

Transportation, Fee-for-Service Table of Contents

John R. Kasich, Governor

John B. McCarthy, Director

Ohio Department of Medicaid

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Medical Assistance Letters

MAL 572 (Medicaid Reimbursement of Hospital-to-Hospital Transportation for Residents of Nursing Facilities)

Medical Assistance Letter (MAL) 572

November 8, 2010

TO: Providers of Ground Ambulance Services
Providers of Air Ambulance Services
Providers of Wheelchair Van ("Ambulette") Services
Directors, County Departments of Job and Family Services

FROM: Douglas E. Lumpkin, Director

SUBJECT: Medicaid Reimbursement of Hospital-to-Hospital Transportation for Residents of Nursing Facilities

Policy Clarification

As was previously noted in Medical Assistance Letter No. 560, under terms of Amended Substitute House Bill 1 (128th General Assembly), transportation is "bundled" into the services provided by a nursing facility (NF) to its Medicaid-eligible residents.

Transportation of a NF resident from one hospital to another, however, is not subject to this "bundling" policy. The decision to transfer a resident between hospitals is made solely by the hospitals; the NF has no role in it.

Therefore, for valid clean claims with dates of service August 1, 2009, or later that are submitted for interhospital transportation provided to NF residents, Medicaid will pay fee-for-service providers the appropriate reimbursement or cost-sharing amounts. (Hospital-to-hospital trips are represented on a claim by the modifier HH appended to a transportation procedure code.)

NFs remain responsible for payment, including cost-sharing amounts, for other transportation services provided to their residents from August 1, 2009, through August 17, 2009, and on or after October 1, 2009.

Access to Rules and Related Material

The Ohio Department of Job and Family Services maintains an "electronic manuals" web page of the department's rules, manuals, letters, forms, and handbooks. The URL for this "eManuals" page is <http://emanuals.odjfs.state.oh.us/emanuals/>.

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Additional Information

Questions pertaining to this MAL should be addressed to:

Office of Ohio Health Plans
Bureau of Provider Services

P.O. Box 1461
Columbus, OH 43216-1461
(800) 686-1516

MAL 562 (Community Provider Fee Decrease)

Medical Assistance Letter (MAL) 562

January 8, 2010

TO: All Eligible Ambulance and Ambulette Providers
Directors, County Departments of Job and Family Services

FROM: Douglas E. Lumpkin, Director

SUBJECT: Community Provider Fee Decrease

This letter provides information regarding the amendment of Ohio Administrative Code (OAC) rules 5101:3-1-60, 5101:3-4-21.2, 5101:3-5-02, 5101:3-5-04, 5101:3-10-05, 5101:3-10-26, 5101:3-12-05 and 5101:3-12-06. These rules are being amended to comply with provisions of Amended Substitute House Bill 1 which reduced expenditures to certain community providers by an aggregate amount of three percent effective for dates of service on and after January 1, 2010. Total annual savings as a result of these reductions are estimated at approximately \$19,736,109.

OAC rule [5101:3-1-60](#), entitled Medicaid Reimbursement, sets forth payment amounts for services provided by a number of different community provider types including: advance practice nurses, ambulance and ambulette providers, ambulatory health care clinics, ambulatory surgery centers, chiropractors, dentists, durable medical equipment suppliers, freestanding laboratories, independent diagnostic testing facilities, occupational therapists, opticians, optometrists, orthotists, physical therapists, physicians, podiatrists, portable x-ray suppliers, psychologists and prosthetists. The payment reductions affecting specific provider types reimbursed through this rule are outlined below.

Ambulance and ambulette providers bill and are reimbursed on the basis of Healthcare Common Procedural Coding System (HCPCS) codes. The reimbursement amount for each of the HCPCS codes billed by these providers has been reduced by three percent, resulting in annual savings of approximately \$1,098,661.

Ambulatory surgery centers bill and are reimbursed on the basis of nine surgical groupings. The reimbursement amount for each of these nine groupings has been reduced by three percent, resulting in annual savings of approximately \$82,260.

Chiropractors bill and are reimbursed on the basis of Current Procedural Terminology (CPT) codes. The reimbursement amount for each of the CPT codes billed by chiropractors has been reduced by three percent, resulting in annual savings of approximately \$16,339.

Durable Medical Equipment (DME) suppliers bill and are reimbursed on the basis of HCPCS codes. The reimbursement amount for each of the adult incontinent garment HCPCS codes has been reduced by 10 percent resulting in an annual savings of approximately \$1,253,824. The reimbursement amount for each of the HCPCS codes for orthotics and prosthetics has been reduced by three percent, resulting in annual savings of approximately \$335,717.

Freestanding laboratories bill and are reimbursed on the basis of both CPT and HCPCS codes. The reimbursement amount for each CPT and HCPCS code billed by freestanding laboratories has been reduced by three percent, resulting in annual savings of approximately \$569,824.

Therapy services including those provided by physical, occupational and speech therapists are billed and reimbursed on the basis of CPT codes. The reimbursement amount for each of the CPT codes billed by these practitioners has been reduced by three percent, resulting in annual savings of approximately \$388,099.

Vision services provided by opticians, optometrists and physicians are billed and reimbursed on the basis of CPT codes. The reimbursement amount for each of the CPT vision codes billed by these practitioners has been reduced by three percent, resulting in annual savings of approximately \$228,490.

In addition to the reductions identified above, the maximum amount Medicaid will reimburse for any CPT code (i.e., the ceiling price) has been reduced from 100 to 90 percent of the Medicare price. This reduction affects 606 CPT codes and results in annual savings of approximately \$4,430,541. These 606 codes represent 10 percent of the 5,836 CPT codes billable to and reimbursed by Ohio Medicaid. Four hundred forty-five (74 percent) of the 606 codes were surgical codes, 94 (16 percent) were radiology codes, and 67 (11 percent) were medicine codes, of which 37 (55 percent) were cardiovascular in nature.

Providers of physician services bill and are reimbursed for the developmental testing of young children using CPT codes. The reimbursement amount for targeted developmental screening codes has been increased by 10 percent, resulting in an annual increase of expenditures of approximately \$21,321.

Two unrelated changes are being made to the pricing in 5101:3-1-60 at this time to comply with recent findings by the Auditor of State. The reimbursement amount for HCPCS code E0305, bed side rails, is being decreased from \$185.02 to \$185.01. The reimbursement amount for HCPCS code E2366, wheelchair battery charger, is being increased from \$202.00 to \$210.90. The impact of these changes on annual expenditures will be negligible.

OAC rule [5101:3-4-21.2](#), entitled Anesthesia Conversion Factors, sets forth payment amounts for services provided by anesthesiologists, anesthesia assistants and certified registered nurse anesthetists. These providers bill and are reimbursed on the basis of modifiers and conversion factors applied to CPT codes. The reimbursement rate for each of the conversion factors has been reduced by three percent, resulting in an annual savings of approximately \$194,457.

OAC rule [5101:3-5-02](#), entitled Dental Program: Covered Diagnostic Services and Limitations, sets forth the coverage criteria for oral examinations and diagnostic imaging in the dental program. Covered periodic oral examinations for adults age 21 years and older have been reduced from one every one hundred eighty days to one every 365 days, resulting in an annual savings of approximately \$200,946.

OAC rule [5101:3-5-04](#), entitled Dental Program: Covered Preventive Services and Limitations, sets forth the coverage criteria for preventive services in the dental program. Covered dental prophylaxis for adults age 21 years and older has been reduced from one every one hundred eighty days to one every 365 days, resulting in an annual savings of approximately \$491,720.

OAC rule [5101:3-10-05](#), entitled Reimbursement for Covered Services, sets forth among other things the manner in which providers may bill and be reimbursed for DME. Some DME items are not reimbursed according to the prices listed in 5101:3-1-60 but are instead reimbursed at the lesser of the provider's usual and customary charge or 75 percent of the list price presented to the department. This reimbursement level has been reduced by three percent, to 72 percent of the list price. When no list price is presented to the department, DME items are reimbursed at the lesser of the provider's usual and customary charge or one hundred fifty percent of the provider's invoice price less any discounts or applicable rebates. This reimbursement level has been reduced by three percent, to one hundred forty-seven per cent of the invoice price. These reductions in the percents paid of list and invoice prices are estimated to result in annual savings of approximately \$272,067.

OAC rule [3-10-26](#), entitled Enteral Nutritional Products, sets forth coverage criteria and reimbursement policies for enteral nutrition products. Some enteral nutrition products are not reimbursed according to the prices listed in 5101:3-1-60 but are instead reimbursed at the supplier's average wholesale price minus twenty percent. This figure has been reduced to minus twenty-three percent of the supplier's average wholesale price, resulting in annual savings of approximately \$285,921.

OAC rule [5101:3-12-05](#), entitled Reimbursement: Home Health Services, sets forth payment amounts for home health nursing, home health nursing aide, physical therapy, occupational therapy, and speech-language pathology. Home health service providers bill and are reimbursed on the basis of HCPCS codes. The reimbursement rate for each of these codes has been reduced by three percent, resulting in an annual savings of approximately \$5,676,688.

OAC rule [5101:3-12-06](#), entitled Reimbursement: Private Duty Nursing Services, sets forth payment amounts for private duty nurses. Private duty nurses bill and are reimbursed using a single HCPCS code. The

reimbursement amount for this code has been reduced by three percent, resulting in an annual savings of approximately \$4,231,876.

Web Page:

The Ohio Department of Job and Family Services maintains an "electronic manuals" web page of the department's rules, manuals, letters, forms, and handbooks. The URL for this "eManuals" page is <http://emanuals.odjfs.state.oh.us/emanuals/>.

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- (1) Selecting the "Ohio Health Plans - Provider" folder;
- (2) Selecting the appropriate service provider type or handbook;
- (3) Selecting the "Table of Contents";
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Most current Medicaid maximum reimbursement rates are listed in rule [5101:3-1-60](#) or in Appendix DD to that rule. Providers may view these rates by:

- (1) Selecting the "Ohio Health Plans - Provider" folder;
- (2) Selecting "General Information for Medicaid Providers";
- (3) Selecting "General Information for Medicaid Providers (Rules)";
- (4) Selecting "5101:3-1-60 Medicaid Reimbursement" from the "Table of Contents" pull-down menu.

The Legal/Policy Central - Calendar site (<http://www.odjfs.state.oh.us/lpc/calendar/>) is a quick reference for finding documents that have recently been published. This site also provides a link to a listing of ODJFS manual transmittal letters (<http://www.odjfs.state.oh.us/lpc/mtl/>). The listing is categorized by letter number and subject, and a link is provided to each easy-print (PDF) document.

To receive electronic notification when new Medicaid transmittal letters are published, subscribe at: <http://www.odjfs.state.oh.us/subscribe/>.

Questions:

Questions pertaining to this letter should be addressed to:

Ohio Department of Job and Family Services
Office of Ohio Health Plans, Bureau of Provider Services
P.O. Box 1461
Columbus, OH 43216-1461
Telephone 800-686-1516

MAL 560

Medical Assistance Letter (MAL) No. 560

October 30, 2009

TO: Providers of Ground Ambulance Services
Providers of Air Ambulance Services
Providers of Wheelchair Van ("Ambulette") Services
Directors, County Departments of Job and Family Services

FROM: Douglas E. Lumpkin, Director

SUBJECT: Changes in Medicaid Reimbursement of Transportation Services

Rule Changes

Because of Amended Substitute House Bill 1 (128th General Assembly), rule [5101:3-15-02.8](#), titled *Medical transportation services: eligible providers*, has been amended to specify that the provision of transportation services to residents of a nursing facility (NF) is the responsibility of the NF and is reimbursed through an additional per diem payment. Unless otherwise noted, changes to this rule became effective on August 1, 2009.

