JOHNS HOPKINS HEALTH PLANS	Johns Hopkins Health Plans **Provider Relations and Network Innovation Reimbursement Policy**	*Policy Number*	RPC.037
		Effective Date	09/06/2024
		Approval Date	06/12/2024
	Subject **Priority Partners (PPMCO) Ambulance and Medical Transportation Services**	*Supersedes Date*	N/A
		Original Date	N/A
		Page	1 of 6

This document applies to the following Participating Organizations:

Priority Partners

Keywords: Air Ambulance, Ambulance, Medical Transportation

Table of Contents		Page Number
I.	ABOUT OUR REIMBURSEMENT POLICIES	1
II.	PURPOSE	2
III.	POLICY STATMENT	2
IV.	GENERAL BILLING GUIDELINES AND PAYMENT METHODOLOGY	2
V.	MOBILE INTEGRATED HEALTH (MIH) SERVICES	3
VI.	NON–COVERED AMBULANCE AND MEDICAL TRANSPORTATION SERVICES	3
VII.	CODES, TERMS and DEFINITIONS	4
VIII.	REFERENCES	6
IX.	APPROVALS	6

I. ABOUT OUR REIMBURSEMENT POLICIES

The most current version of the reimbursement policies can be found on www.hopkinsmedicine.org.

Johns Hopkins Health Plan LLC (JHHP) reimbursement policies as a guide to assist in accurate claim submissions and outline the basis for reimbursement of services covered by a member's JHHP benefit plan. The determination that a service, procedure, item, etc. is covered under a member's benefit plan is not a determination that you will be reimbursed. Services must meet authorization and medical necessity guidelines appropriate to the procedure and diagnosis, as well as to the member's state of residence. Providers are expected to and must follow proper billing and submission guidelines. Providers are required to use industry standard, compliant codes on all claim submissions. Services must be billed with valid ICD-10 diagnosis codes, Healthcare Common Procedure Coding System/Current Procedural Terminology (HCPCS/CPT) codes, place of service (POS) codes, and/or revenue codes as defined by the Centers for Medicare & Medicaid Services (CMS) and in the American Medical Association's (AMA's) "CPT Manual". The codes denote the services and/or procedures performed.

The codes billed should denote the services and/or procedures performed. The billed code(s) are required to be fully supported in the patient's medical record and/or office notes and JHHP reserves the right to request the records. If a corrected claim is filed, it must comply with timely filing to be reprocessed through the claims system. Issues related to inconsistent, missing, conflicting, or unclear documentation must be resolved by the provider submitting the claim. Corrected claims are for administrative errors on the claim (i.e., misspelled name, CPT/HCPCS code transposed, wrong DOB, missing modifier, etc.). Intentionally changing the CPT/HCPCS or diagnosis code in order to get the claim paid, after the billed service was denied, is not a correction. The medical records must match the services billed. Unless otherwise noted within the policy, our policies apply to both participating and nonparticipating providers and facilities.

JHHP policies apply to all practitioners, hospitals, providers, or suppliers eligible to bill the relevant HCPCS/CPT codes pursuant to applicable portions of the Social Security Act (SSA) of 1965, the Code of Federal Regulations (CFR), and Medicare rules. JHHP reimbursement policies are developed based on nationally accepted industry standards, coding principles, and follows the CMS developed National Correct Coding Initiative (NCCI) program to prevent inappropriate payment of services that should not be reported together. These policies may be superseded by mandates in provider or state

contracts, or state, federal or CMS contracts and/or requirements. If appropriate, when coding/billing guidelines or current reimbursement policies are not followed, JHHP may:

- Reject or deny the claim
- Recover and/or recoup claim payment

JHHP reserves the right to modify policies at any time and publish new versions when necessary. System logic or setup may prevent the loading of policies into the claims platforms in the same manner as described; however, JHHP strives to minimize these variations. When there is an update, policies will be published on our website.

II. PURPOSE

To provide basic billing and reimbursement guidance for Ambulance and Medical Transportation (emergency and non-emergency) services billed for a Priority Partner member, in alignment with Maryland Department of Health (MDH) Medicaid guidance and Code of Maryland Regulations (COMAR).

III. POLICY STATMENT

JHHP understands that ambulance and medical transportation may be necessary at times because of the member's medical condition, requiring transport to the nearest, appropriate medical or treatment facility due to various factors. Each line of business possesses its own unique contract and guidelines for benefit and payment purposes. As such, there could be various factors that may impact reimbursement, including but not limited to legislative mandates, provider contracts, and/or the member's benefit coverage, prior authorization, including provisions addressing services rendered by non-participating providers, which may supplement, modify, or supersede this policy. Claims for ambulance services and medical transportation may be reviewed prior to payment being rendered.

