCO, the MCO shall verify the following prior to scheduling: enrollee eligibility, that the originating or destination address belongs to a medical facility, and that a completed Certification of Ambulance Transportation form for the date of service is obtained, reviewed, and accepted by the MCO or its transportation broker. Once the trip has been dispatched to an ambulance provider and completed, the ambulance provider shall be reimbursed upon submission of the clean claim for the transport.
- If transportation is scheduled through the ambulance provider, the MCO shall require the ambulance provider to verify the following prior to reimbursement: enrollee eligibility, that the originating or destination address belongs to a medical facility, and that a completed Certification of Ambulance Transportation form for the date of service is obtained, reviewed, and accepted by the ambulance provider. The MCO shall reimburse the ambulance provider only if a completed Certification of Ambulance Transportation form is submitted with the clean claim or is on file with the MCO or its transportation broker prior to reimbursement.

Mileage must be reimbursed in accordance with the type of service indicated by the licensed medical professional on the Certification of Ambulance Transportation.

The Certification of Ambulance Transportation (CAT) form is available at www.lamedicaid.com.

Out-of-State Transportation

Enrollees may seek medically necessary services in another state when it is the nearest option available. All out-of-state NEAT transportation to facilities that are not the nearest available option, must be prior approved by the MCO. The MCO may approve transportation to out-of-state medical care only if the enrollee has been granted approval to receive medical treatment out of state.

The MCO must maintain documentation to support compliance with these standards and must submit documentation to LDH upon request.

Scheduling and Dispatching

The transportation broker shall make every effort to schedule urgent transportation requests and may not deny a request based solely on the appointment being scheduled less than 48 hours in advance. Urgent transportation refers to a request for transportation made by a healthcare provider for a medical service which does not warrant emergency transport but cannot be postponed. Urgent transportation shall include chemotherapy, radiation, dialysis, Opioid Treatment Program (OTP), or other necessary medical care that cannot be rescheduled to a later time. An urgent transportation request may occur concurrently with a standing order.

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Additional Passengers

The transportation broker shall prohibit ambulance providers from charging the beneficiary or anyone else for the transportation of additional passengers and shall not reimburse any claims submitted for transporting additional passengers.

Attendants

An attendant shall be required when the beneficiary is under the age of 17 years. This attendant must:

- Be a parent, legal guardian, or responsible person designated by the parent/legal guardian; and
- Be able to authorize medical treatment and care for the beneficiary.

Attendants may not:

- Be under the age of 17 years; or
- Be a Medicaid provider or employee of a Medicaid provider that is providing services to the beneficiary being transported, except for employees of a mental health facility in the event a beneficiary has been identified as being a danger to their self or to others or at risk for elopement.

Exceptions

All females, regardless of their age, seeking prenatal and/or postpartum care shall not be required to have an attendant.

Nursing Facility Ambulance Transportation

Nursing facilities are required to provide medically necessary transportation services for Medicaid beneficiaries residing in their facilities. Any nursing facility beneficiary needing non-emergency, non-ambulance transportation services are the financial responsibility of the nursing facility. NEAT services provided to a nursing facility beneficiary must include the Certification of Ambulance Transportation, in accordance with the Coverage Requirements section, to be reimbursable by Louisiana Medicaid; otherwise, the nursing facility shall be responsible for reimbursement for such services.

Applicable Codes

The following list(s) of procedure and/or diagnosis codes is provided for reference purposes only and may not be all inclusive. Listing of a code in this policy does not imply that the service described by the code is a covered or non-covered health service. Benefit coverage for health services is determined by federal, state, or contractual requirements and applicable laws that may require coverage for a specific service. The inclusion of a code does not imply any right to reimbursement or guarantee claim payment. Other Policies and Guidelines may apply.

When billing for procedure codes A0425-A0429, A0433-A0434 and A0436 for ambulance transportation services, the provider shall be required to also enter a valid 2-digit modifier at the end of the associated 5-digit procedure code. Different modifiers may be used for the same procedure code. Spaces will not be recognized as a valid modifier for those procedures requiring a modifier. The following table identifies the valid modifiers for the state of Louisiana only.