Am. Sub. H.B. 1 has changed how Medicaid will reimburse some services provided to NF residents, such as oxygen, custom wheelchairs, therapies (physical, occupational, and speech language pathology/audiology), medically-related transportation, and some over-the-counter drugs. These services were previously provided by, and reimbursed to, fee-for-service providers. Under terms of Am. Sub. H.B. 1, NFs are now responsible for providing these services to Medicaid NF residents, for which they will be reimbursed through an additional per diem payment. Making NFs responsible for providing these services to Medicaid NF residents provides opportunities for improved coordination of services received by NF residents and creates incentives for more effective use of health care expenditures.

As a result of various court decisions, however, clean claims submitted to Medicaid for transportation provided to NF residents with dates of service from August 18, 2009, through September 30, 2009, will be paid by Medicaid; cost-sharing amounts for transportation provided on these dates of service will also be paid by Medicaid. NFs are responsible for payment for transportation services provided to their residents, including cost-sharing amounts, for dates of service from August 1, 2009, through August 17, 2009, and on or after October 1, 2009.

Access to Rules and Related Material

The Ohio Department of Job and Family Services maintains an "electronic manuals" web page of the department's rules, manuals, letters, forms, and handbooks. The URL for this "eManuals" page is <http://emanuals.odjfs.state.oh.us/emanuals/>.

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- (2) Select the appropriate subfolder (e.g., 'Transportation, Fee-for-Service').
- (3) Select the appropriate topic (e.g., Transportation, 'Fee-for-Service Rules' or 'Medical Assistance Letters') from the document list.
- (4) Select the desired item from the 'Table of Contents' pull-down menu.

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Additional Information

Questions pertaining to this MAL should be addressed to:

Office of Ohio Health Plans
Bureau of Provider Services
P.O. Box 1461
Columbus, OH 43216-1461
800-686-1516

MAL 538

Medical Assistance Letter (MAL) No. 538

June 27, 2008

To: Providers of Ground Ambulance Services
Providers of Air Ambulance Services
Providers of Ambulette Services
Directors, County Departments of Job and Family Services
Medical Assistance Coordinators

From: Helen E. Jones-Kelley, Director

Subject: Changes in Medicaid Maximum Reimbursement Amounts for Ambulance and Ambulette Services

This Medical Assistance Letter (MAL) transmits rule 5101:3-15-04, *Medical transportation services: reimbursement*, and it announces changes in Medicaid maximum reimbursement amounts for ambulance and ambulette services. These changes will affect 15 procedure codes:

- A0130 - Transport by wheelchair-accessible vehicle
- A0424 - Attendant, ambulance
- A0425 - Mileage, ground ambulance
- A0426 - Advanced life support, level 1, non-emergency
- A0427 - Advanced life support, level 1, emergency
- A0428 - Basic life support, non-emergency
- A0429 - Basic life support, emergency
- A0430 - Fixed-wing ambulance
- A0431 - Rotary-wing ambulance
- A0433 - Advanced life support, level 2
- A0434 - Specialty care transport
- A0435 - Mileage, fixed-wing ambulance
- A0436 - Mileage, rotary-wing ambulance
- S0209 - Mileage, wheelchair-accessible vehicle
- T2001 - Attendant, wheelchair-accessible vehicle

Three major modifications are being made to rule 5101:3-15-04:

1. The text is being reorganized and streamlined.
2. A provision explicitly covering attendant services, which had previously been omitted, is being added.
3. The basis for mileage reimbursement is being changed from a tiered scale to a fixed amount per mile.

For claims with dates of service on or after July 1, 2008, the Medicaid maximum reimbursement amounts for all 15 procedure codes will each increase by three percent (3%). The new amounts will be listed in Appendix DD to rule 5101:3-1-60 of the Ohio Administrative Code.

Providers will receive one printed copy of this transmittal letter and an accompanying JFS 03400, "Ohio Department of Job and Family Services, Service Provider Update Request Form." Providers may request a

second printed copy of this letter and a copy of rule 5101:3-15-04 by completing the JFS 03400 and returning it to the Ohio Department of Job and Family Services in accordance with the instructions at the top of the form.

Information related to ambulance and ambulette services (such as ODJFS transmittal letters, rules, and forms) may also be viewed online at the ODJFS "electronic manuals" web page, <http://emanuals.odjfs.state.oh.us/emanuals/>, by:

- (1) Selecting "Ohio Health Plans - Provider";
- (2) Selecting "Next Page";
- (3) Selecting "Transportation, Fee-for-Service"; and
- (4) Selecting the desired item from the "Table of Contents" pull-down menu.

Questions pertaining to this MAL should be addressed to:

Office of Ohio Health Plans

Provider Services Section

P.O. Box 1461

Columbus, Ohio 43215-1461

Toll-Free Telephone Number (800) 686-1516

MAL 532

Medical Assistance Letter No 532 (June 7, 2007 - Information Providers Must Know about the National Provider Identifier (NPI) in Order to Get Paid), is maintained in the Ambulatory Surgery Center Services e-book.

[Click here to view MAL 532, Information Providers Must Know about the National Provider Identifier \(NPI\) in Order to Get Paid.](#)

MAL 522

Medical Assistance Letter No 522 (August 14, 2007 - Guidance on the Implementation of Employee Education about False Claims Recovery as provided in MAL 516), is maintained in the General Information e-book.

[Click here to view MAL 522, August, 2007 - Guidance on the Implementation of Employee Education about False Claims Recovery as provided in MAL 516.](#)

MAL 516

Medical Assistance Letter No 516 (November 9, 2006 - Employee Education About False Claims Recovery), is maintained in the General Information e-book.

[Click here to view MAL 516, Employee Education About False Claims Recovery.](#)

MAL 502

Medical Assistance Letter (MAL) No. 502

July 18, 2006

To: Providers of Medical Transportation
Directors, County Department of Job and Family Services
Medical Assistance Coordinators (MACs)

From: Barbara E. Riley, Director

Subject: Ambulette Licensure

This Medical Assistance Letter (MAL) is to remind providers of state plan Medicaid ambulette service of the requirements to comply with licensure and the consequences for being non-compliant. Ambulette providers must be licensed by the Ohio Medical Transportation Board (hereafter referred to as Board) in accordance with Chapter 4766. of the Revised Code unless they qualify for exemption as determined by the Board.

Medicaid providers have signed a provider agreement and have agreed to comply with the provider agreement, Ohio Revised Code, Ohio Administrative Code, and federal statutes and rules. In addition, medical transportation providers are to render services in accordance with Chapter 5101:3-15 of the Administrative Code and are to operate in accordance with all applicable local, state, and federal laws and regulations, including any applicable requirements developed by the Board under Chapter 4766. of the Revised Code.

Since the licensure requirements went into effect the Department has worked with the Board to identify non-compliant providers. Providers identified as non-compliant with the licensure requirements will cause ODJFS to begin the process of termination of the provider agreement pursuant to Chapter 119. of the Revised Code. Non-compliant providers will also have claims placed in prepayment review status requiring claims to be supported by licensure for the date of service in order to be paid.

A non-compliant provider that subsequently obtains licensure from the Board will be considered compliant on the date licensure is granted. Services rendered during the time period of non-compliance with the licensure requirements are not reimbursable by Medicaid.

The Ohio Department of Job and Family Services values the service and commitment that the providers of medical transportation provide to Medicaid consumers. The licensure for state plan Medicaid providers of ambulette services will ensure that Medicaid consumers continue to receive quality care, have access to transportation and attention to safety.

Web Page:

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- (2) Select "Transportation Services."
- (3) From the drop-down menu "Table of Contents" at the top of the page, scroll to and select the desired MAL number.

Questions pertaining to this MAL should be addressed to:

Bureau of Plan Operations
Provider Network Management Section
P.O. Box 1461

Columbus, OH 43216-1461

In-State toll free number: 1-800-686-1516

MAL 500

Medical Assistance Letter (MAL) No. 500

March 3, 2006

TO: All Medical Transportation Providers
Directors, County Departments of Job and Family Services
Medical Assistance Coordinators

FROM: Barbara E. Riley, Director

SUBJECT: Medical Transportation Services

The purpose of this Medical Assistance Letter (MAL) is to notify medical transportation service providers that new rules 5101:3-15-01, 5101:3-15-02, 5101:3-15-02.8, 5101:15-03 and 5101:3-15-04 were filed on an emergency basis effective December 30, 2005.

The new rules replace rules with the same rule numbers that were rescinded on an emergency basis effective December 30, 2005 because they had an expiration date of December 31, 2005. The new rules were adopted so that the existing provisions for medical transportation services will continue without interruption. The rules were proposed for permanent adoption on January 10, 2006, with an intended effective date of March 27, 2006.

The updates that are announced in this Medical Assistance Letter (MAL) can be found on our website at <http://emanuals.odjfs.state.oh.us/emanuals/medicaid> in Transportation Services.

Questions pertaining to this MAL should be addressed to:

Bureau of Plan Operations
Provider Network Management Section
P.O. Box 1461
Columbus, OH 43216-1461
In-State toll free number: 1-800-686-1516

MAL 493

Medical Assistance Letter No. 493

December 27, 2005

To: All Providers of Medical Transportation
Medical Assistance Coordinators

FROM: Barbara E. Riley, Director

SUBJECT: Ground Ambulance use as Ambulette

The purpose of this Medical Assistance Letter (MAL) is to announce to providers of medical transportation the continuation of rule 5101:3-15-05, entitled Medical transportation services: ambulette services provided by ground ambulance vehicles. The rule was set to expire December 31, 2005. After review, the Ohio Department of Job and Family Services determined to continue the rule allowing ground ambulance to provide ambulette services.

This information has been posted to the department's web site at <http://emanuals.odjfs.state.oh.us/emanuals/medicaid> in Transportation Services

Questions pertaining to this MAL should be addressed to:

Bureau of Plan Operations
The Provider Network Management Section
P.O. Box 1461
Columbus, Ohio 43216
In-state toll free telephone number 1-800-686-1516

MAL 484

Medical Assistance Letter (MAL) No. 484

July 29, 2005

TO: All Transportation Providers
Directors, County Departments of Job and Family Services
Medical Assistance Coordinators

FROM: Barbara E. Riley, Director

SUBJECT: Transportation Billing Procedures

The purpose of this Medical Assistance Letter (MAL) is to notify Transportation providers of billing procedures.

Effective August 1, 2005, The department will no longer be accepting the JFS 06780 for claims to transportation services. Previous [MAL 457](#) notified providers of the transition from the JFS 06780 to the CMS 1500 claim form. Providers must use the CMS 1500 claim form and can see section [BIN.1001](#) of the Ohio Medicaid Provider Handbook for instructions on how the form is to be completed.

The updates that are announced in this Medical Assistance Letter (MAL) can be found on our website at <http://emanuals.odjfs.state.oh.us/emanuals/medicaid> in Transportation Services.

Questions pertaining to this MAL should be addressed to:

Bureau of Plan Operations
Provider Network Management Section
P.O. Box 1461
Columbus, OH 43216-1461
In-State toll free number: 1-800-686-1516

MAL 457A

Medical Assistance Letter (MAL) No. 457-A

December 14, 2004

TO: All Providers of Transportation Services
Trading Partners
Medical Assistance Coordinators

FROM: Thomas J. Hayes, Director

SUBJECT: Transportation Services Billing Update: Time of Transport

The purpose of this Medical Assistance Letter (MAL) is to clarify billing instructions that were transmitted in MAL 457 to transportation providers and trading partners (vendors) who bill on behalf of providers. Currently transportation providers or trading partners may use the JFS 06780, the NSF tape format, the CMS 1500, or the electronic data interchange (EDI) using the 837P format to bill for transportation services. The clarification transmitted in this letter **MUST** be used by transportation providers or trading partners who bill on the CMS 1500 or the EDI 837P format to be reimbursed.