IV. GENERAL BILLING GUIDELINES AND PAYMENT METHODOLOGY

1. In certain situations, prior authorizations/referrals may be required for items or services. In such cases, payments are subject to determination of a member's eligibility, eligibility of charges as covered expenses, and the application of the exclusions and limitations and other provisions of the policy at the time services are provided.
2. Services requiring a prior authorization must be approved prior to services being rendered or the claim may be denied. Prior authorization is not a guarantee of payment.
3. In all cases, the appropriate documentation must be kept on file and, upon request, presented to JHHP. It is important to note that the presence (or absence) of a physician's order for a transport by ambulance does not necessarily prove (or disprove) whether the transport was medically necessary. The ambulance service must meet all program coverage criteria in order for payment to be made.
4. When applicable, JHHP requires providers to report the coding and sequencing of diagnosis codes in alignment with CMS, the National Center for Health Statistics (NCHS), the Department of Health and Human Services (DHHS), and the Uniform Hospital Discharge Data Set (UHDDS), which is based on the International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM) for Coding and Reporting guidelines.
5. JHHP utilizes coding edits to identify when an ICD-10 code is submitted incorrectly or when an inappropriate diagnosis is pointed to or linked as primary on the claim form. When this occurs, JHHP will deny the associated claim line.
6. In alignment with CMS, JHHP requires that Ambulance or Medical Transportation HCPCS codes must be reported with the appropriate modifier, when applicable.
7. For ambulance service claims, institutional-based providers and suppliers must report an origin and destination modifier for each ambulance trip provided in HCPCS/Rates.
8. Institutional-based providers must report the appropriate modifier (QM or QN) with every HCPCS code to describe whether the service was provided under arrangement or directly.

9. Consistent with COMAR and MDH guidance, medical transportation services furnished to a JHHP member is covered when the following, fundamental conditions are met:
    i. Must be medically necessary; and
    ii. The patient is being transported due to a procedure not available at the first hospital (e.g., PET scan, MRI) and must be transported to a second hospital to receive the service/procedure.
        a. Patient must return on the same day to the first hospital for continued inpatient care. In such a case, the transportation is a covered hospital service and is reimbursed under the appropriate revenue code.
        b. Institution based ambulance providers may bill on the ASC X12 837 institutional claim transaction or Form CMS 1450.
10. In alignment with the MDH, JHHP requires all providers (i.e., ordering, referring, rendering, servicing, billing) delivering services to JHHP members to have an active enrollment status in the electronic Provider Revalidation and Enrollment Portal (ePREP) on the date of service.
    i. Claims submitted by individual providers, provider groups and facilities who are inactive or unregistered in ePREP will not be reimbursed.
    ii. Providers are solely responsible for ensuring their information in the ePREP portal is valid and active.

V. MOBILE INTEGRATED HEALTH (MIH) SERVICES

1. JHHP will reimburse Jurisdictional Emergency Medical Services Operational Programs (JEMSOPs) for mobile integrated health (MIH) services when the following conditions are met:
    i. JEMSOPs must bill for MIH services using only HCPCS code A0998.
    ii. JEMSOPs must be actively enrolled as an ambulance company (provider type T1, Category of Service designation TM) on the date of service and active in their covered service areas.
    iii. MIH services must be delivered in a participant's home or other community-based setting, any other place of service reported will be denied.
2. Reimbursement for MIH services are not provided in response to a 9-1-1 call.
3. Reimbursement for an MIH visit is inclusive of all services rendered during the MIH visit.
4. JEMSOPs and other provider types may not bill separately for clinical services delivered during a MIH visit.
    i. For example, if the JEMSOP consults with a contracted physician through a telehealth appointment during an MIH visit, only the MIH visit will be reimbursed by JHHP.
    ii. It is the responsibility of the JEMSOP to ensure that any contracted entities or providers are aware of this guidance.

VI. NON–COVERED AMBULANCE AND MEDICAL TRANSPORTATION SERVICES

1. In accordance with MDH and COMAR guidance, JHHP Priority Partners is ***NOT*** responsible to provide reimbursement to a supplier for Medical Transportation or Ambulance Services, as follows (list is not all inclusive):
    a. When used to transport sick or injured people to a hospital in an emergency or non-emergent situation via:
        - Air Ambulance service
        - Ground Ambulance service
        - Rotary Air Transport service
        - Fixed Wing Transport service
        - Water Ambulance service
        - Other Ambulance service
2. Transportation services requested by police, fire department, or medical authorities at the site of an emergency.
3. Transportation to a hospital that provides a required higher level of care that was not available at the original hospital.
4. When the member is being discharged from one hospital and admitted to another hospital or facility.