Modifier	Location
Ambulance Modifiers Ambulance claims are billed with the following modifiers. The first modifier indicates the place of origin, and the second modifier indicates the destination.	
DD	Trip from DX/Therapeutic Site to another DX/Therapeutic Site
DE	Trip from DX/Therapeutic Site to Residential, Domiciliary, Custodial Facility
DH	Trip from DX/Therapeutic Site to Hospital
DI	Diagnostic-Therapeutic Site/Transfer Airport Heli Pad
DJ	Diagnostic/therapeutic site other than P/H to a Non-Hospital-based Dialysis facility
DP	Trip from DX/Therapeutic Site to Physician’s Office
DR	Trip from DX/Therapeutic Site to Home
DX	Trip from DX/Therapeutic Site to MD to Hospital
ED	Trip from an RDC or Nursing home to DX/Therapeutic Site
EG	Trip from an RDC or Nursing home to Dialysis Facility (Hospital based)
EH	Trip from an RDC or Nursing home to Hospital

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Modifier	Location
Ambulance Modifiers Ambulance claims are billed with the following modifiers. The first modifier indicates the place of origin, and the second modifier indicates the destination.	
EI	Residential Domicile Custody Facility/Transfer Airport Heli Pad
EJ	Trip from an RDC or Nursing home to Dialysis Facility (non-Hospital based)
EN	Trip from an RDC or Nursing home to SNF
EP	Trip from an RDC or Nursing home to Physician's Office
ER	Trip from an RDC or Nursing home to Physician's Office
EX	Trip from RDC to MD to Hospital
GE	Trip from HB Dialysis Facility to an RDC or Nursing Home
GG	Trip from HB Dialysis Facility to Dialysis Facility (Hospital Based)
GH	Trip from HB Dialysis Facility to Hospital
GI	HB Dialysis Facility/Transfer Airport Heli Pad
GJ	Trip from HB Dialysis Facility to Dialysis Facility (non-Hospital Based)
GN	Trip from HB Dialysis Facility to SNF
GP	Trip from HB Dialysis Facility to Physician's Office
GR	Trip from HB Dialysis Facility to Patient's Residence
GX	Trip from HB Dialysis Facility to MD to Hospital
HD	Trip from Hospital to DX/Therapeutic Site
HE	Trip from Hospital to an RDC or Nursing Home
HG	Trip from Hospital to Dialysis Facility (Hospital Based)
HH	Trip from One Hospital to Another Hospital
HI	Hospital/Transfer Airport Heli Pad
HJ	Trip from Hospital to Dialysis Facility
HN	Trip from Hospital SNF
HP	Trip from Hospital to Physician's Office
HR	Trip from Hospital to Patient's Residence
IH	Transfer Airport Heli Pad/Hospital
II	Site of Ambulance transport modes transfer to another Site of Ambulance transport modes transfer
JD	Non-Hospital-based Dialysis facility to a Diagnostic/therapeutic site other than P/H
JE	Trip from NHB Dialysis Facility to RDC or Nursing Home
JG	Trip from NHB Dialysis Facility to Dialysis Facility (Hospital Based)
JH	Trip from NHB Dialysis Facility to Hospital
JI	NHB Dialysis Facility/Transfer Airport Heli Pad
JN	Trip from NHB Dialysis Facility to SNF
JP	Trip from NHB Dialysis Facility to Physician's Office
JR	Trip from NHB Dialysis Facility to Patient's Residence
JX	Trip from NHB Dialysis Facility to MD to Hospital
ND	Trip from SNF to DX/Therapeutic Site
NE	Trip from SNF to an RDC or Nursing Home
NG	Trip from SNF to Dialysis Facility (Hospital based)
NH	Trip from SNF to Hospital
NI	Skilled Nursing Facility/Transfer Airport Heli Pad
NJ	Trip from SNF to Dialysis Facility (non-Hospital based)
NN	Trip from SNF to SNF
NP	Trip from SNF to Physician's Office

