Rules of
Department of Social Services
Division 70—Division of Medical Services
Chapter 6—Emergency Ambulance Program

Title 13—DEPARTMENT OF SOCIAL SERVICES
Division 70—Division of Medical Services
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13 CSR 70-6.010 Emergency Ambulance Program

PURPOSE: This rule establishes the regulatory basis for the administration of the emergency ambulance program. This rule provides for such methods and procedures relating to the utilization of, and the payment for, care and services available under the Medicaid program as may be necessary to safeguard against unnecessary utilization of such care and services and to assure that payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area. Specific details of provider participation, criteria and methodology for provider reimbursement, recipient eligibility, and amount, duration and scope of services covered are included in the ambulance program manual, which is incorporated by reference in this rule and available at the website.

PUBLISHER'S NOTE: The secretary of state has determined that the publication of the entire text of the material which is incorporated by reference as a portion of this rule would be unduly cumbersome or expensive. This material as incorporated by reference in this rule shall be maintained by the agency at its headquarters and shall be made available to the public for inspection and copying at no more than the actual cost of reproduction. This note applies only to the reference material. The entire text of the rule is printed here.

(1) Administration. The Missouri Medicaid ambulance program shall be administered by the Department of Social Services, Division of Medical Services. The ambulance program services covered and not covered, the limitations under which services are covered, and the maximum allowable fees for all covered services shall be determined by the Division of Medical Services and shall be included in the ambulance program provider manual, which is incorporated by reference in this rule and made part of this rule as published by the Department of Social Services, Division of Medical Services, 615 Howerton Court, Jefferson City, MO 65109, at its website at www.dss.mo.gov/dms, February 10, 2006. This rule does not incorporate any subsequent amendments or additions.

(2) Eligible Providers. To be eligible for participation in Missouri Medicaid, the following requirements shall be met:

(A) Ground Ambulance.

1. The provider must be licensed by the Missouri Department of Health and Senior Services if located in Missouri or licensed by the state regulating authority if located outside the state of Missouri.

2. The provider must be certified to participate in the Title XVIII Medicare program and have a signed and accepted Participation Agreement in effect with the Missouri Department of Social Services, Division of Medical Services; and

(B) Air Ambulance. Air ambulance is defined as any privately or publicly owned conventional air service, rotary wing specially designed, constructed or modified, maintained or equipped with the intent to be used for the transportation of patients as defined in Federal Aviation Regulations, Part 135.

1. The air ambulance provider must have a current valid air ambulance license, be licensed by the state regulating authority if located outside of Missouri, have submitted a copy of the current Federal Aviation Regulations, Part 135, (FFA) Air Carrier Certificate issued by the United States Department of Transportation.

2. The air ambulance provider must have a signed and accepted Participation Agreement for the air ambulance program in effect with the Missouri Department of Social Services, Division of Medical Services.

(3) Recipient Eligibility. The ambulance provider must ascertain the patient's Medicaid status before billing for services. The recipient's Medicaid/MC+ eligibility is determined by the Family Support Division. The recipient must be eligible for Medicaid on the date that a service is provided in order for a provider to receive Medicaid reimbursement. It is the provider's responsibility to determine the coverage benefits for a recipient based on their type of assistance as outlined in the ambulance program manual. The recipient's eligibility shall be verified in accordance with methodology outlined in the ambulance program manual.

(4) Prior Authorization. Emergency ambulance services do not require prior authorization. All non-emergency, Medicaid covered services that are to be performed or furnished out-of-state for eligible Missouri Medicaid recipients and for which Missouri Medicaid is to be billed, must be prior authorized before the out-of-state services are provided. A prior authorization is not required for out-of-state emergency services.

(5) Services Covered and Service Limitations. The Medicaid ambulance manual shall provide the detailed listing of procedure codes and pricing information covered by the Missouri Medicaid ambulance program.

(A) Ambulance services are covered if they are emergency services and transportation is made to the nearest appropriate hospital.

(B) Emergency services are services required when there is a sudden or unforeseen situation or occurrence or a sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that 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. Nearest appropriate hospital is the hospital that is equipped and staffed to provide the needed care for the illness or injury involved. Medicaid does not allow transportation to a more distant hospital solely to avail a patient of the services of a specific physician or family or personal preference when considering the nearest appropriate facility.

(C) Exceptions to Emergency Services.

1. Missouri Medicaid covers medically necessary ambulance services for recipients under twenty-one (21) years of age through the Healthy Children and Youth (EPSDT/HCY) program. The Omnibus Budget Reconciliation Act of 1989 (OBRA 89) expanded medically necessary services for children under the age of twenty-one (21) through the Early Periodic Screening, Diagnosis and Treatment (EPSDT) program, also known as the Healthy Children and Youth (HCY) program. Transport by ambulance is covered if it is medically necessary and any other method of transportation would endanger the child's health.

