Ambulance Services - Medicaid

The 2 week comment period for the Ambulance Services – Medicaid policy ended May 25, 2022. During this period, HHSC received comments from stakeholders. A summary of comments relating to the proposed policy and HHSC's responses follow.

Policy Comment Responses

1. **Comment**: Multiple commenters supported the proposed policy and provided positive feedback for the inclusion of Emergency Triage, Treat and Transport (ET3) services as an expansion of the emergency ambulance services.

   Response: HHSC acknowledges this comment and appreciates the support.

2. **Comment**: Feedback was received from two stakeholders related to new language in the draft policy that lists 'Non medically necessary' as one of the potential scenarios an emergency team may encounter when arriving at the scene. The stakeholders expressed concerns the term might disincentivize EMS agencies from providing ET3 services even when it could be medically appropriate.

   Response: HHSC agrees to amend the policy language to remove 'Not medically necessary' as one of the listed potential scenarios emergency teams may encounter upon arrival on the scene. HHSC determined under ET3 services, beneficiaries who do not meet medical necessity for admission to an emergency department and who have conditions that are non-emergent but medically necessary may benefit from being transported to an alternative destination, or by receiving Treatment in Place (TIP). The amended language is in alignment with guidance from the Centers for Medicare & Medicaid Services (CMS).[1]

3. **Comment**: Two stakeholders provided feedback related to section 12.3 of the draft policy and requested to delete one of the requirements for transports to an alternative destination.

[1] https://innovation.cms.gov/innovation-models/et3/faq

Response: HHSC declines to amend policy language in response to this comment. The policy statement "There is no other appropriate transportation available" in section 12.3 of the policy is in alignment with the Texas Medicaid State Plan payment requirements for transportation which states that "Medical necessity is established when the recipient's condition is such that use of any other method of transportation is contraindicated and no other suitable transportation is available."[2]

4. **Comment**: Two commenters requested to add oxygen (procedure code A0422) to the list of reimbursable codes for TIP.

   Response: HHSC added policy language in response to this comment to clarify that procedure code A0422 may be reimbursed to ambulance providers for TIP services.

5. **Comment**: Two commenters requested to revise policy language referring to a client's condition determined to be 'non-emergent' and suggested replacing the term with 'low-acuity'.

   Response: HHSC acknowledges this comment; however, declines to make changes at this time. The term 'non-emergent' is appropriate and included in guidance provided by CMS related to ET3 services.[3]

6. **Comment**: One stakeholder expressed concerns with prior authorization (PA) requirements outlined in section 42.1 of the draft policy and requested for PA timelines not to be broadened to 180 days for nonemergency ambulance transports.

   Response: HHSC declines to revise policy language in response to this comment. The 180-day limit is a language-only policy update to align with requirements from Chapter 32 of the Human Resources Code (herein referred to as the Code), Section 32.024 (t)(3).[4] Authorizations for nonemergency transports that extend longer than 60 days are considered 'exception requests' for clients with debilitating conditions and in need of recurring trips. Requirements for '61-180 Day Exception Requests' are outlined in sections 47 through 49 of the Medicaid Ambulance Services Policy.

[2] Appendix 1 to Attachment 3.1 https://apps.hhs.texas.gov/documents/medicaid-chip-state-plan-attachments.pdf
[3] https://www.ems.gov/pdf/2013/EMS_Innovation_White_Paper-draft.pdf
[4] HUMAN RESOURCES CODE CHAPTER 32. MEDICAL ASSISTANCE PROGRAM (texas.gov)

7. **Comment:** A stakeholder requested confirmation that the required timelines to respond to a PA request are applicable only in fee-for-service (FFS) and managed care organizations (MCOs) may follow requirements as defined by other statutes and contracts.

   Response: HHSC acknowledges the comment. MCOs may follow PA guidelines in the policy or use their own guidelines, as long as those PA guidelines do not impact the services being provided in the same amount, duration and scope as traditional FFS Medicaid.

8. **Comment**: A commenter expressed concern Advanced Life Support (ALS) supply codes could be excessively billed with policy change, and asked HHSC to reconsider the limitations on ALS and Basic Life Support (BLS) supply codes to avoid potential incorrect use of ambulance supply code billing.

   Response: HHSC acknowledges the comment; however, HHSC declines to revise current limitations at this time. Reimbursement for BLS and ALS disposable supplies is separate from the established fee for ALS and BLS ambulance transports and is limited to one billable procedure code per transport.

   Requirements for the provision of ALS services and supplies are outlined in the 9 Texas Health and Safety Code, Chapter 773 – Emergency Medical Services.[5]. Ambulance providers must keep documentation supporting an ALS assessment by ALS personnel and that use of supplies was necessary because the client's reported condition at the time of dispatch was such that only an ALS crew was qualified to perform the assessment[6]. Providers are frequently reminded all ambulance services are subject to retrospective review, and recoupment if documentation does not support the service billed, or if policy requirements are not met.