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Modifier	Location
Ambulance Modifiers Ambulance claims are billed with the following modifiers. The first modifier indicates the place of origin, and the second modifier indicates the destination.	
NR	Trip from SNF to Patient's Residence
NX	Trip from SNF to MD to Hospital
PD	Trip from a Physician's Office to DX/Therapeutic Site
PE	Trip from a Physician's Office to an RDC or Nursing Home
PG	Trip from a Physician's Office to Dialysis Facility (Hospital based)
PH	Trip from a Physician's Office to a Hospital
PI	Physician's Office/Transfer Airport Heli Pad
PJ	Trip from a Physician's Office to Dialysis Facility (non-Hospital based)
PN	Ambulance trip from the Physician's Office to Skilled Nursing Facility
PP	Ambulance trip from Physician to Physician's Office
PR	Trip from Physician's Office to Patient's Residence
RD	Trip from the Patient's Residence to DX/Therapeutic Site
RE	Trip from the Patient's Residence to an RDC or Nursing Home
RG	Trip from the Patient's Residence to Dialysis Facility (Hospital based)
RH	Trip from the Patient's Residence to a Hospital
RI	Residence/Transfer Airport Heli Pad
RJ	Trip from the Patient's Residence to Dialysis Facility (non-Hospital based)
RN	Trip from the Patient's Residence to Skilled Nursing Facility
RP	Trip from the Patient's Residence to a Physician's Office
RX	Trip from Patient's Residence to MD to Hospital
SH	Trip from the Scene of an Accident to a Hospital
SI	Accident Scene, Acute Event/Transfer Airport, Heli Pad
TN	Rural Area (for rotary wing emergency air ambulance trips only)

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HCPCS Code	Description
Air Ambulance (*Also see Air Ambulance Revenue Code 0545 below*)	
A0430	Ambulance service, conventional air service, transport, one way (fixed wing)
A0431	Ambulance service, conventional air services, transport, one way (rotary wing)
A0435	Fixed wing air mileage, per statute mile
A0436	Rotary wing air mileage, per statute mile
Ground/Other Ambulance	
A0382	BLS routine disposable supplies
A0394	ALS specialized service disposable supplies*Only payable when determined as medically necessary
A0398	ALS routine disposable supplies
A0422	Ambulance (ALS or BLS) oxygen and oxygen supplies, life sustaining situation
A0425	Ground mileage, per statute mile
A0426	Ambulance service, advanced life support, non-emergency transport, level 1 (ALS 1)
A0427	Ambulance service, advanced life support, emergency transport, level 1 (ALS 1 emergency)
A0428	Ambulance service, basic life support, non-emergency transport (BLS)
A0429	Ambulance service, basic life support, emergency transport (BLS, emergency)
A0433	Advanced life support, level 2 (ALS 2)
A0434	Specialty care transport (SCT)

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HCPCS Code	Description
Ground/Other Ambulance	
G2022	Beneficiary refuses services covered under the model (transport to an alternate destination/treatment in place)

Revenue Code	Description
0540	Ambulance; general classification
0541	Ambulance; supplies
0542	Ambulance; medical transport
0543	Ambulance; heart mobile
0544	Ambulance; oxygen
0545	Ambulance; Air ambulance
0546	Ambulance; Neo-natal ambulance
0547	Ambulance; pharmacy
0548	Ambulance; EKG transmission
0549	Ambulance; Other

References

Louisiana Department of Health. Louisiana Medicaid Managed Care Organization (MCO) Manual. Updated Dec 13, 2023. https://ldh.la.gov/assets/medicaid/Manuals/MCO_Manual.pdf. Accessed January 22, 2024.

Policy History/Revision Information

Date	Summary of Changes

06/01/2024	**Template Update**
	• Changed policy type from "Coverage Determination Guideline" to "Medical Policy"
	Coverage Rationale
	Indications for Coverage
	• Removed language indicating ambulance services are not covered when another means of transportation could be utilized without endangering the individual's health
	• Updated definition (as utilized in the Medicaid fee schedule) of:
	  ○ Basic Life Support (BLS)
	  ○ Advanced Life Support (ALS)
	Hospital-Based Ambulance Services
	• Revised language to indicate:
	Inpatient Hospital-Based Ambulance Services
	  ○ If a hospital admits an inpatient that is transported by its own hospital-based ambulance (ground or air), the MCO shall cover the ambulance charges, which must be billed as part of inpatient hospital services
	  ○ It may be necessary to transport an inpatient temporarily to another hospital for specialized care while the enrollee maintains inpatient status; these services are not billable ambulance services
	  ○ If a hospital-based ambulance transports an enrollee for inpatient admission to any other hospital, the ambulance service is not part of the hospital service and may be covered under the independent ambulance provider number
	  ○ Hospital-based ambulances must meet equipment and personnel standards set by the Bureau of Emergency Services (EMS); hospitals must submit a copy of the EMS certification to Provider Enrollment for recognition to bill ambulance services
	Outpatient Hospital-Based Ambulance Services
	  ○ The MCO shall cover emergency transports by a hospital's own hospital-based ambulance (ground only) for enrollees treated and released as an outpatient; these must be billed as part of outpatient hospital services