As the department began the implementation of the EDI 837P format, it came to our attention that there are no fields for "time of transport" on either the CMS 1500 paper claim form or on the 837P for claims submitted through EDI. This has caused claims to deny as duplicates when a patient is transported twice in the same day to the same destination setting and back.. Once two round trips are billed for the same procedure codes(s) and modifier(s) are billed for the same date of service on different claims, the system will always deny the second claim as a duplicate. To avoid denial of such claims, providers or their trading partners who bill using the 837P format must bill all eight line items on the same claim. Since the CMS 1500 cannot accommodate eight lines (i.e., when same procedure codes and modifiers are submitted on two separate claims), providers, or their trading partners, who use this form must bill both of the "to" trips on one claim form and both of the "return" trips on a second claim form.

The second page of this MAL contains an example of this situation and how it should be billed.

Example:

A consumer is transported from a residence to a physician's office by ambulette in the morning and then returned home. In the afternoon, the same consumer has another appointment with a physician and the trip is repeated.

Billing EDI (837P Format):

If billing EDI 837P format, the ambulette provider (or trading partner) in the example above would bill the following codes and modifiers on the **same** 837P claim as shown below:

A0130 PR
S0209 PR
A0130 RP
S0209 RP
A0130 PR
S0209 PR
A0130 RP
S0209 RP

Billing on a CMS 1500 Paper Form:

If billing on a CMS 1500 paper form, the ambulette provider (or trading partner) in the example above must bill both of the "to" trips on one claim form and both of the "return" trips on a second claim form as shown below:

Claim One	Claim Two
A0130 PR	A0130 RP
S0209 PR	S0209 RP
A0130 PR	A0130 RP
S0209 PR	S0209 RP

Adjustment for Previously Denied Claims

If a provider has had a claim denied as a duplicate for a legitimate second trip, an adjustment may be requested by submitting a copy of the applicable remittance advices along with a completed adjustment request form (JFS 06767).

Questions pertaining to this MAL should be addressed to:

The Bureau of Plan Operations
Provider Network Management Section
P.O. Box 1461
Columbus, Ohio 43216-1461
Toll-free number: 1-800-686-1516

MAL 457

Medical Assistance Letter (MAL) No. 457

October 16, 2003

TO: All Providers of Transportation Services
Directors, County Departments of Human Services
Medical Assistance Coordinators

FROM: Thomas J. Hayes, Director

SUBJECT: Medicaid Rules For Transportation Services

ALL TRANSPORTATION CHANGES ARE EFFECTIVE OCTOBER 1, 2003

The department has updated the transportation rules, chapter 5101:3-15 of the Ohio Administrative Code, to become compliant with the provisions of the Health Insurance Portability and Accountability Act (HIPAA). In addition to becoming HIPAA compliant, changes in policy were made with the input of various internal and external stakeholders and professional associations.

New/Revised Forms to Certify Medical Necessity of Transportation

The department has revised the form, JFS 03452 and renamed it, Ambulette Certification of Medical Necessity, and has created a new form JFS 01960 titled, Ambulance Certification of Medical Necessity. These forms are required for practitioner certification of medical necessity for ambulette and ambulance transport (see attached). The forms have been revised or created to ensure consistency with revisions to documentation requirements in transportation rule 5101:3-15-02, which is discussed in this Medical Assistance Letter. Both forms will be effective October 1, 2003. Both forms are reproduced by the provider and will not be available from the warehouse.

Medical Transportation HIPAA Compliance

HIPAA requires the use of standard code sets. These code sets include the AMA CPT coding system and the Health Care Procedural Coding System (HCPCS). As a result local level codes for transportation services must be eliminated. The following table identifies the current local level codes and the crosswalk to the new codes/modifiers to be used beginning October 1, 2003.

Local Level Code to HIPAA Compliant Codes/Modifiers Crosswalk

Local Level Code to HIPAA Compliant Codes/Modifiers Crosswalk *This table only includes transportation codes that are affected by HIPAA requirements.	
Current Local Level Code	New Code/Modifier (Effective Oct. 1, 2003)
Z0160 - Ambulette/Wheelchair, Loaded Mileage	S0209 - WC van mileage per mi
Z0040 - Extra Attendant for Ambulette/Ambulance	T2001 - Non-emergency transportation attendant/escort.
Z0040 - Extra Attendant for Ambulette/Ambulance	A0424 -Extra ambulance attendant, ground (ALS or BLS) or air (fixed or rotary winged)
Z0050 - Ambulette Second Passenger	A0130 - Ambulette services with U1, second passenger, modifier

Z0051 - Ambulette Three or More Passengers	A0130 - Ambulette services with U2, three or more passengers, modifier
Z0060 - BLS Non-Emer., Second Passenger	A0428 - BLS non-emergency with U1, second passenger, modifier
Z0061 - BLS Non-Emer, Three or More Passengers	A0428 - BLS non-emergency with U2, three or more passengers, modifier
Z0070 - BLS Emergency, Second Passenger	A0429 - BLS emergency with U1, second passenger, modifier
Z0071 -BLS Emergency, Three or More Passengers	A0429 - BLS emergency with U2, three or more passengers, modifier
Z0080 - ALS, Emergency Second Passenger	A0427 - ALS level 1 with U1, second passenger, modifier
Z0081 - ALS, Emergency, Three or More Passengers	A0427 - ALS level 1 with U2, three or more passengers, modifier
<p>Note: The U1, second passenger, and U2, three or more passengers, modifiers must also be used with A0433 - ALS level 2, A0434 - Specialty Care Transport (SCT), A0430 - Fixed Wing Air Ambulance, and A0431 - Rotary Wing Air Ambulance when multiple passengers are being transported.</p>	
<p>Note: In addition to the coding changes the following modifiers were added:</p> <ul style="list-style-type: none"> * "I" or site of transfer was added as a possible origin/destination for the point of transport modifiers. (Rule 5101:3-15-03(D)) * "U3", ambulette service by ambulance vehicle (Rule 5101:3-15-05(C)) * "U4", origin is school or work (Rule 5101:3-15-03(D)) * "U5", origin/destination is not otherwise specified (Rule 5101:3-15-03(D)) * "U6", service unavailable/cancelled (Rule 5101:3-15-03(D)) * "U7", destination is school or work (Rule 5101:3-15-03(D)) 	

Policy Clarifications and Updates

In addition to the changes required by HIPAA, policy clarifications and updates were made to the transportation rules (please see attached). Some of the changes were wording changes or minor in nature others were more substantial and are outlined below. The following summary of changes is intended as a quick reference, not a substitute for review of the actual rule, which may include additional language and details not listed below.

5101: 3-15-01

- The following definitions for Medicaid-covered destination, loaded mileage and non-ambulatory were revised.
- The definitions for practitioner certification form, medical transportation provider and pilot were added.

5101: 3-15-02

- Language revised to allow any new developments occurring in Chapter 4650 or 4766 of the Revised Code to supersede our rules.
- A driving record for Ambulance and Ambulette drivers cannot have more than six points.

- Current employees of Ambulette providers must have a first aid card, CPR certificate or EMT certificate available for inspection upon request to ODJFS. The provider must maintain copies of these on file.
- Ambulette driver's I.D. may now include a unique identifier instead of the driver's name.
- Ambulette providers who are in the process of becoming an enrolled provider cannot hire applicants on a temporary provisional basis.
- Self-insurance coverage has been deleted as an option for providers of Ambulette services.
- Basic vehicle requirements and provider qualifications for air ambulance were added.
- The form's requirements were revised to include a hospital discharge planner and revised the time period for temporary non-ambulatory patients.

5101: 3-15-02.8

- This rule is new and clarifies the eligibility requirements for providers of ambulette and ambulance and air ambulance. It requires that by January 1, 2006 that all providers must own at least one vehicle in order to qualify as a provider of that type of service.

5101: 3-15-03

- Most revisions in this rule were made to be compliant with HIPAA requirements.
- Emergency transport is medically necessary when transport to a Trauma Center is required.
- Multiple passenger modifiers, point of transport modifier and a modifier to use when a Medicaid service was unavailable/cancelled were added.
- Policy was added to allow reimbursement of transportation services, which were rendered, but upon arrival at the destination it was discovered that the appointment had been cancelled.
- Ambulette providers must now document the reason for transport when the destination occurs outside of the patient's community or else the mileage over 50 miles will not be covered.
- Medical necessity criteria were changed for non-emergency ambulance services. Non-emergency ambulance services are considered medically necessary when the individual does not meet any other medical necessity criteria in the rule but requires oxygen administration during the transport and the patient is unable to self-administer or self regulate the oxygen, or the patient requiring oxygen administration has been discharged.
- Prior authorization for non-emergency ambulance transports was eliminated for the Medicaid covered points of transport unless the point of transport is not otherwise specified or is an unusual circumstance.
- Basic crew for Air Ambulance was changed to require a registered nurse as one of the crew and to add other health professionals as the second member of the crew.

5101: 3-15-04

- Multiple revisions in this rule to allow for U1, second passenger, and U2, three or more passengers, modifiers. These modifiers reduce transportation provider reimbursement to fifty percent for the second passenger and twenty-five percent for each passenger over two of the Medicaid maximum base rate. The reimbursement for multiple passenger transport is not a policy change, but a coding change.

5101: 3-15-05

- This rule was added to allow ambulette services provided by ground ambulance vehicles to be reimbursed. The modifier, U3, will be required.

Billing Updates

The department is phasing out the JFS 06780 claim form for transportation services. You may begin transitioning to the CMS 1500 claim form on October 16, 2003. Providers should see section BIN.1001. of the Ohio Medicaid Provider Handbook for instructions on completing the CMS 1500 claim form (see attached). ODJFS will notify providers in 2004 of the last day they may submit a JFS 06780 claim form.

Up to four modifiers can be billed per claim line item beginning October 1, 2003. Please note that in certain circumstances multiple modifiers may be required to receive reimbursement for medical transportation services. Please note that providers who submit paper claims must use the CMS 1500 anytime they bill for multiple modifiers because JFS 06780 paper claim form cannot be used for billing multiple modifiers. In

addition, when billing for an attendant, providers should **not** use modifiers or the line item will deny. The claim line item for attendants will be paid without any modifiers.

To obtain a copy of the rules and future program updates:

The rules that are announced in this Medical Assistance Letter (MAL) can be found at on our website at: <http://dynaweb.odjfs.state.oh.us:6336/dynaweb/medicaid> or if you do not have internet access you may request a paper copy of the rules by completing the attached JFS 03400. If you have received **ONLY** a paper copy of this MAL and you wish to be notified in the future by e-mail of program updates the week that they are published, please send an email to: provider_subscribe@odjfs.state.oh.us and include your provider number.