2. Transportation to and from one hospital to another and return for specialized testing and/or treatment is covered.

3. Medicaid covers transportation from the point of pickup to two (2) different hospitals made on the same day by the same ambulance provider when it is medically necessary.

4. Ground ambulance transfers of patients from one hospital to another hospital to receive medically necessary inpatient services not available at the first facility shall be covered by Missouri Medicaid. Hospital transfers shall be covered when the patient

has been stabilized at the first hospital, but needs a higher level of care available only at the second hospital.

(D) Missouri Medicaid covers emergency air ambulance only when transportation by ground ambulance is contraindicated and when the patient's medical condition is such that immediate and rapid ambulance transportation is essential and cannot be provided by ground ambulance, great distances or other obstacles are involved in getting the patient to the nearest hospital with appropriate facilities, the patient's medical condition is such that the time needed to transport by land, or the instability of transportation by land poses a threat to the patient's survival or seriously endangers the patient's health, the point of pickup is inaccessible by land vehicle, and all other Medicaid requirements for coverage are met.

(6) Services Not Covered.

(A) Ground Ambulance. The following services are not covered under the ground ambulance program:

1. Ambulance transportation to a physician's office, a dentist's office, a nursing home, or a patient's home except for recipients under twenty-one (21) (except ME codes 76-79) through the EPSDT/HCY program;

2. Ambulance services to a hospital for the first stage of labor;

3. Non-emergency ambulance trips are not covered with the exceptions of those services listed above;

4. If a recipient is pronounced dead before the ambulance is called, no Medicaid payment is made; or

5. Ancillary services and supplies are not covered when the patient is not transported.

(B) Air Ambulance. The following services are not covered under the air ambulance program:

1. Air ambulance trip for the patient's personal preference;

2. Patient not transported to the nearest hospital with appropriate facilities;

3. Transports by fixed-wing aircraft;

4. Ambulance trips ordered by the Veteran's Administration Hospital;

5. Transport of medical team (or other medical professionals) to meet a patient;

6. Ground mileage;

7. Transport to a facility that is not an acute care hospital, such as a nursing facility or physician's office;

8. If a recipient is pronounced dead before the air ambulance is called; or

9. Ancillary services and supplies are not covered when the patient is not transported.

(C) When individuals are transported by ambulance to an emergency room and are subsequently treated and released without admission to the hospital, the return trip is not covered under the emergency ambulance program.

(7) General Regulations. General regulations of the Missouri Medicaid program apply to the ambulance program.

(8) Reimbursement. Payment will be made in accordance with the fee per unit of service as defined and determined by the Division of Medical Services. Providers must bill their usual and customary charge for ambulance services. Reimbursement will not exceed the lesser of the maximum allowed or the provider's billed charges. Ambulance program services are only payable to the enrolled, eligible, participating provider. The Medicaid program cannot reimburse for services performed by non-enrolled providers.

(9) Other Source Payment. The Medicaid payment for ambulance services cannot duplicate or replace benefits available to the recipient from any other source, public or private. A settlement received from private insurance or litigation as the result of an accident must be used toward payment of the ambulance bill. Medicaid shall be the last source of payment on any claim. Any payment received from a private insurance carrier or other acceptable source shall be listed on the claim form. If the settlement received is equal to or exceeds the fee that could be allowed by Medicaid, no payment shall be made by Medicaid.

(10) Documentation Requirements for Emergency Ambulance Program. All services must be adequately documented in the medical record. Adequate documentation means documentation from which services rendered and the amount of reimbursement received by a provider can be readily discerned and verified with reasonable certainty. Documentation includes the Missouri Ambulance Reporting Form (trip ticket). In addition to the above documentation requirements, each licensee of an air ambulance must maintain accurate records that contain information concerning the air transportation of each patient. The patient record shall be maintained and shall accurately document the patient care rendered by the medical flight crew and the disposition of the patient at the receiving facility. The documentation of the emergency air ambulance flight record (trip ticket) must contain a description of the patient's medical condition with sufficient detail to demonstrate the need for emergency air ambulance.

(11) Records Retention. The enrolled Medicaid ambulance provider shall agree to keep any records necessary to disclose the extent of services the provider furnishes to recipients. These records must be retained for five (5) years from the date of service. Fiscal and medical records coincide with and fully document services billed to the Medicaid agency. Providers must furnish or make the records available for inspection or audit by the Department of Social Services or its representative upon request. Failure to furnish, reveal or retain adequate documentation for services billed to the Medicaid program, as specified above, is a violation of this regulation.

AUTHORITY: sections 208.152, RSMo Supp. 2005 and 208.201, RSMo 2000. Original rule filed Feb. 10, 2006, effective Sept. 30, 2006.*

**Original authority: 208.152, RSMo 1967, amended 1969, 1971, 1972, 1973, 1975, 1977, 1978, 1978, 1981, 1986, 1988, 1990, 1992, 1993, 2004, 2005 and 208.201, RSMo 1987.*