Ambulance

7.1 Enrollment ................................................................. 7-2
7.2 Reimbursement .......................................................... 7-2
7.3 Benefits and Limitations ................................................. 7-2
  7.3.1 Emergency Ground Ambulance Transportation .......... 7-3
  7.3.2 Nonemergency Ground Ambulance Transportation ........ 7-3
  7.3.3 Air Ambulance Transport Services ............................. 7-3
  7.3.4 Billing for Ambulance Services ................................. 7-3
7.4 Claims Information ..................................................... 7-4
7.1 Enrollment
To enroll in the CSHCN Services Program, ambulance providers must be actively enrolled in the Texas Medicaid Program, have a valid Provider Agreement with the CSHCN Services Program, have completed the CSHCN Services Program enrollment process, and comply with all applicable state laws and requirements.

A hospital-operated ambulance provider must enroll as an ambulance provider and submit claims using the ambulance provider identifier, not the hospital provider identifier.

Out-of-state ambulance and air ambulance providers must be located in the United States, within 50 miles of the Texas state border, and approved by the Department of State Health Services (DSHS). Ambulance and air ambulance providers must submit a copy of their permit/license from DSHS.

Refer to: Section 3.1, ‘Provider Enrollment,’ on page 3-2, for more detailed information about CSHCN Services Program provider enrollment procedures.

7.2 Reimbursement
Ambulance providers are reimbursed the lower of the billed amount or the amount allowed by the Texas Medicaid Program.

The ambulance provider is responsible for the integrity of the information about the client’s condition necessitating the transport and the medical necessity of the transport. The ambulance provider may be sanctioned, including exclusion from the CSHCN Services Program, for completing or signing a claim form that includes false or misleading representation of the client’s condition or of the medical necessity of the transport.

7.3 Benefits and Limitations
The CSHCN Services Program may reimburse emergency and nonemergency ground, and emergency air ambulance transportation for eligible clients. Procedure codes and descriptions on the claim are required to correspond to the circumstance at the time of service and are classified according to emergency or nonemergency categories.

The CSHCN Services Program does not reimburse for the return trip of an empty ambulance, for an ambulance call that does not result in transport, or for any other contingencies.

The CSHCN Services Program may reimburse for waiting time (procedure code 9-A0420) which may be billed up to one hour when it is the general billing practice of local ambulance companies to charge for unusual waiting time (over 30 minutes). The circumstances necessitating a wait time and the exact time involved must be documented on the claim form. The amount charged for waiting time must not exceed the charge for a one-way transport.

The CSHCN Services Program may reimburse for an extra attendant (procedure code 9-A0424). Reimbursement is limited to emergency ground transport, and documentation of medical necessity of advance life-support services must be provided on the claim. Only a quantity of one extra attendant is considered for reimbursement.

The CSHCN Services Program may reimburse for oxygen supplies (procedure code 9-A0422) separately from the established global fee for ambulance transport, and reimbursement is limited to one billable code per trip during emergency and nonemergency ambulance transports.

CSHCN Services Program may reimburse for disposable supplies (procedure code 9-A0382) separately from the established global fee for ambulance transport, and reimbursement is limited to one billable code per trip.

Specific procedure or diagnosis codes related to program benefits and coverage may be listed in sections that follow. These listings are intended to provide helpful information, but should not be considered all-inclusive. From time to time, codes are added, deleted, or revised. Coverage and coding information is updated in the CSHCN Provider Bulletin. Call the TMHP-CSHCN Contact Center at 1-800-568-2413 with questions about covered procedures or diagnosis codes.
The following Healthcare Common Procedure Coding System (HCPCS) codes are considered for reimbursement:

<table>
<thead>
<tr>
<th>Procedure Codes</th>
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<tbody>
<tr>
<td>9-A0382</td>
<td>9-A0420</td>
</tr>
<tr>
<td>9-A0425</td>
<td>9-A0429</td>
</tr>
<tr>
<td>9-A0425 with modifier ET</td>
<td>9-A0430</td>
</tr>
<tr>
<td>9-A0435</td>
<td>9-A0436</td>
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### 7.3.1 Emergency Ground Ambulance Transportation

An emergency is defined as the “sudden onset of a life-threatening situation in which a severe debilitating condition or death would result if immediate medical care is not provided.” When the condition of the client is life-threatening and requires use of special equipment, life support systems, and close monitoring by trained attendants while en route to the nearest appropriate facility, the ambulance transport is an emergency service.