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Date	Summary of Changes
	◦ If a hospital-based ambulance transports a patient for emergency outpatient treatment to any other hospital, the ambulance service is not part of the hospital service and may be covered under the independent ambulance provider number ◦ Hospital-based ambulances may be used only to transport enrollees to the hospital in an emergency so they may be stabilized ◦ The MCO shall not cover non-emergency transport by a hospital-based ambulance as a hospital service ◦ Air ambulance is not covered as an outpatient service ◦ Hospital-based ambulances must meet equipment and personnel standards set by the Bureau of Emergency Medical Services (EMS); hospitals must submit a copy of EMS certification to Provider Enrollment for recognition to bill ambulance charges ***Air Ambulance*** • Replaced reference to "*land* ambulance" with "*ground* ambulance" ***Emergency Ambulance Transportation*** • Added language to indicate: ◦ The MCO may not require prior review or authorization for emergency ambulance transportation ◦ The MCO 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 by the MCO, clinical documentation shall be required post claim submission • Removed language indicating prior review or authorization is not permitted for emergency ambulance transportation Emergency Action Procedure • Added language to indicate the ambulance driver must immediately assess the situation and determine whether to proceed immediately to the closest, most appropriate healthcare facility if a medical emergency arises while transporting a beneficiary; 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 **Treatment-in-Place** • Revised language to indicate: ◦ 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: ▪ If a treatment-in-place ambulance claim is billed with mileage, the entire claim document shall be denied ▪ 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 ▪ Claims for allowable telehealth procedure codes must be billed with procedure code G2021and the code shall be accepted, paid at $0.00, and used by the transportation provider to identify treatment-in-place telehealth services ▪ 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 are valid treatment-in-place ambulance claim modifiers: DW, EW, GW, HW, IW, JW, NW, PW, RW, and SW

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Date	Summary of Changes
	○ 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 but 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 ▪ Procedure code G2022 shall be accepted, paid at $0.00, and used by the transportation provider to identify beneficiary refusal of treatment-in-place services ***Ambulance Service Exclusions*** • Added language to indicate ambulance providers shall code and bill such non-emergency services [listed in the policy] using modifiers GY, QL, or TQ to indicate that the services performed were non-covered Medicaid services ***Non-Emergency Ambulance Transportation*** • Added language to clarify non-emergency ambulance transportation (NEAT) is transportation provided by ground or air ambulance to a Medicaid beneficiary to and/or from a Medicaid covered service, *including carved-out services or value-added benefits (VAB),* when no other means of transportation is available and the beneficiary's condition is such that use of any other method of transportation is contraindicated or would make the beneficiary susceptible to injury Coverage Requirements • Added language to indicate the certifying authority shall complete the date range on the Certification of Ambulance Transportation (CAT), which shall be no more than 180 days ○ A single CAT should be utilized by the transportation broker for all of the beneficiary's transports within the specified date range ○ A new CAT form from the certifying authority may not be required for the same beneficiary during this date range • Revised criteria for NEAT scheduled by the beneficiary or a medical facility through the transportation broker or the ambulance provider; replaced criterion requiring: ○ "If transportation is scheduled through the *transportation broker, the transportation broker* shall verify, prior to scheduling, *beneficiary* eligibility, that the originating or destination address belongs to a medical facility, and that a completed Certification of Ambulance Transportation form is *received* for the date of service" with "if transportation is scheduled through the *MCO, the MCO* shall verify the following prior to scheduling: *enrollee* eligibility, that the originating or destination address belongs to a medical facility, and that a completed Certification of Ambulance Transportation form for the date of service is *obtained, reviewed, and accepted by the MCO or its transportation broker*" ○ "If transportation is scheduled through the ambulance provider, the ambulance provider must verify *beneficiary* eligibility, that the originating or destination address belongs to a medical facility, and that a completed Certification of Ambulance Transportation form is *received* for the date of service; the *transportation broker* shall reimburse the ambulance provider only if a completed Certification of Ambulance Transportation form is submitted with the clean claim or is on file with the transportation broker prior to reimbursement" with "if transportation is scheduled through the ambulance provider, the *MCO shall require* the ambulance provider to verify the following *prior to reimbursement*: *enrollee* eligibility, that the originating or destination address belongs to a medical facility, and that a completed Certification of Ambulance Transportation form for the date of service *is obtained, reviewed, and accepted by the ambulance provider*; the *MCO* shall reimburse the ambulance provider only if a completed Certification of Ambulance Transportation form is submitted with the clean claim or is on file with the *MCO or* its transportation broker prior to reimbursement"