9. **Comment**: A commenter suggested updating Table D of the draft policy to reflect the listed codes are origin or destination codes and not modifiers.

   Response: HHSC declines to revise Table D language at this time. Origin and destination codes are frequently called modifiers. While combinations of these items may duplicate other Healthcare Common Procedure Coding System (HCPCS) modifiers, when billed with an ambulance transportation code, the reported modifiers can only indicate origin/destination. Policy language is in alignment with CMS guidance specific to ambulance service

[5] https://statutes.capitol.texas.gov/Docs/HS/htm/HS.773.htm
[6] https://innovation.cms.gov/innovation-models/et3/faq#general

claims for the ET3 Model, which describes the new codes as "alpha character modifiers to be used in the destination position of the origin/destination modifier combination on the ET3 Model"[7].

10. **Comment**: A commenter proposed to revise Table D in policy with list of origin codes allowed for Treatment-in-Place and requested to remove 'Site of Transfer'.

    Response: After further review, HHSC amended Table D and removed IW (site of transfer) as a valid origin code for TIP to be submitted on ambulance claims.

11. **Comment**: A commenter expressed concern regarding updates in paragraph 100 of the draft policy and potential impacts on both emergency and nonemergency ambulance processes.

    Response: HHSC declines to revise policy language in response to this comment. While paragraph 100 of the policy states that certain procedure codes for ground ambulance transports must be billed with mileage, paragraph 101 clarifies that emergency ground ambulance transport codes 9-A0427 and 9-A0429 may be billed without mileage code for reimbursement of TIP, and also states providers must include TIP destination code 'W' on the claim, in the destination position of the origin/destination modifier combination.

12. **Comment**: A commenter asked if ET3 services can only be provided by a transport capable unit.

    Response: In response to this comment the following clarification is provided. In alignment with guidance provided by CMS, ET3 services are considered emergency transport. In order to bill at the ALS or BLS level, a provider must meet all licensing Emergency Medical Services requirements outlined in 25 Texas Administrative Code §157.11, including transportation by a ground ambulance vehicle.

13. **Comment**: A commenter asked if a "pre-established arrangement" could be accomplished by a real-time phone call to the physician office and upon their acceptance of the patient as a "walk-in" visit.

    Response: In response to this comment the following clarification is provided. It will depend on the ambulance company's protocols approved by

[7] https://www.cms.gov/files/document/origin-and-destination-codes-specific-ambulance-service-claims-and-emergency-triage-treat-and.pdf

their medical director if the scenario presented by the commenter is considered a "pre-established arrangement." The protocols usually have guidelines for when transports to a physician's office is acceptable. Transports to alternative destinations must be approved by the provider's medical director.

14. **Comment**: A stakeholder asked if a Texas Medicaid provider will be allowed to bill a telemedicine visit for services rendered as part of TIP scenario.

    Response: In response to this comment the following clarification is provided. Reimbursement may be considered for Medicaid-enrolled health care professionals who provide telemedicine or telehealth services in accordance with requirements and guidelines outlined in the Telecommunications Services Handbook.

15. **Comment**: One stakeholder recommended modifying the "run sheet" language and changing it to "patient care report."

    Response: HHSC declines to revise the policy in response to this comment. A run sheet is used as a medical record for ambulance services and may serve as a legal document to verify the care provided. This language is part of the Nonemergency Ambulance Transport section of the policy. Nonemergency transports are out of scope of this review.

16. **Comment**: A commenter asked if the level of services need to include a modifier to recognize availability of advanced medical authority/decision making through telemedicine consultation (Basic Life Support-Telemedicine to identify a Basic Life Support ambulance with real time video consultation capability with an APRN/MD/DO) or does this change the level of the ambulance?

    Response: In response to this comment the following clarification is provided. A modifier is not required to bill for TIP with a telemedicine or telehealth intervention. The ambulance provider will be reimbursed at the BLS or at the ALS1-E rate, depending on the level of service ambulance staff provide to the client. Requirements for levels of service are outlined in section 26 of our policy. Ambulance providers should have protocols in place with guidelines for BLS or ALS assessment and triage to telemedicine or telehealth. The healthcare professional providing telemedicine or telehealth services will be reimbursed for the evaluation and management services rendered.

17. **Comment**: A stakeholder inquired if Volume 2 of the Texas Medicaid Provider Procedures Manual (TMPPM) will be updated with guidance for

Medicaid-enrolled providers regarding TIP at the scene and TIP via telehealth.

Response: In response to this comment the following clarification is provided. Volume 2 of the TMPPM has been updated and the Ambulance Services Handbook includes guidance for ambulance providers on how to bill claims for TIP at the scene and TIP via telemedicine or telehealth.