When submitting ambulance claims for payment for emergency ground transportation, providers must submit HCPCS procedure codes 9-A0425 with modifier ET and 9-A0429. Ambulance providers must use an appropriate *International Classification of Diseases, Ninth Revision, Clinical Modification* (ICD-9-CM) diagnosis code on the claim form to document the client’s condition and reason for the transport. If a diagnosis is not known at the time of transport, providers must code based on physical signs and symptoms of the client.

### 7.3.2 Nonemergency Ground Ambulance Transportation

When the client has a medical problem requiring treatment in another location and he or she is so severely disabled that the use of an ambulance is the only appropriate means of transport, the ambulance transport is considered a nonemergency service. The definition of a severely disabled client is “one whose physical handicap limits their mobility to the extent that they must be transported by litter or requires life support systems, and an ambulance is the most appropriate means of transport.”

Nonemergency ambulance transport must be to or from a scheduled medical appointment at the nearest appropriate facility for medically necessary care that is approved by the CSHCN Services Program.

The client’s current medical condition requiring the nonemergency ambulance transport must be indicated clearly on the claim. When submitting claims for nonemergency ambulance transport, providers must use HCPCS procedure codes 9-A0425 and 9-A0428.

### 7.3.3 Air Ambulance Transport Services

CSHCN Services Program coverage for emergency air ambulance transport is limited to instances where the client’s pickup point is inaccessible by ground transport, or when great distance interferes with the immediate admission to a medical treatment facility appropriate for the client’s condition.

When submitting claims for air ambulance transport services, providers must use HCPCS procedure codes 9-A0430, 9-A0431, 9-A0435, and 9-A0436.

### 7.3.4 Billing for Ambulance Services

Claims for ambulance services must include the number of loaded miles traveled for more than the base rate to be paid. If mileage (procedure code 9-A0425) is not indicated on the claim, only the base rate (procedure code 9-A0429) may be reimbursed. The claim must show the service was an emergency to be paid at emergency rates. Providers should use modifier ET to indicate an emergency transport. If an emergency is not indicated on the claim, the claim is considered for payment at nonemergency rates.
7.4 Claims Information

Claims for ambulance services must be submitted to TMHP in an approved electronic format or on the CMS-1500 claim form. Run sheets, medical records, or emergency room records are not required to be submitted with the claim submission. Although run sheets are not required for submission of claims, providers must ensure that any documentation that substantiates the medical need for the transport is available to the CSHCN Services Program or its designee upon request.

Emergency ambulance claims must include the appropriate ICD-9-CM diagnosis code in Block 21 of the CMS-1500 claim form or electronic equivalent. Emergency ambulance claims submitted without the ICD-9-CM diagnosis code are denied. If the diagnosis is not known at the time of transport, providers must code based on the physical signs and symptoms of the client. For all ambulance claims, providers also must submit the following additional information with the claim for reimbursement consideration:

- Distance of transport
- Time of transport
- Acuity of client, origin/destination modifier, and relevant vital signs

For emergency and nonemergency claims, providers must enter data to support the necessity for the transport on the claim form. Providers billing electronically can use the Comments field and the Purpose of Stretcher field to enter data to support the necessity for an emergency or nonemergency transport. For providers billing on paper, relevant vital signs and narrative must be documented in Block 19 or 21 of the CMS-1500. When documenting the narrative, provide a detailed description. For nonemergency transports, the degree of disability or the client’s current medical condition requiring the transport must be indicated clearly on the claim. An emergency medical technician’s signature is required on all documentation submitted for the claim. Providers must submit one of the following modifiers to indicate the origin and destination of the transport.

<table>
<thead>
<tr>
<th>Ambulance Modifiers</th>
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<tbody>
<tr>
<td>DD  DE  DG  DH  DI  DJ  DN  DP</td>
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<tr>
<td>DR  DX  ED  EG  EH  EI  EJ  EN</td>
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<tr>
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<td>NX  PD  PE  PG  PH  PI  PJ  PN</td>
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<tr>
<td>PP  PR  PX  RD  RE  RG  RH  RI</td>
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<tr>
<td>RJ  RN  RP  RR  RX  SD  SG  SH</td>
</tr>
<tr>
<td>SI  SJ  SN  SP  SX</td>
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</tbody>
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 Providers may purchase CMS-1500 claim forms from the vendor of their choice. TMHP does not supply the forms.

When completing a CMS-1500 claim form, all pertinent information must be included on the claim, as information is not keyed from attachments. Superbills, or itemized statements, are not accepted as claim supplements.

Instructions for proper completion of claims are provided in Appendix B, “Forms and Form Examples.” Blocks within the claim forms that are not referenced are not required for processing by TMHP and may be left blank.