Questions pertaining to this MAL should be addressed to:

The Bureau of Plan Operations
Provider Network Management Section
P.O. Box 1461
Columbus, Ohio 43216-1461

In-State: 1-800-686-6108 (toll-free) or (614) 728-3288 or Out-of-State:(614) 728-3288

Transportation, Fee-for-Service Rules

MAL 500

Effective Date: March 27, 2006

(A) The following definitions are applicable to this chapter

- (1) "Advanced life support services" (ALS) are defined as those services which are beyond the scope of services that may be provided by EMT-basic and within the scope of practice of an EMT-intermediate or a paramedic in accordance with Chapter 4765. of the Revised Code.
- (2) "Air ambulance" is defined as an air ambulance vehicle that is equipped and staffed to handle the transport of a patient whose condition meets the criteria for transport via air ambulance specified in paragraph (C) of rule 5101:3-15-03 of the Administrative Code.
- (3) "Ambulance, land ambulance, or ground ambulance" is defined as a vehicle that is designed to transport individuals in a supine position and meets the standards and license requirements specified in Chapter 4766. of the Revised Code.
- (4) "Ambulette" is defined as a vehicle that is designed to transport individuals sitting in wheelchairs and meets standards specified in rule 5101:3-15-02 of the Administrative Code.
- (5) "Attendant" is defined as an individual employed by the transportation provider separate from the basic crew of the ambulance or ambulette vehicle who meets the qualifications specified in paragraph (B)(2) of rule 5101:3-15-02 of the Administrative Code for ambulance and paragraph (C)(3) of rule 5101:3-15-02 of the Administrative Code for ambulette and is present to aid in the transfer of medicaid covered patients who meet the criteria for transport specified in rule 5101:3-15-03 of the Administrative Code.
- (6) "Attending practitioner" is defined as the practitioner (i.e., primary care practitioner or specialist) who provides care and treatment to the patient on an ongoing basis and who can certify the medical necessity for the transport. The attending practitioner is responsible for the ongoing care and management of the patient and can certify the non-ambulatory status of the patient and the medical need for ambulance or ambulette transport, the type of certification, and length of time the non-ambulatory status will remain unchanged. Attending practitioner also refers to a designated practitioner who is covering for the attending practitioner in his or her absence or a practitioner who is a member of the same group practice as the attending practitioner and in which it is customary for the members of the practice to cross cover for each other's patients. Practitioners must hold a valid and current license or certification to practice as at least one of the following:
 - (a) A doctor of medicine;
 - (b) A doctor of osteopathy;
 - (c) A doctor of podiatric medicine; or
 - (d) An advanced practice nurse (APN).
- (7) "Basic crew" is defined as the minimum necessary staff members for each type of transport as set forth in rule 5101:3-15-03 of the Administrative Code and section 4765.43 of the Revised Code.
- (8) "Basic life support services" (BLS) are defined as those services which are in the scope of services of an emergency medical technician-basic as set forth under section 4765.37 of the Revised Code.
- (9) "Covered medical transportation services" are defined as those transports covered in accordance with rule 5101:3-15-03 of the Administrative Code.

- (10) "Dispatcher" is defined as an individual employed by the transportation provider to set the schedule of transportation runs for the ambulette and/or ambulance vehicles.
- (11) "Driver" is defined as an individual employed by the transportation provider as part of the basic crew to drive the ambulette or ambulance vehicle to the medicaid covered point(s) of transport and who meets the qualifications specified in paragraph (B)(2) of rule 5101:3-15-02 of the Administrative Code for ambulance and paragraph (C)(3) of rule 5101:3-15-02 of the Administrative Code for ambulette.
- (12) "Emergency service" is a service that is provided after the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity that in the absence of immediate medical attention could reasonably be expected to result in placing the patient's health in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part.
- (13) "Emergency medical technician" (EMT) is defined as an individual who holds a current, valid certificate as an emergency medical technician issued under section 4765.30 of the Revised Code.
- (14) "Loaded mileage" is defined as the number of miles a patient is transported in the ambulance or ambulette to or from a medicaid covered service. Air ambulance mileage is statute miles.
- (15) "Long term care facility" is defined as an intermediate care facility for the mentally retarded (ICF-MR) and/or a nursing facility (NF) as defined in paragraphs (N) and (Q) of rule 5101:3-3-01 of the Administrative Code.
- (16) "Medicaid covered point(s) of transport" is defined as the origin, where transport begins or the destination, where transport ends. One of the points of transport, the origin or destination, must be a medicaid covered service. The modifier for the point(s) of transport must be specified as covered in rule 5101:3-15-03 of the Administrative Code.
- (17) "Medicaid covered service" is defined as a service reimbursable under the Ohio medicaid program in accordance with Chapters 5101:3-1 to 5101:3-56 of the Administrative Code, excluding those services specified in paragraph (E) of rule 5101:3-15-03 of the Administrative Code.
- (18) "Medical transportation service(s)" are defined as a general term for those service(s) covered in accordance with rule 5101:3-15-03 of the Administrative Code.
- (19) "Medical transportation provider" is defined as a general term for providers of air ambulance, ambulance and ambulette services in accordance with this chapter.
- (20) "Nonambulatory" for the purpose of this rule, is defined as those permanently or temporarily disabling conditions which preclude transportation in motor vehicle(s) or motor carriers as defined in section 4919.75 of the Revised Code that are not modified or created for transporting a person with a disabling condition. The permanently or temporarily disabling conditions must require transport by air ambulance, ambulance or ambulette (for example, patients requiring stretcher transportation or wheelchair-bound individuals) in accordance with this rule.
- (21) "Non-emergency transportation" is defined as a prescheduled or unscheduled ambulance or ambulette transport for a patient whose medical condition does not require immediate response for the provision of medical treatment.
- (22) "Paramedic" is defined as an individual who holds a current, valid certificate issued under section 4765.30 of the Revised Code.
- (23) "Paramedic ALS Intercept" (PI) services are defined as ALS services furnished by an entity that does not provide the ambulance transport.
- (24) "Pilot" is defined as an individual employed by the transportation provider as part of the basic crew to pilot the air ambulance and who meets the qualifications specified in paragraph (D)(2) of rule 5101:3-15-02 of the Administrative Code.

- (25) "Practitioner certification form" is the general term for the JFS 01960 "Ambulance Certification of Medical Necessity Form" (rev. July 2003) that certifies the medical necessity of land ambulance services and the JFS 03452 "Ambulette Certification of Medical Necessity Form" (rev. July 2003) certifies the medical necessity of ambulette services and the written documentation required to certify medical necessity for air ambulance services.
- (26) "Specialty care transport services (SCT)" is defined as a level of interhospital services which is beyond the scope of the paramedic and must be furnished by one or more health professionals who are trained in an appropriate specialty area (for example, nursing, emergency medicine, respiratory care, cardiovascular care or paramedic with additional training).

Replaces: 5101:3-15-01

Effective: 03/27/2006

R.C. 119.032 review dates:

Certification

Date

Promulgated Under: 119.03

Statutory Authority: 5111.02

Rule Amplifies: 5111.01, 5111.02

Prior Effective Dates: 4/7/77, 5/9/86, 12/1/89, 5/1/92 (Emer), 7/31/92, 3/01/00, 12/27/01, 10/1/03, 12/30/05 (Emer)

MAL 500

Effective Date: March 27, 2006

(A) General requirements for eligible providers of air ambulance, ambulance and ambulette services.

(1) Verification of compliance

Providers of air ambulance, ambulance and ambulette services who meet the minimum requirements specified in this rule are eligible to participate in the Ohio Medicaid program upon execution of a provider agreement. In determining whether applicant providers meet such requirements, the department will require verification of compliance as identified in each of the following paragraphs of this rule. The required documentation must apply to all air ambulance, ambulance and ambulette vehicles operated by the provider and to all air ambulance, ambulance and ambulette personnel. The department may contact enrolled providers to assure continued compliance with requirements contained in this rule.

(2) Federal, state and local laws and regulations

Providers of air ambulance, ambulance and ambulette services must operate in accordance with all applicable local, state, and federal laws and regulations, including any applicable requirements developed by the Ohio medical transportation board as provided in Chapter 4765. of the Revised Code or applicable requirements developed for transportation in accordance with Chapter 4766. of the Revised Code.

(3) Vehicle and staffing documentation

The following information must be available in the provider's office and provided to the department upon request:

- (a) Documentation identifying the total number and type (ambulance, ambulette, fixed wing air ambulance or rotary wing air ambulance) of vehicles operated by the provider;
- (b) Documentation that all vehicles meet the standards specified in this rule or Chapter 4766. of the Revised Code where applicable;
- (c) A list of equipment carried in the vehicles as required in appendix A of rule 4766-11-02 of the Administrative Code for ambulance or paragraph (C)(1) of this rule for ambulette;
- (d) Verification of personnel qualifications as required in paragraph (B)(2) of this rule for ambulance providers and paragraph (C)(3) of this rule for ambulette providers.

(B) Eligible providers of ambulance services

(1) Certification requirements

All providers of ground ambulance services must be certified under and participating in medicare. All Ohio providers of ground ambulance services must be licensed in accordance with Chapter 4766. of the Revised Code and comply with all specifications of Chapter 4766. of the Revised Code, unless the provider is exempt from licensure as specified in section 4766.09 of the Revised Code. Providers in states other than Ohio must be licensed by the state in which they are located.

(2) Driver and attendant qualifications

Providers of ambulance services must maintain on file records verifying that drivers and attendants meet the following requirements on the date of the transportation service:

- (a) Each individual who functions primarily as an ambulance driver complies with local, state and federal laws and regulations.

- (b) The qualifications of each ambulance driver meets the specifications set forth in Chapters 4765. and 4766. of the Revised Code; and
- (c) Each ambulance attendant must have a current emergency medical technician (EMT) certification card issued by the division of emergency medical services (EMS) under the Ohio department of public safety; and
- (d) Ambulance attendants employed by out of state providers must have a current EMT certification issued by the appropriate agency in the state in which they are employed; and
- (e) The level of EMT certification must be appropriate to the level of service provided (i.e., advanced life support, basic life support, non-emergency).
- (f) Effective January, 1 2004, each ambulance driver must provide from the bureau of motor vehicles his/her driving record at the time of application for employment and annually thereafter. The date of the driving record submitted at the time of application must be no more than fourteen calendar days prior to the date of application for employment. Persons having six or more points on their driving record in accordance with section 4507.02 of the Revised Code cannot be an ambulance driver. Providers may use documentation from their commercial insurance carrier as proof the standard in this paragraph has been met.

(C) Eligible providers of ambulette services.

(1) Vehicle requirements.

All ambulette vehicles operated by providers of ambulette services must have at a minimum the following equipment and features:

- (a) Each vehicle must be specifically designed to transport one or more patients sitting in wheelchairs and have permanent fasteners to secure the wheelchair to the floor or side of the vehicle to prevent wheelchair movement; and
- (b) Each vehicle must have safety restraints in the vehicle for the purpose of restraining the patient in the wheelchair; and
- (c) Each vehicle must be equipped with a stable access ramp or hydraulic lift; and
- (d) Each vehicle must have provisions for secure storage of removable equipment and passenger property in order to prevent projectile injuries to passengers and driver in the event of an accident; and
- (e) Each vehicle must be equipped with, at a minimum, a fire extinguisher and an emergency first-aid kit that is safely secured; and
- (f) Each vehicle must be equipped with a communication system capable of two-way communication. Cellular communication is an acceptable means of two-way communication; and
- (g) Each vehicle must display the company logo, insignia, or name on both sides and rear of vehicle; and
- (h) Each vehicle must have a minimum ceiling to floor height of fifty-six inches.

(2) All providers of ambulette services must comply with the following regulations and provide documentation of compliance to the department upon request:

- (a) Each provider must conduct daily inspection and testing of the hydraulic lift or access ramp prior to transporting any wheelchair bound patient; and
- (b) Each provider must complete vehicle inspection documentation in the form of a checklist to include at a minimum that the following was performed: the daily inspection and testing of the wheelchair restraints, wheelchair lifts and/or access ramps, the lights, the windshield wipers/washers, the emergency equipment, mirrors, and the brakes; and

(c) Each provider must provide evidence that at least an annual vehicle inspection was completed on each vehicle by the Ohio state highway patrol safety inspection unit, or a certified mechanic, and the vehicle has been determined to be in good working condition.