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Date	Summary of Changes

	Out-of-State Transportation
	• Revised language to indicate:
	  ○ Enrollees may seek medically necessary services in another state when it is the nearest option available
	  ○ All out-of-state NEAT transportation to facilities that are not the nearest available option must be prior approved by the MCO
	  ○ The MCO may approve transportation to out-of-state medical care only if the enrollee has been granted approval to receive medical treatment out of state
	  ○ The MCO must maintain documentation to support compliance with these standards and must submit documentation to LDH upon request
	Scheduling and Dispatching
	• Added language to indicate:
	  ○ The transportation broker shall make every effort to schedule urgent transportation requests and may not deny a request based solely on the appointment being scheduled less than 48 hours in advance
	  ○ Urgent transportation refers to a request for transportation made by a healthcare provider for a medical service which does not warrant emergency transport but cannot be postponed
	  ○ Urgent transportation shall include chemotherapy, radiation, dialysis, opioid treatment program (OTP), or other necessary medical care that cannot be rescheduled to a later time
	  ○ An urgent transportation request may occur concurrently with a standing order
	Additional Passengers
	• Added language to indicate the transportation broker shall prohibit ambulance providers from charging the beneficiary or anyone else for the transportation of additional passengers and shall not reimburse any claims submitted for transporting additional passengers
	Attendants
	• Added language to indicate:
	  ○ An attendant shall be required when the beneficiary is under the age of 17 years; this attendant must:
	    ▪ Be a parent, legal guardian, or responsible person designated by the parent/legal guardian
	    ▪ Be able to authorize medical treatment and care for the beneficiary
	  ○ Attendants may not:
	    ▪ Be under the age of 17 years
	    ▪ Be a Medicaid provider or employee of a Medicaid provider that is providing services to the beneficiary being transported, except for employees of a mental health facility in the event a beneficiary has been identified as being a danger to their self or to others or at risk for elopement
	  ○ All females, regardless of their age, seeking prenatal and/or postpartum care shall not be required to have an attendant
	Nursing Facility Ambulance Transportation
	• Added language to clarify NEAT services provided to a nursing facility beneficiary must include the Certification of Ambulance Transportation, *in accordance with the Coverage Requirements section [of the policy]*, to be reimbursable by Louisiana Medicaid; otherwise, the nursing facility shall be responsible for reimbursement for such services
	Applicable Codes
	• Added modifiers DJ, II, and JD
	• Updated coding clarification to indicate the provider shall be required to enter a valid 2-digit modifier at the end of the associated 5-digit procedure code when billing for HCPCS codes A0425-A0429, A0433-A0434, *and A0436* for ambulance transportation services
	Supporting Information
	• Updated *References* section to reflect the most current information
	• Archived previous policy version CS003LA.L

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Instructions for Use

This Medical Policy provides assistance in interpreting UnitedHealthcare standard benefit plans. When deciding coverage, the federal, state or contractual requirements for benefit plan coverage must be referenced as the terms of the federal, state or contractual requirements for benefit plan coverage may differ from the standard benefit plan. In the event of a conflict, the federal, state or contractual requirements for benefit plan coverage govern. Before using this guideline, please check the federal, state or contractual requirements for benefit plan coverage. UnitedHealthcare reserves the right to modify its Policies and Guidelines as necessary. This Medical Policy is provided for informational purposes. It does not constitute medical advice.

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