18. **Comment:** A stakeholder suggested, for future reporting processes, to differentiate if a destination code is for a patient's existing primary care physician's office or for a new physician's office. The stakeholder further suggested the same should apply for community mental health centers and federally qualified health centers.

    Response: HHSC acknowledges the comment. Medicaid will not differentiate between new and existing patient providers. Texas is adopting destination codes developed and approved by CMS for billing and reimbursement of ET3 services. HHSC will continue to monitor CMS guidance and updates available to ET3 Model participants.

19. **Comment:** A commenter asked if a telemedicine provider qualifies as an extra attendant when providing direct oversight of care during transport.

    Response: In response to this comment the following clarification is provided. The use of an additional attendant must be related to extraordinary circumstances when the basic crew is unable to safely transport a client. Extra attendants must be certified by DSHS to provide emergency medical services.

20. **Comment**: A stakeholder suggested to require ambulance providers mandatory inclusion of code G2022 on the claim.

    Response: In response to this comment the following clarification is provided. If a beneficiary meets ET3 requirements but declines the services, ambulance providers may include procedure code G2022 on claims for ambulance transportation to an emergency department, to indicate a client's refusal to use ET3 services. Use of this informational procedure code is optional and does not affect reimbursement of the ambulance transport.

21. **Comment:** A stakeholder inquired about the scenario where a nursing home or a primary care physician's office call 911 instead of scheduling a transport and the ambulance crew decision is transporting the client to an alternate destination.

Response: In response to this comment the following clarification is provided. Ambulance providers responding to a 911 emergency call originated in a nursing home or physician's office should exercise their best standard of care in accordance with the provider's scope of practice, their emergency transport service's medical direction and established protocols. They must determine if the client's condition is an emergency and requires transport to an ED or if the condition is non-emergent but medically necessary and an alternative destination will meet the client's level of need more appropriately.

22. **Comment:** A stakeholder asked if the ET3 services apply to an individual discharged from a doctor's office following an alternate destination-based visit.

    Response: In response to this comment the following clarification is provided. ET3 services are provided in response to a 911 call, fire, police, or other locally established system for emergency calls. The scenario described does not meet requirements for ET3 services and the transport from the doctor's office should not be billed as an ET3 service.

23. **Comment:** A commenter questioned policy guidance related to modifier 'GY', used to indicate there was no medical necessity for a transport. The commenter also asked if TIP will be reimbursed even when a patient refuses treatment.

    Response: HHSC declines to revise policy language in response to the comment related to modifier GY. This review addresses ET3 services and section 'All Transports' in the policy is out of scope for this review. HHSC will take this feedback into consideration for a future review of the Medicaid Ambulance Services policy. With regard to the second question, ambulance providers may include procedure code G2022 on ambulance transportation claims to an emergency department that met ET3 requirements, when the patient refuses TIP or transportation to an alternative destination.

24. **Comment:** A commenter asked if ambulance providers will be reimbursed by simply converting a no-transport situation into a TIP scenario.

    Response: In response to this comment the following clarification is provided. In alignment with federal and state rules[8], Texas Medicaid requires an ambulance transport to be medically necessary in order for the service to be eligible for payment. As stated in paragraph #16 of the draft

[8] 42 C.F.R. § 410.40(e)

policy, TIP may be provided when a client's condition is determined to be medically necessary, but non-emergent.

25. **Comment:** A commenter provided information indicating Medicare provides a 15% night-time additional reimbursement via the "UJ" modifier for ET3 services.

    Response: HHSC acknowledges the comment.

26. **Comment:** A commenter stated when emergency triage services are rendered to Medicaid members by providers not enrolled in Texas Medicaid, the MCO is not able to reimburse the provider and Medicaid members may be at risk of being billed for services.

    Response: In response to this comment the following clarification is provided. ET3 services are considered emergency ambulance transportation services and requirements reside under the same rules (1TAC §354.1115)[9]. As such, to bill for ET3 services providers must be enrolled in Texas Medicaid as an ambulance provider. As stated in 1TAC §353.4 (c)[10] related to MCOs requirements concerning coverage for emergency services by out-of-network providers, an MCO may not refuse to reimburse an out-of-network provider for medically necessary emergency services. In addition, Volume 1 of the TMPPM, Provider Enrollment and Responsibilities, Section 1.7.11 states "A provider cannot require a down payment before providing Medicaid-allowable services to eligible clients, bill, nor take recourse against eligible clients for denied or reduced claims for services that are within the amount, duration, and scope of benefits of Texas Medicaid."[11]

[9] Texas Administrative Code (state.tx.us)
[10] Texas Administrative Code (state.tx.us)
[11] Texas Medicaid Provider Procedures Manual | TMHP