(3) Driver and attendant qualifications

(a) All drivers and attendants employed by providers of ambulette services must meet the following requirements specified in paragraph (C)(3)(a) of this rule and meet those qualifications on the effective date of this rule and thereafter:

- (i) The qualifications of each driver and each attendant must comply with local, state and federal laws and regulations.
- (ii) Each driver and each attendant must have a current card issued and signed by a certified trainer as proof of successful completion of the "American Red Cross" (or equivalent certifying organization) basic course in first aid and a CPR certificate or EMT certification. A copy of both sides of the card must be maintained by the provider and provided upon request to the department or their designee. All current employees must provide their current card (not a copy) for inspection upon request to ODJFS or its designee. Providers of ambulette services may keep and produce the current card on behalf of the employee upon request to ODJFS or its designee.
- (iii) Each ambulette driver and each attendant must submit himself or herself for criminal background checks in accordance with section 109.572 of the Revised Code. Any applicant or employee who has been convicted of or pleaded guilty to violations cited in divisions (A)(1)(a), (A)(2)(a), (A)(4)(a), and/or (A)(5)(a) of section 109.572 of the Revised Code shall not provide services to medicaid patients unless the exceptions set forth in paragraphs (A) and (B) of rule 3701-13-06 of the Administrative Code apply.
- (iv) Each ambulette driver and each attendant must provide a signed statement from a licensed physician declaring that he or she does not have a medical condition, a physical condition, including a vision impairment (not corrected), and a hearing impairment (not corrected), or mental condition which could interfere with safe driving, safe passenger assistance, the provision of emergency treatment activity, or could jeopardize the health or welfare of patients being transported.
- (v) Each ambulette driver must undergo testing for alcohol and controlled substances by a laboratory certified for such testing under CLIA and be determined to be drug and alcohol free as specified in the paragraphs below:
 - (a) Except as provided for in paragraph (C)(3)(b) of this rule, the tests must be performed and the results placed in the employee's file prior to rendering ambulette services;
 - (b) Repeat drug and alcohol testing must be performed at a minimum whenever the driver has been involved in a motor vehicle accident for which he/she was the driver; and
 - (c) The drugs to be included in the drug testing are those required in accordance with 49 C.F.R. 382 (dated October 1, 2005).
- (vi) Each ambulette driver must provide from the bureau of motor vehicles his/her driving record at the time of application for employment and annually thereafter. The date of the driving record submitted at the time of application must be no more than fourteen calendar days prior to the date of application for employment. Persons having six or more points on their driving record in accordance with section 4507.02 of the Revised Code cannot be an ambulette driver. Providers may use documentation from their commercial insurance carrier as proof the standard in this paragraph has been met.

- (vii) Each ambulette driver and each attendant must have completed a passenger assistance training course to include at a minimum the basic characteristics of major disabling conditions affecting ambulation, basic considerations for functional factors, management of wheelchairs, assistance and transfer techniques, environmental considerations, and emergency procedures.
- (viii) Each ambulette driver must have a valid driver's license and be eighteen years or older.
- (ix) Each ambulette driver and each attendant must have an identification card visible to the patient identifying at a minimum his/her first name and last initial or unique identifier and company affiliation.
- (b) A provider may employ an applicant on a temporary provisional basis pending the results of the required information set forth in paragraphs (C)(3)(a)(iii), (C)(3)(a)(iv) and (C)(3)(a)(v) of this rule if the following conditions are met. Providers who are in the process of becoming an enrolled provider cannot hire applicants on a temporary provisional basis.

 - (i) The length of the temporary provisional period shall be sixty days or the period established by another state government agency or board with the authority under Ohio law to regulate providers of ambulette services, whichever is greater.
 - (ii) No applicant shall be accepted for permanent employment as an ambulette driver or attendant unless all the requirements of paragraph (C)(3)(a) of this rule have been met.
 - (iii) A provider may employ an applicant only conditionally prior to obtaining the results of a criminal records check, the results of the drug and alcohol testing and/or the physician's statement for the applicant if the requirements listed in this paragraph are met.

 - (a) A provider shall not employ an applicant prior to obtaining the completed form(s) and fingerprint impression sheet(s) from the applicant as required in paragraph (F) of rule 3701-13-03 of the Administrative Code. For purposes of this prohibition, the applicant cannot perform or participate in any job related activity pertaining to a position involving the provision of direct care to an older adult that places the applicant in an active pay status.
 - (b) A provider shall request a criminal records check by submitting the request to BCII, no later than five business days after the individual begins conditional employment.
 - (c) The sample for the drug and alcohol testing has been obtained and submitted to the laboratory for testing.
 - (d) Arrangements have been made for the required physical.
 - (iv) A provider shall terminate the individual's conditional employment as an ambulette driver if:

 - (a) The results of any part of the records check, are not obtained within sixty days after the date the request is made; or
 - (b) The results of any part of the records check indicate that the individual has been convicted of or pleaded guilty to any of the offenses listed or described in paragraph (A) of rule 3701-13-05 of the Administrative Code, unless the organization chooses to employ the applicant pursuant to rule 3701-13-06 of the Administrative Code.
 - (c) The results of the drug and alcohol test do not come back as negative, or have not been received within the sixty days; or

(d) The signed physician statement is not obtained, or does not support that the individual meets the provisions of paragraph (C)(3)(a)(iv) of this rule.

(4) Insurance requirements

All ambulance vehicles operated by providers of ambulance services must have at a minimum the following insurance coverage:

- (a) Every provider of ambulance services directed under this chapter must maintain and disclose upon the request of the department adequate evidence of liability insurance coverage, in an amount of not less than five hundred thousand dollars per occurrence and not less than five hundred thousand dollars in the aggregate, for any cause for which the provider would be liable.
- (b) In addition to the insurance requirements of paragraph (C)(4)(a) of this rule, every provider shall carry bodily injury and property damage insurance with solvent and responsible insurers licensed to do business in this state for any loss or damage resulting from any occurrence arising out of or caused by the operation or use of any ambulance vehicle. The insurance plan shall insure each vehicle for the sum of not less than one hundred thousand dollars for bodily injury to or death of more than one person in any one accident and for the sum of fifty thousand dollars for damage to property arising from any one accident.
- (c) Each policy or contract of insurance issued shall provide for the payment and satisfaction of any financial judgement entered against the provider and any person operating the vehicle and for a thirty-day cancellation notice to ODJFS.

(D) Eligible providers of air ambulance services

(1) Vehicle requirements

Providers of air ambulance services must assure their vehicles are operating in accordance with all applicable state laws for air ambulance.

(2) Providers of air ambulance services must maintain on file, records verifying that the pilot and basic crew meet the following requirements:

- (a) A pilot must have a currently effective airman's license issued by the federal aviation administration.
- (b) A paramedic must hold a current, valid certificate issued under section 4765.30 of the Revised Code.
- (c) A respiratory therapist must hold a current, valid license issued under section 4761.05 of the Revised Code.
- (d) A registered nurse must hold a current, valid license in accordance with section 4723.09 of the Revised Code.
- (e) A doctor of medicine or doctor of osteopathy must hold a current, valid license in accordance with Chapter 4731-6 of the Administrative Code.

(E) Documentation requirements

(1) Providers of air ambulance, ambulance and ambulance services must maintain records which fully describe the extent of services provided. Services are not eligible for reimbursement if the documentation specified is not obtained prior to billing the department and maintained in accordance with paragraphs (E)(2)(a) to (E)(2)(d) of this rule.

(2) Records which must be maintained include, but are not limited to, the records listed in paragraph (E)(2)(a) to (E)(2)(d) of this rule. All records and documentation required by this rule must be retained in accordance with rules 5101:3-1-17.2 and 5101:3-1-27 of the Administrative Code.

- (a) A record or set of records for all transports on that date of service which documents time of scheduled pick up and drop off, full name(s) of attendant(s), full name(s) of patient(s), medicaid patient number, full name of driver, vehicle identification, full name of the medicaid covered service provider which is one of the medicaid covered point(s) of transport, pick-up and drop-off times, complete medicaid covered point(s) of transport addresses, the type of transport provided, and mileage; and
 - (b) The original "practitioner certification form", completed by the attending practitioner, documenting the medical necessity of the transport, in accordance with this rule; and
 - (c) Copies of prior authorization forms, when applicable; and
 - (d) Copies of the pilot's/driver's/attendant's certification or licensure, which must be current at the time of the transport, in accordance with paragraph (D)(2) of this rule for air ambulance, paragraph (B)(2) of this rule for ambulance and paragraph (C)(3) of this rule for ambulette.
- (3) Should ODJFS determine that the medical transportation provider was/is not in compliance with all licensure, certification and documentation requirements of this rule and all other provisions in Chapter 5101:3-15 of the Administrative Code on the date of the transportation service and was unable to supply the required documentation upon request, ODJFS will proceed in accordance with the provider agreement termination and denial provisions of rule 5101:3-1-17.6 of the Administrative Code. In addition, the department will seek remuneration for medicaid payments for the services that did not comply with Chapter 5101:3-15 of the Administrative Code.
- (4) Practitioner certification form
- (a) The attending practitioner, or a hospital discharge planner or a registered nurse acting under the orders of the attending practitioner in accordance with paragraph (E)(4)(b) of this rule, must complete a "Practitioner Certification Form" for all medical transportation services except:
 - (i) ALS and/or BLS ambulance transportation to a hospital emergency room in an emergency situation; or
 - (ii) Ambulance or ambulette transfer of a non-ambulatory patient from one hospital to another hospital if the services provided at the second hospital are covered by medicaid
 - (b) For the purpose of this rule, a registered nurse, with an order from the attending practitioner, may write the practitioner's name on the ordering line of the practitioner certification form, sign his or her own full name and the professional letters "R.N." after the practitioner's name on the signature line and enter the date of signature. The professional letters "R.N." must follow the nurse's last name or;

A hospital discharge planner with a written order from the attending practitioner, may write the practitioner's name on the ordering line of the practitioner certification form, sign his or her own full name on the signature line and enter the date of signature. The discharge planner must be employed by the hospital where the patient is being treated and from which the patient is transported. The discharge planner must be a social worker who is practicing within his or her scope of practice in accordance with Chapter 4757. of the Revised Code.
 - (c) Medical condition

The practitioner certification form must state the specific medical conditions related to the ambulatory status of the patient which contraindicate transportation by any other means on the date of the transport, and use the correct form which specifies the mode of medical transportation (ambulance or ambulette) the patient will require. The attending practitioner must clearly specify the condition of the patient which renders transport by ambulance or ambulette medically necessary.

- (d) The practitioner certification form is required to certify that ambulance and ambulette services are medically necessary. The completed practitioner certification form must be signed and dated no more than one hundred eighty days after the first date of transport. The completed, signed and dated practitioner certification form must be obtained by the transportation provider before billing the department for the transport. The date of signature entered on the practitioner certification form must be the date that the practitioner certification form was actually signed and must be prior to the date of the claim submission
- (i) Providers must always obtain the completed, signed and dated practitioner certification form before billing the transport. However, the following documented exceptions will be accepted if the practitioner certification form is not obtained within the one hundred- eighty-day period after the first date of transport.
- (a) Patient is pending medicaid eligibility as specified in Chapters 5101:1-38 to 5101:1-40 of the Administrative Code;
- (b) No response from patient's insurance after monthly (i.e., every thirty days) attempts to obtain the signed certification form;
- (c) No response from practitioner after monthly (i.e., every thirty days) attempts to obtain the signed certification form;
- (d) Process of trying to exhaust other insurance coverage is longer than one hundred eighty days;
- (e) Documentation of the above reasons for the extension must be made in writing and maintained in the individuals patient's file.
- (ii) The practitioner certification form must be maintained on file at the provider's office for a minimum of six years from the date of receipt of payment based upon those records or until any initiated audit or review is completed, whichever occurs later, in accordance with rule 5101:3-1-17.2 of the Administrative Code.
- (iii) The practitioner certification form is non-transferrable from one transportation provider to another.
- (e) The practitioner certification form is only valid as long as the patient's ambulatory status does not change. If a transportation provider suspects a patient has had a change in their ambulatory status the transportation provider will need to obtain a new form from the attending practitioner.
- (f) Practitioner certification for patients who are permanently nonambulatory. The practitioner certification form is required to certify that ambulance and ambulette services are medically necessary. Providers may maintain annual certification for permanently nonambulatory patients. If a patient is determined by the attending practitioner to be permanently nonambulatory, the practitioner certification form documenting the permanently nonambulatory status is valid for three hundred sixty-five days from the date of first transport for ambulance and ambulette transports to all medicaid covered services.
- (g) Practitioner certification for patients who are nonambulatory at the time of transport, but are temporarily nonambulatory. The practitioner certification form is required to certify that ambulance and ambulette service are medically necessary. The attending practitioner must certify the estimated length of time that individual is temporarily nonambulatory and transport by ambulance or ambulette would be required. The certification form documenting the temporary nonambulatory status is valid for the estimated length of time as designated by the attending practitioner unless the temporary nonambulatory status length of time exceeds ninety days. If the length of time exceeds ninety days a new certification form must be obtained to certify a new estimated length of time. Transport is certified for those only temporarily nonambulatory for the indicated time

period to all medicaid covered services, except for persons certified solely because they are receiving dialysis treatment. These individuals can only be transported from their dialysis treatment as medically indicated.