5. Transport is primarily for the preference or convenience of the participant or provider.
6. Transportation for a scheduled medical service/procedure to/from:
   - Home
   - Diagnostic or therapeutic site other than hospital
   - Residential, domiciliary, custodial facility
   - Skilled Nursing Facility (SNF)
   - Physician office
   - Hospital (except as noted above in section III)
   - Custodial facility
   - Long Term or Acute Care facility
   - ESRD facility
7. Ambulance or Medical Transportation services reported without a valid modifier, HCPCS code, or Revenue code will be denied.
8. The unbundling of supplies, drugs, ancillary services or any other services that are not to be separately reimbursed when reported with an ambulance transportation code.

VII. CODES, TERMS and DEFINITIONS

Definition of Terms

Term	Definition
837I	The 837I (Institutional version) of the standard format used by institutional providers to transmit health care claims electronically. It is the electronic version of CMS-1450.
837P	The 837P (Professional version) of the standard format used by non-institutional providers to transmit health care claims electronically. It is the electronic version of the CMS-1500.
CMS-1450	The CMS-1450, also known as UB-04, is the standard claim form to bill facility claims when a paper claim is allowed. CMS allows providers to bill using a paper claim when the providers fulfill the Administrative Simplification Compliance Act (ASCA) exception to electronic claims provisions.
CMS-1500	The CMS-1500 form is the standard claim form used by a non-institutional provider or supplier to bill carriers when a provider qualifies for a waiver from the Administrative Simplification Compliance Act (ASCA) requirement for electronic submission of claims. Providers sending professional and supplier claims on paper must use Form CMS-1500 in a valid version.

Jurisdictional Emergency Medical Services Operational Programs (JEMSOPs)	For the purposes of this policy and in alignment with MDH guidance, JEMSOP is an ambulance company (provider type T1, Category of Service designation TM) for mobile integrated health services (MIH).
Mobile Integrated Health (MIH)	For the purposes of this policy and in alignment with MDH guidance, MIH is a community-based preventative, primary, chronic, pre-admission or post-admission health care service.
National Uniform Billing Committee (NUBC)	The National Uniform Billing Committee (NUBC) makes its UB-04 manual available through its website. This manual contains the updated specifications for the data elements and codes included on the CMS-1450 and used in the 837I transaction standard.

Procedure codes (CPT/HCPCS)

HCPCS Code	Definition
A0021-A0999	Refer to the AMA HCPCS Level II Coding book for an accurate description of transportation services including ambulance, nonemergency transportation, and ancillary transportation services.
A0998	Ambulance response and treatment, no transport.

Revenue Codes

Revenue Code	Definition
054X- Ambulance	• 0540 – General • 0541 – Supplies • 0542 - Medical transport • 0543 - Heart mobile • 0544 – Oxygen • 0545 - Air ambulance • 0546 - Neonatal ambulance • 0547 – Pharmacy • 0548 - EKG transmission • 0549 - Other

Ambulance Modifiers: For ambulance transportation claims, JHHP has adopted guidelines from CMS that require a provider to report an origin and destination modifier for each trip provided. Origin and destination modifiers used for ambulance services are created by combining two alpha characters. Each alpha character, with the exception of “X”, represents an origin code or a destination code. The pair of alpha codes creates one modifier. The first position alpha code equals origin; the second position alpha code equals destination. Origin and destination codes and their descriptions are listed below.

Modifier Descriptions

D = Diagnostic or therapeutic site other than P or H when these are used as origin codes; E = Residential, domiciliary, custodial facility (other than 1819 facility); G = Hospital based ESRD facility; H = Hospital; I = Site of transfer (e.g. airport or helicopter pad) between modes of ambulance transport; J = Freestanding ESRD facility; N = Skilled nursing facility; P = Physician's office; R = Residence; S = Scene of accident or acute event; X = Intermediate stop at physician's office on way to hospital (destination code only)
QM = Ambulance service provided under arrangement by a provider of services
QN = Ambulance service furnished directly by a provider of services

VIII. REFERENCES

This policy has been developed through consideration of the following:

- COMAR- Maryland Department of Health- Maryland Medicaid Administration
- CPT Copyright American Medical Association. All rights reserved. CPT® is a registered trademark of the American Medical Association
- Johns Hopkins Health Plans Reimbursement Policies
- Medicare Billing Form CMS-1450 and the 837I Booklet
- MDH- Transmittals (maryland.gov)
- MDH Provider Information Site
- Medicare Claims Processing Manual CH. 15- Ambulance
- Priority Partners Provider Manual

IX. APPROVALS

Date	Review/Revison	Reason for Modification	Approved By
6/12/2024	New policy	N/A	Reimbursement Authorization and Coding Committee (RAC)