Replaces: 5101:3-15-02

Effective: 03/27/2006

R.C. 119.032 review dates:

Certification

Date

Promulgated Under: 119.03

Statutory Authority: 5111.02

Rule Amplifies: 5111.01, 5111.02

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5160-15-02.8 Medical Transportation Services: Eligible Providers

~~*Formerly*~~ 5101:3-15-02.8 Medical Transportation Services: Eligible Providers

[MHTL 3334-13-13](#)

Effective Date: January 1, 2014

Most Current Prior Effective Date: [October 29, 2009](#)

~~Medical transportation services will no longer be directly reimbursed for consumers residing in a nursing facility (NF) as defined in section 5111.20 of the Revised Code. Coverage for the direct reimbursement of medical transportation services will continue for residents of an intermediate care facility for the mentally retarded (ICF-MR) as defined in section 5111.20 of the Revised Code. The provisions in Chapter 5101:3-15 of the Administrative Code do not apply to transportation services supplied to the residents of nursing facilities.~~

- (A) The following is in effect for providers who are enrolled after the effective date of this rule.
- (1) Upon the completion of a signed medicaid provider agreement, any business or entity organized for the purpose of providing ground ambulance services may be enrolled as an ambulance provider and provide ground ambulance services under the Ohio medicaid program if the business or entity meets all of the requirements for participation ~~as~~ set forth in paragraphs (A) and (B) of rule ~~5101:3~~5160-15-02 of the Administrative Code and ~~have~~ has at least one ambulance vehicle.
 - (2) Upon the completion of a signed medicaid provider agreement, any business organized for the purpose of providing ambulette services may be enrolled as an ambulette provider and provide ambulette services under the Ohio medicaid program if the business or entity meets all the requirements for participation ~~as~~ set forth in paragraphs (A) and (C) of rule ~~5101:3~~5160-15-02 of the Administrative Code and ~~have~~ has at least one ambulette vehicle.

Ambulance providers may also be eligible providers of ambulette services and provide ambulette services under the Ohio medicaid program if they meet all the requirements for participation ~~specified~~ set forth in paragraphs (A), (B) and (C) of rule ~~5101:3~~5160-15-02 of the Administrative Code and have at least one ambulette vehicle.
 - (3) Upon the completion of a signed medicaid provider agreement, any business organized for the purpose of providing air ambulance services may be enrolled as an ambulance provider and provide air ambulance services under the Ohio medicaid program if the business or entity meets all the requirements for participation ~~as~~ set forth in paragraphs (A) and (D) of rule ~~5101:3~~5160-15-02 of the Administrative Code and ~~have~~ has at least one air ambulance vehicle.
- (B) Effective on January 1, 2006, providers with a current valid provider agreement (i.e., enrolled prior to the effective date of this rule) must comply with paragraphs (A)(1) to (A)(3) of this rule. Prior to January 1, 2006, providers with a current valid provider agreement (i.e., enrolled prior to the effective date of this rule) must comply with paragraphs (A)(1) to (A)(3) of this rule except for the provision in paragraph (A)(1) of this rule to have at least one ambulance vehicle, for the provisions in paragraph (A)(2) of this rule to have at least one ambulette vehicle and for the provision in paragraph (A)(3) of this rule to have at ~~least~~ least one air ambulance vehicle.

Effective:

R.C. 119.032 review dates: 10/15/2013

Certification

Date

Promulgated Under: 119.03

Statutory Authority: 5164.02

Rule Amplifies: 5162.03, 5164.02, 5165.01, 5165.47

Prior Effective Dates: 10/01/2003, 12/30/2005 (Emer), 03/27/2006, 07/31/2009 (Emer), 10/29/2009

MAL 500

Effective Date: March 27, 2006

(A) Land ambulance

(1) Covered land ambulance services

The following land ambulance services are covered if they meet the criteria for coverage as specified in paragraph (A)(2) of this rule.

- (a) "Basic life support, emergency (BLS-emergency)" is the transport of one patient, or the first patient of a multi-passenger transport, who needs on an emergency basis the provision of basic life support services (BLS services) as defined in paragraph (A)(8) of rule 5101:3-15-01 of the Administrative Code.
- (b) "Basic life support, non-emergency (BLS-non-emergency)" is the transport of one patient, or the first patient of a multiple passenger transport, who needs on a non-emergency basis the provision of basic life support services (BLS services) as defined in paragraph (A)(8) of rule 5101:3-15-01 of the Administrative Code.
- (c) "Advanced life support services, level 1; emergency (ALS1-emergency)" is the transport of one patient, or the first patient of a multiple passenger transport, who needs an assessment by a crew member who is trained to the level of the EMT-intermediate or a paramedic and/or needs one or more advanced life support (ALS) services as defined in paragraph (A)(1) of rule 5101:3-15-01 of the Administrative Code.
- (d) "Advanced life support services, level 1; non-emergency (ALS1-non-emergency)" is the transport of one patient who needs on a non-emergency basis an assessment by a crew member who is trained to the level of the EMT-intermediate or a paramedic and/or who needs advanced life support services as defined in paragraph (A)(1) of rule 5101:3-15-01 of the Administrative Code.
- (e) "Advanced life support, level 2 (ALS2)" is the transport of one patient, or the first patient of a multiple passenger transport, who needs the provision at least three different medications and/or the provision of (or attempt of the provision) one or more of the following ALS procedures: Manual defibrillation/cardioversion, endotracheal intubation, central venous line, cardiac pacing, chest decompression, surgical airway or intraosseous line.
- (f) "Specialty Care Transport (SCT)" is the transport of one patient, or the first patient of a multiple patient transport, who requires ongoing care that must be provided by one or more health professionals who are qualified to provide services which are beyond the scope of the paramedic.
- (g) "Attendant services" are the services provided during a covered ambulance service by an attendant as defined in paragraph (A)(5) of rule 5101:3-15-01 of the Administrative Code.
- (h) "Non-emergency ambulance, second passenger" is the transport of the second passenger of a multiple passenger transport and the level of the transport is non-emergency BLS or ALS.
- (i) "Non-emergency ambulance, three or more passengers" is the transport of each passenger over two (i.e., the third passenger, fourth passenger, etc.) and the level of transport is non-emergency BLS or ALS.
- (j) "Basic life support (BLS), emergency, second passenger" is the transport of the second passenger of a multiple passenger transport and the level of the transport is emergency BLS.

- (k) "Basic life support (BLS), emergency, three or more passengers" is the transport of each passenger over two (i.e., the third passenger, fourth passenger, etc.) during a multiple passenger transport and the level of transport is emergency BLS.
- (l) "Advance life support (ALS), emergency, second passenger" is the transport of the second passenger of a multiple passenger transport and the level of transport is emergency ALS1, or ALS2, or SCT.
- (m) "Advanced life support (ALS), three or more passengers" is the transport of each passenger over two (i.e., the third passenger, fourth, etc.) during a multiple passenger transport and the level of transport is emergency ALS1, or ALS2 or SCT.

(2) Criteria for coverage

The criteria listed in this paragraph must be met for a land ambulance service to be covered.

- (a) The land ambulance service must be medically necessary as specified in this paragraph.
 - (i) The patient's condition at the time of the transport is the determining factor in whether medical necessity is met, or not.
 - (ii) For emergency transports, ambulance services are determined to be medically necessary when one or more of the following apply: the individual needs immediate medical attention as a result of accident, injury or acute illness; the individual needs to be restrained; the individual is unconscious or in shock; the individual requires oxygen or other emergency treatment en route; the individual has to remain immobile due to untreated fracture or potential fracture; or the individual, for other reasons, must be moved only by stretcher or meet the requirements for transport to a trauma center in accordance with section 4765.4 of the Revised Code and the situation meets the definition of emergency service in accordance with paragraph (A)(12) of rule 5101:3-15-01 of the Administrative Code.
 - (iii) For non-emergency transports, ambulance services are medically necessary when the patient needs either prescheduled transportation or unscheduled transportation for which an immediate response is not required; and the patient's medical condition meets one of the descriptions in paragraphs (A)(2)(a)(iii)(a) to (A)(2)(a)(iii)(c) of this rule.
 - (a) An individual is nonambulatory and unable to use an ambulette because the individual is unable to get up from bed without assistance; the patient is unable to sit in a chair or wheelchair; and can only be moved only by a stretcher and/or needs to be restrained; or
 - (b) An individual is not in a life-threatening situation, but requires continuous medical supervision or treatment during the transport; or
 - (c) An individual does not meet the criteria in paragraph (A)(2)(a)(iii)(a) or paragraph (A)(2)(a)(iii)(b) of this rule, but requires oxygen administration during the transport, and the patient is unable to self-administer or self-regulate the oxygen or the patient requiring oxygen administration has been discharged from a hospital to a nursing facility.
- (b) The vehicle used for the transport must be an ambulance as defined in paragraph (A)(3) of rule 5101:3-15-01 of the Administrative Code.
- (c) The transport must be either transportation to a medicaid covered service or transportation from a medicaid covered service. "Medicaid covered service" is defined in paragraph (A)(17) of rule 5101:3-15-01 of the Administrative Code.
- (d) The transport must provide transportation from a medicaid covered point of transport as listed in paragraph (D) of this rule. Point of transport not listed as covered in paragraph

(D) of this rule may be covered on a case-by-case basis through the prior authorization process set forth in paragraph (F) of this rule.

- (e) The transport must be staffed with the appropriate basic crew members corresponding to the level of service billed.

 - (i) The basic crew for a basic life support ambulance is defined as at least two emergency medical technicians (EMTs) as described in section 4765.43 of the Revised Code and the driver if the driver is not one of the two emergency medical technicians.
 - (ii) The basic crew for an advanced life support ambulance is defined as at least two emergency medical technicians as described in section 4765.43 of the Revised Code and the driver if the driver is not one of the two emergency medical technicians.
 - (iii) The basic crew for specialty care transport must be in accordance with Chapters 4765. and 4766. of the Revised Code.
- (f) For services defined as emergency in the descriptor, the transport must be provided after an accident, injury or the sudden onset of a medical condition which manifests itself by acute symptoms of sufficient severity that in the absence of immediate medical attention could reasonably be expected to result in placing the patient's health in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part.
- (g) Ambulance services that do not meet the criteria for an emergency transport as described in paragraph (A)(2)(f) of this rule are covered only as a non-emergency transport.
- (h) For attendant services, the use of additional attendant(s) must be related to extraordinary circumstances which would require the services of staff members in addition to the basic crew (e.g., existence of unusual structural barriers such as tight, angled hallways or excessive number of steps; unusual patient obesity; and/or necessity of special medical treatment in route to destination).

 - (i) Documentation supporting the need and use of the additional attendants(s) must be maintained by the provider.
 - (ii) Since medical facilities, especially hospitals, traditionally have access ramps and personnel to assist in maneuvering stretchers or wheelchairs, providers must make use of such existing resources without charging for additional attendant(s).
- (i) Under the medicaid program services to individuals who are deceased are not covered. Therefore, the time of the pronouncement of death affects the coverage of ambulance services as described below:

 - (i) If the patient was pronounced dead by an individual who is licensed to pronounce death under Ohio law prior to the time that the ambulance is called, the ambulance service is not covered.
 - (ii) If the patient is pronounced dead after the ambulance is called but before the ambulance arrives at the scene, a BLS-emergency service is covered but compensation for loaded mileage is not covered.
 - (iii) If the patient is pronounced dead after being loaded into the ambulance, the ambulance transport is covered and reimbursed as if the death of the patient had not occurred.
- (j) Ambulance services to all eligible medicare patient are to be billed to medicare. If the patient has medicare coverage, the department will reimburse only part-B co-insurance and deductible amounts.

(B) Ambulette services coverage and limitations

(1) Covered ambulette services

The following ambulette services are covered if the criteria for coverage is met in accordance with paragraph (B)(2) of this rule.

- (a) "Ambulette services" is the transport of one individual, or the first passenger of a multiple passenger transport in an ambulette.
- (b) "Ambulette services, second passenger" is the transport of the second passenger of a multiple passenger transport in an ambulette.
- (c) "Ambulette services, three or more passengers" is the transport of each passage over two (i.e., the third passenger, fourth, etc.) during a multiple passenger transport in a ambulette
- (d) "Attendant services" are the services provided during a covered medical transportation services by an attendant as defined in paragraph (A)(5) of rule 5101:3-15-01 of the Administrative Code.

(2) Covered ambulette transports

Except as provided elsewhere in this chapter, ambulette services are covered only when all the requirements in this paragraph are met.

- (a) The ambulette services must be medically necessary as specified below:
 - (i) The individual has been determined and certified by the attending practitioner to be nonambulatory at the time of transport as defined in paragraph (A)(20) of rule 5101:3-15-01 of the Administrative Code; and
 - (ii) The attending practitioner has certified that the individual does not require ambulance services; the individual does not use passenger vehicles as defined in paragraph (A)(20) of rule 5101:3-15-01 of the Administrative Code as transport to non-medicaid services.; and the individual is physically able to be safely transported in a wheelchair.
- (b) The vehicle used for the transport must be an ambulette as defined in paragraph (A)(4) of rule 5101:3-15-01 of the Administrative Code.
- (c) The transport must be either transportation to a medicaid covered service or transportation from a medicaid covered service as defined in paragraph (A)(17) of rule 5101:3-15-01 of the Administrative Code.
- (d) The transport must be transportation from a medicaid covered point of transport in accordance with paragraph (D) of this rule. Point of transport modifiers not listed as covered in paragraph (D) of this rule may be covered if prior authorized in accordance with paragraph (F) of this rule.
- (e) The individual must actually be transported in a wheel chair.
- (f) The basic crew for ambulette services includes only the driver. For attendant services to be covered, the use of an additional attendant can be covered and reimbursed only when the safe transportation of the patient requires additional handling, such as due to unusual patient obesity, or the need to negotiate a minimal number of accessible steps. Documentation supporting the need and use of the additional attendant(s) must be maintained by the provider. Providers must make use of existing medical facility resources (access ramps and personnel) without charging for an additional attendant. When the patient needs anticipated medical treatment or attention during the transport, the transport is not reimbursable as an ambulette service.

(C) Covered air ambulance transports

- (1) Two types of air ambulance services are covered:

- (a) "Fixed wing air ambulance (FWAIR)" is the transport of a patient in a fixed wing (i.e., airplane) air ambulance.
- (b) "Rotary wing air ambulance (RWAIR)" is the transport of a patient in a rotary wing (i.e., helicopter) air ambulance.

(2) The criteria as detailed in this paragraph must be met for an air ambulance service to be covered:

- (a) The medical condition of the patient at the time of the transport is such that transport by land ambulance is contraindicated and at least one of the following apply:
 - (i) The patient's medical condition meets the medical necessity requirements for land ambulance transport in accordance with paragraph (A)(2)(a) of this rule but the point of pick up is inaccessible by land ambulance;
 - (ii) The patient's medical condition meets the criteria for coverage of an emergency land ambulance service requiring the provision of advanced life support services and the time needed to transport the patient by land is a threat to the survival or seriously endangers the patient's health.
 - (a) The department will generally assume that air ambulance is necessary for emergency transports when the patient is critically ill or critically injured (e.g., multiple trauma, massive bleeding, severe burns, etc.) and it will take greater than thirty minutes to transport the patient by land ambulance to the nearest appropriate facility due to the distance by land or other obstacles (e.g., heavy traffic, or road blockage).
 - (b) The department will recognize that the medical necessity of air ambulance transport could also be established when the transport of a critically ill or critically injured patient by land ambulance would take less than thirty minutes if it is documented that the time saved by air transport significantly increased the patient's chances of survival and/or reduce the risk of further injury or bodily impairment; or
 - (iii) The patient's medical condition met the criteria for the coverage of non-emergency scheduled or unscheduled land ambulance; it is documented that the transport by land ambulance would endanger the health of the patient; and one of the situations in paragraphs (C)(2)(a)(iii)(a) and (C)(2)(a)(iii)(b) of this rule apply:
 - (a) The patient needed to be transferred from one acute care hospital to another acute care hospital because the hospital does not have adequate medical services needed by the patient (e.g., does not have burn units, cardiac units, and trauma units) and/or the physician specialty services needed (e.g., neurosurgeon); or
 - (b) The patient was not a hospital inpatient but has been approved by the department to receive services at an acute care hospital outside of Ohio or outside any of the states which are contiguous to Ohio; the hospitals in the aforementioned geographical area do not provide the medical specialty services needed by the patient; and the nearest appropriate facility is more than one hundred-eighty miles away from the patient's place of residence.
- (b) The following air ambulance vehicle and staffing requirements must be met:
 - (i) The air ambulance is designed and equipped to respond to medical emergencies and in non-emergency situations able to provide the continual and expected care specific to the medical condition of the patient being transported;
 - (ii) The vehicle must comply with state and local laws governing licensing and certification of an emergency medical transportation vehicle and must contain at a

minimum a stretcher, linens, emergency medical supplies, oxygen equipment, and be equipped with telecommunications equipment; and

(iii) The basic crew must include:

(a) A registered nurse; and

(b) One of the following health professionals: paramedic, respiratory therapist, doctor of medicine, doctor of osteopathy, advanced practice nurse or registered nurse. The health professional selected must be appropriate for the medical condition of the patient. The health professional must have any specialty care training appropriate to provide the medical care needed during the transport; and

(c) A pilot.

(c) The air ambulance service must be for transportation to a medicaid covered service or from a medicaid covered service as defined in paragraph (A)(17) of rule 5101:3-15-01 of the Administrative Code.

(d) The transport must be transportation from a medicaid covered point of transport as listed in paragraph (D) of this rule. Point of transport not listed as covered in paragraph (D) of this rule may be covered if prior authorized in accordance with paragraph (F) of this rule.

(e) Air ambulance services provided to all eligible medicare patients are to be billed to medicare. If a patient has medicare coverage, the department will reimburse part-A or part-B co-insurance and deductible amounts.

(f) The provisions of the pronouncement of death as specified in paragraph (A)(2)(i)(i) of this rule apply to air ambulance services except for paragraph (A)(2)(i)(ii) of this rule. Instead, if the patient is pronounced dead after the ambulance is called but before the ambulance arrives at the scene, a fixed wing air ambulance or rotary wing air ambulance service is covered but compensation for loaded mileage is not covered.

(D) Modifiers for the point of transport are required for all covered service codes as described in this rule.

(1) Modifiers for the point of transport is a two-position modifier that is constructed from the following values. The first position alphabetic value is used to report the origin or "from" of service. The second position alphabetic value is used for the destination or "to" of service.

(a) "D" is a diagnostic or therapeutic site other than P or H. Examples of this value would include but is not limited to alcohol and drug rehabilitation centers, independent laboratories, ambulatory surgical centers, oncology treatment centers, medical equipment supplier or any other medicaid provider entities not otherwise listed.

(b) "E" is a residential, domiciliary, custodial facility (e.g. nursing home-not skilled nursing facility). Examples of this value would include but is not limited to nursing facilities or ICF-MR facilities.

(c) "G" is a hospital-based dialysis facility (hospital or hospital-related).

(d) "H" is a hospital. Examples of this value would include but is not limited to general, mental or TB hospital.

(e) "I" is a site of transfer. Examples of this value would include but is not limited to airport strips or helicopter pads.

(f) "J" is a non-hospital based dialysis facility

(g) "N" is a skilled nursing facility (SNF)

(h) "P" is a physician's office (includes HMO non-hospital facility, clinic, etc.) Examples of this value would include but is not limited to an individual or group: physician, osteopath, other health practitioners such as advanced practice nurses, chiropractors, optometrist, optician, podiatrist, physical therapist, psychologist, dentist. Other examples would

include outpatient health facilities, rural health facilities, federally qualified health centers, public health center, or medical equipment supplier.

- (i) "R" is a residence. Examples of this value would include but is not limited to any place where the patient permanently or temporarily resides other than a long term care facility.
- (j) "S" is the scene of an accident or acute event.

- (2) Instead of the two position point of transport modifiers identified in paragraph (D)(1) of this rule, "U4", medicaid level of care 4, origin school or work, and "U7", medicaid level of care 7, destination school or work, are used whenever the origin or destination, respectively, of a medicaid covered point of transport is school or work.
- (3) The medicaid covered point of transport modifiers for non-emergency ground ambulance and ambulette services are DD, DE, DG, DH, DI, DJ, DN, DP, DR, ED, EE, EG, EH, EI, EJ, EN, EP, ER, GD, GE, GH, GI, GN, GP, GR, HD, HE, HH, HI, HJ, HN, HP, HR, ID, IE, IG, IH, II, IJ, IN, IP, IR, JD, JE, JH, JI, JJ, JN, JP, JR, ND, NE, NG, NH, NI, NJ, NN, NP, NR, PD, PE, PG, PH, PI, PJ, PN, PP, PR, RD, RE, RG, RH, RI, RJ, RN, and RP.
- (4) The medicaid covered point of transport modifiers for emergency ground ambulance services are DH, DI, EH, EI, GH, GI, HH, HI, IH, II, JH, JI, NH, NI, PH, PI, RH, RI, SH, SI, and U4.
- (5) The medicaid covered point of transport modifier for air ambulance fixed wing is II. The medicaid covered point of transport modifiers for air ambulance, rotary wing is DH, EH, GH, HH, IH, JH, NH, PH, RH, SH, DI, EI, GI, HI, II,JI, NI, PI, RI, SI, HE, HN, IE, and IN.
- (6) Providers of medical transportation services may request that the department cover point of transport modifiers listed in paragraph (D)(1) or (D)(2) of this rule but not listed as covered in paragraph (D)(3), (D)(4) or (D)(5) of this rule. Providers may request special consideration in extraordinary circumstances by submitting their request to the prior authorization unit as specified in paragraph (F) of this rule. The appropriate point of transfer modifier constructed from paragraph (D)(1) of this rule would be used when billing.

Providers of medical transportation service may request the department cover additional point(s) of transport that are not listed in paragraph (D)(1) or (D)(2) of this rule by submitting their request to the prior authorization unit as specified in paragraph (F) of this rule. For those point(s) of transport the modifier "U5", medicaid level of care 5, origin/destination is not otherwise specified, is used.

(E) Service limitations

The following services are not covered:

- (1) Unloaded transports (i.e., no medicaid patient in the vehicle);
- (2) Services which are available to the general public without charge;
- (3) Excessive mileage charges, resulting from the use of indirect routes;
- (4) Non-emergency ambulance and ambulette services for transport of long-term care facility residents in order to receive services which are reimbursable to the long-term care facility; e.g., therapy services as defined in rule 5101:3-3-47.1 of the Administrative Code, are the responsibility of the facility and are not separately reimbursable to the transportation provider.
- (5) Medical transportation providers cannot bill for the services of hospital staff as attendants during transportation. Services provided by hospital staff are covered and reimbursed as an inpatient or outpatient hospital services. Services related to the use and operation of the transport vehicle, including standard equipment and driver, are reimbursed as an ambulance or ambulette service. The provisions of this paragraph apply to ambulance and ambulette services provided to or from the hospital, including interhospital air ambulance, ambulance or ambulette services.
- (6) Transportation of passenger(s) accompanying the patient who requires the medical transportation services;

- (7) Services available to the patient through county contract or the non-emergency transportation (NET) program as specified in Chapter 5101:3-24 of the Administrative Code;
- (8) Transport of a patient who is ambulatory at the time of the transport unless the patient meets criteria in paragraph (A)(2) of this rule;
- (9) Transportation of a patient for purposes other than for the receipt of medicaid covered services;
- (10) Mileage and extra attendant charges for additional passengers;
- (11) Transportation to outpatient services provided in psychiatric hospitals;
- (12) Transport to a certified habilitation center that has been billed to the department.
- (13) Transport to services that are covered by any HCBS waivers specified in division-level 5101:3 of the Administrative Code.
- (14) Transport to services that are needed in order for the individual to receive medical care related to the terminal illness which are covered through the hospice services program as defined in Chapter 5101:3-56 of the Administrative Code;
- (15) Transportation services for individuals who are not medicaid eligible at the time of transport.

(F) Prior authorization

- (1) Prior authorization is required for the point of transport modifiers of medical transportation services as described in paragraph (D)(6) of this rule.
- (2) All requests must be in writing. Approval of a prior authorization request confirms that the patient is in need of the medical transportation service and that the transportation service will be covered by the medicaid program if the patient is eligible on the date(s) of service.
- (3) All requests for prior authorization of medical transportation services must include:
 - (a) A complete JFS 03142 "Prior Authorization Request Form" (rev. February 2003); and
 - (b) A complete description of the service requested, date(s) to be rendered, pick-up and destination points, special services involved and explanation of the need for any additional attendant(s); and
 - (c) A complete JFS 01960 "Ambulance Certification of Medical Necessity Form" (rev. July 2003) and JFS 03452 "Ambulette Certification of Medical Necessity Form" (rev. July 2003) establishing medical necessity as detailed in rule 5101:3-15-02 of the Administrative Code..
 - (d) Details of any related special circumstances which should be considered in the review of the request for prior authorization.

(G) Transportation of Ohio medicaid patients to treatment facilities outside of Ohio.

If the patient is transported by a provider located in a state other than Ohio, the transportation provider may be reimbursed for the transport if the provider is an Ohio medicaid provider. If the provider is not an Ohio Medicaid provider at the time of transport, the provider may apply to become an Ohio medicaid provider. If approved for medicaid provider status in Ohio, the provider may submit a claim for the transport of the Ohio medicaid patient in accordance with rule 5101:3-1-19.3 of the Administrative Code.

Out-of-state destinations are approved for states contiguous to Ohio for ambulette or ground ambulance services as long as the conditions for coverage are met. Out-of-state destinations are approved to any state for the air ambulance as long as the conditions for coverage are met in accordance with rule 5101:3-15-03 of the Administrative Code.

(H) Medical transportation providers, when providing a non-emergency ground ambulance, or ambulette service must document the reason for transport when the destination occurs outside of the patient's community, (a fifty mile radius from the patient's residence). Mileage greater than fifty miles will not be

covered if the provider is unable to produce the documentation which gives the reason for the transport to be out of the patient's community.

(I) Transportation to and from psychiatric hospitals

(1) Covered transportation services include the ambulance or ambulette transport of medicaid patients to and from public and private psychiatric hospitals for inpatient psychiatric hospital services only when the patient is age twenty-one and younger, or sixty-five and older, and the inpatient psychiatric services are eligible for reimbursement by medicaid in accordance the Chapter 5101:3-2 of the Administrative Code.

(2) Psychiatric hospital is defined as a hospital that is eligible to participate in the medicaid program only for the provision of inpatient psychiatric services.

(J) Critical care services provided by a physician or advanced nurse practitioner which are medically necessary are reimbursable services when provided and billed in accordance with rule 5101:3-4-06 or 5101:3-54-06.1 of the Administrative Code

(K) Medical transportation services cannot be billed to the department for medicaid patients enrolled in medicaid health maintenance organizations (HMOs) or medicaid managed care plans (MCPs) because transportation coverage is the responsibility of the HMO or MCP in which the patient is enrolled.

(L) Transport of an individual to a medicaid covered service that was cancelled or unavailable may be reimbursed if:

(1) The transport was provided in accordance with all other requirements of this chapter.

(2) The transportation provider had no prior notice of the unavailability or cancellation from the medicaid covered service provider or the individual.

(3) The medical transportation provider obtained written documentation, which can be handwritten, from the medicaid covered service provider before billing the department for transport. The written documentation must include:

(a) A business name, address, and phone number of the medicaid covered service provider.

(b) The date and time of the cancelled or unavailable service.

(c) A description of the reason(s) for the cancellation or unavailability of the service.

(d) A statement indicating that the medicaid covered service provider was unable to notify the medicaid transportation provider or the individual of the cancellation or unavailability of the service prior to the arrival at the destination, and

(e) The printed name and signature of the business/office manager or nurse.

(4) For reimbursement, the medical transportation provider must use modifier U6, service unavailable/cancelled; for both the base rate and loaded mileage procedure codes

(5) The reason for the cancellation or unavailability of the service did not occurs due to the action or inaction of the individual being transported or the medical transportation provider.

Replaces: 5101:3-15-03

Effective: 03/27/2006

R.C. 119.032 review dates:

Certification

Date

Promulgated Under: 119.03

Statutory Authority: 5111.02

Rule Amplifies: 5111.01, 5111.02

Prior Effective Dates: 4/7/77, 5/9/86, 7/5/93, 3/01/00, 12/27/01, 10/1/03, 12/30/05 (Emer)

MAL 538

Effective Date: July 1, 2008

Most Current Prior Effective Date: March 27, 2006

Transportation services provided by land ambulance, by air ambulance, or by ambulette and covered in accordance with rule **5101:3-15-03** of the Administrative Code are reimbursed as set forth in this rule.

- (A) For the one-way transport of one passenger, or the first passenger of a multiple-passenger trip, the provider is reimbursed a base amount for the service and a loaded mileage amount for each mile the passenger was transported.
- (1) The base amount is the lesser of either the provider's billed charge or the medicaid maximum listed in appendix DD to rule **5101:3-1-60** of the Administrative Code.
 - (2) The loaded mileage amount is the lesser of either the provider's billed charge or the medicaid maximum listed in appendix DD to rule 5101:3-1-60 of the Administrative Code.
- (B) For the one-way transport of each additional passenger of a multiple-passenger trip, the provider is reimbursed a base amount for the service.
- (1) The base amount is the lesser of either the provider's billed charge or a fixed portion of the medicaid maximum listed in appendix DD to rule 5101:3-1-60 of the Administrative Code.
 - (a) For transport by land ambulance or by ambulette, the fixed portion for the second passenger is fifty per cent, and the fixed portion for each additional passenger thereafter is twenty-five per cent.
 - (b) For transport by air ambulance, the fixed portion for the second passenger and for each additional passenger thereafter is one hundred per cent.
 - (2) No reimbursement is made for loaded mileage.
- (C) For attendant services provided in conjunction with transport by land ambulance or by ambulette, the provider is reimbursed the lesser of either the provider's billed charge or the medicaid maximum listed in appendix DD to rule 5101:3-1-60 of the Administrative Code.
- (D) In billing for services, the provider must specify certain information:
- (1) The most appropriate code for the base service and, where applicable, for the loaded mileage;
 - (2) The origin and destination of transport, where applicable;
 - (3) For a multi-passenger trip, whether the service was provided to the first passenger or to an additional passenger; and
 - (4) Any other factor necessary for the correct adjudication or payment of the claim.

Replaces: 5101:3-15-04

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Date

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~~*Formerly*~~ 5101:3-15-05 Medical Transportation Services: Ambulette Services Provided by Ground Ambulance Vehicles

MAL 493

Effective Date: January 1, 2006

~~(A) From January 1, 2002 through September 30, 2003 reimbursement for transportation of passengers whose medical condition requires ambulette services (as defined in rule 5101:3-15-03 of the Administrative Code) by ground ambulance will be at the ambulette rate.~~

~~(B)~~(A) ~~From October 1, 2003 through December 31, 2005 a~~ The transportation provider, who meets the requirements set forth for both ambulette and ground ambulance providers as specified in rule 5101:3-15-02 of the Administrative Code, may be reimbursed for providing the ambulette service with an ambulance vehicle if the following criteria ~~is~~are met.

- (1) The patient must meet the criteria for the ambulette service as specified in paragraph (B) of rule 5101:3-15-03 of the Administrative Code except for paragraphs (B)(2)(b) and (B)(2)(e) of rule 5101:3-15-03 of the Administrative Code.
- (2) The ground ambulance vehicle must meet requirements as specified in rule 5101:3-15-02 of the Administrative Code.
- (3) The rendering transportation provider has documented that ~~their~~its ambulette vehicles were unavailable and has documented referral attempts to a competing transportation provider or the rendering transportation provider has documented that delaying, deferring or missing the transport to or from the medicaid covered service would jeopardize the patient's health or cause excessive patient waiting time.
- (4) The rendering transportation provider has taken appropriate preventive measure(s) and developed protocols for telephone screening to encourage institutions, facilities, and patients to request the appropriate type of transport.
- (5) The rendering transportation provider, who owns at least one ambulette vehicle, is using the ambulance transport as backup to ~~their~~its ambulette vehicle and not because the provider has intentionally over booked ~~their~~its ambulette vans and is relying on the ambulance as primary transport for ~~patient's~~patients needing the ambulette service.
- (6) The safety of the patient is assured by adhering to all standards specified for ambulance transport in accordance with rule 5101:3-15-02 of the Administrative Code. The unoccupied patient's wheelchair cannot be transported unsecured inside the ambulance. The method for securing the wheelchair must assure that during transport or an accident that the wheelchair will not move.
- (7) Documentation must be provided upon request verifying paragraphs ~~(B)(2)~~(A)(2) to ~~(B)(6)~~(A)(6) of this rule to ODJFS.

~~(C)~~(B) Reimbursement of the ambulette service provided in an ambulance as specified in paragraph (B) of this rule ~~is~~as follows:

- (1) For the one-way ground ambulance transport of one passenger, the provider shall be reimbursed a base rate for the service and a loaded mileage rate for each mile the passenger was transported.
 - (a) The amount of reimbursement for the base rate shall be the lesser of the provider's billed charge or twenty-eight per cent of the medicaid maximum rate as set forth in appendix DD of rule 5101:3-1-60 of the Administrative Code for "Basic life support, non-emergency (BLS non-emergency)"; and
 - (b) The amount of reimbursement for the loaded mileage shall be the lesser of the provider's billed charge or forty-eight per cent of the loaded mileage code for ambulances.

- (c) For the total reimbursement, the provider must bill the "Basic life support, non emergency (BLS-~~Non-Emergency~~non-emergency)" code and the code for the loaded land ambulance mileage. Both codes must be modified with the appropriate medicaid covered point of transport modifier and U3, ambulance service by ambulance vehicle, modifier (two modifiers in total).
- (2) For the one-way ground ambulance transport of two or more passengers, the provider shall be reimbursed only a base rate for the service. No reimbursement shall be made for loaded mileage.
 - (a) The amount of reimbursement for the base rate for the second passengers of a multiple passenger transport will be further reduced by fifty per cent and the amount of reimbursement for the base rate for two or more passengers will be further reduced by twenty-five per cent.
 - (b) For reimbursement the provider must bill the base rate with the U3, ambulance service by ambulance vehicle, modifier, the appropriate medicaid covered point of transport modifier, and the appropriate multiple passenger modifier, U1, second passenger modifier, or U2, three or more passenger modifier (three modifiers in total).

Effective: 01/01/2006

R.C. 119.032 review dates: 10/01/2008

Certification: CERTIFIED ELECTRONICALLY

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Statutory Authority: 5111.02

Rule Amplifies: 5111.01, 5111.02

Prior Effective Dates: 10/1/03

Reference Material

General Billing Instructions / Certification of Medical Necessity Forms

[Click here to link to the General Billing Instructions e-book.](#)