INDEPENDENT CARE HEALTH PLAN

*i*Care Guide for Ambulance Claims Processing Overview

Reviewed: July 2019

Ambulance Services

- Disclaimer: This information is provided as a courtesy from *i*Care to assist you with claims submission and billing. This does not replace Forward Health and CMS Guidelines. *i*Care relies upon Forward Health and CMS for payment rules and regulations for claim submission.

Medicare Ambulance Services

- Medicare covers ground ambulance transportation when you need to be transported to a hospital, critical access hospital, or skilled nursing facility for medically necessary services, and transportation in any other vehicle could endanger your health.
- Medicare may pay for emergency ambulance transportation in an airplane or helicopter to a hospital if you need immediate and rapid ambulance transportation that ground transportation can't provide. In some cases, Medicare may pay for limited, medically necessary, nonemergency ambulance transportation if you have a written order from your doctor stating that ambulance transportation is medically necessary.

Medicaid Ambulance Services

- ForwardHealth covers ambulance transportation only for enrolled members who are going to and from a covered service.
  - More information can be found at https://www.forwardhealth.wi.gov/WIPortal/Subsystem/KW/Display.aspx?ia=1&p=1&sa=2&s=2&c=61

Ambulance HCPCS codes and Definitions

A0998 Ambulance response and treatment, no transport

A0999 Unlisted ambulance service

A0225 Ambulance service, neonatal transport, base rate, emergency transport, one way

A0380 Bls mileage (per mile)

A0382 Bls routine disposable supplies

A0384 Bls specialized service disposable supplies; defibrillation (used by als ambulances and bls ambulances in jurisdictions where defibrillation is permitted in bls ambulances)

A0390 Als mileage (per mile)

A0392 Als specialized service disposable supplies; defibrillation (to be used only in jurisdictions where defibrillation cannot be performed in bls ambulances)

A0394 Als specialized service disposable supplies; iv drug therapy

A0396 Als specialized service disposable supplies; esophageal intubation

A0398 Als routine disposable supplies

A0420 Ambulance waiting time (als or bls), one half (1/2) hour increments

Ambulance HCPCS codes and Definitions

A0422 Ambulance (als or bls) oxygen and oxygen supplies, life sustaining situation

A0424 Extra ambulance attendant, ground (als or bls) or air (fixed or rotary winged); (requires medical review)

A0425 Ground mileage, per statute mile

A0426 Ambulance service, advanced life support, non-emergency transport, level 1 (als 1)

A0427 Ambulance service, advanced life support, emergency transport, level 1 (als 1 - emergency)

A0428 Ambulance service, basic life support, non-emergency transport, (bls)

A0429 Ambulance service, basic life support, emergency transport (bls-emergency)

A0430 Ambulance service, conventional air services, transport, one way (fixed wing)

A0431 Ambulance service, conventional air services, transport, one way (rotary wing)

A0432 Paramedic intercept (pi), rural area, transport furnished by a volunteer ambulance company which is prohibited by state law from billing third party payers

A0433 Advanced life support, level 2 (als 2)

A0434 Specialty care transport (sct)

A0435 Fixed wing air mileage, per statute mile

A0436 Rotary wing air mileage, per statute mile

Ambulance Services – Modifiers

Origin/Destination	Description
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 (This is a destination code only)

Ambulance Services - Modifiers

Multiple Carry Modifier	Description
GM	Multiple patients on one ambulance trip

Pronouncement of Death Modifier	Description
QL	Patient pronounced dead after ambulance called

Trip Modifiers	Description
U1	First or only trip
U2	Second trip
U3	Third trip
U4	Fourth trip
U5	Fifth trip
U6	Sixth trip

*i*Care Contact Information

Customer Service-Milwaukee Office
(Monday-Friday 8:00-5:00)
Member Local: 414-223-4847
Out Of Area: 1-800-777-4376

Provider Local: 414-231-1029
Out of Area: 1/877-333-6820
Email:
providerservices@icarehealthplan.org

iCare Dane County Office
1-800-777-4376

Inpatient Admissions Notification
414-225-4760
FAX: 414-231-1075

Interdisciplinary Team
414-231-4847

Member Rights Specialist
414-231-1076
Fax: 414-231-1026

Pharmacy
1-800-910-4743
1-877-333-6820

Provider Contracting
414-225-4741
FAX: 414-272-5618

Claim Filing Limits

- Timely filing limits for all providers is 120 days from the date of service, unless otherwise agreed upon and included in the Provider's service agreement with *i*Care.
- Providers are to submit all claims for services rendered where *i*Care Medicare is primary or *i*Care Medicaid is primary according to the terms of the contract. Timely filing limits apply to initial claim submissions, resubmissions and corrected claims.

Clean Claim Forms

iCare Requirements for Clean Claim (UB-04)

Box	Description	Comments
1	Provider Name and Address	
4	Bill Type	
5	Federal Tax ID	
6	Statement Covers Period	From and Through Dates of Claim
8b	Patient Name	
9a-e	Patient Address	
10	Date of Birth	
11	Patient Sex	
12	Admission Date	Required Inpatient, Home Health and SNF
14	Admission Type	Inpatient claims only
15	Admission Source	
17	Discharge Status	Not required for rural health or federally qualified clinics.
18-28	Condition Codes	
29	Accident State	
42	Revenue Codes	If Revenue code of 0022, 0023, 0024 is listed in box 42 and there is no entry box on 44, reject claim for RUGS code missing
44	HCPCS/Rate	Required based on Type of Bill
45	Service Date	
46	Service Units	
47	Total/Line Item Charges	Negative Amount: Claim will reject for "No Dollar Amount". Total Charges must equal the sum of the line item charges or claim will reject "Total charge does not match line charge totals". Total charges with claim with Revenue Codes 0022, 0023, 0024 may be zero.
49	Unlabeled	
56	NPI	
57a-57c	Other Provider ID	
58a	Insured's Name	
59a	Relationship to Uninsured	
60a	Insured Identification Number	

iCare Requirements for Clean Claim (CMS 1500)

Box	Description	Comments
1a	Insured's ID Number	
2	Patient Name	
3	Birth Date and Sex	Date of birth must be valid date and not future date
5	Patient Address	
12	Patient's or Authorized Person's Signature and Date Signed	Acceptable alternatives: Unable to sign, signature on file, SOF, Computer generated, signature marked with "X", Authorization of File, Medicare/Medicaid Reclamation Claims, Transportation, Lodging
21	Diagnosis or Nature of Illness	
24a	Dates of Service	Claim must include one detail line, must be a valid date, From date cannot include a future date, cannot have a date span into the future, cannot span a calendar year
24b	Place of Service	Must be 2 characters
24d	Procedures, Services or Supplies	Must be at least 5 characters
24f	Charges	A negative amount will be neglected
24g	Days or Units	
24i/j	Taxonomy code and prefix	Must be present here or in Box 33b. Not required for SMV, personal care attendant, Blood bank or Community Care Organization. Prefix of PXC is required for all 5010 electronic submission, for paper submission either ZZ or blank is accepted.
24J (b)	NPI	Must be 10 numerical characters. Not required for SMV claims billed with POS 41,42,99
25	Federal Tax ID Number	Must be 9 numerical characters
28	Total Charge	Total charges must equal the sum of the line charges
31	Signature of Physician or Supplier Physician	Not required for SMV claims billed with POS 41,42,99
33	Physician/Provider's Name, Billing Address, Zip Code	
33a	Billing Physician/Provider NPI	Must be 10 numerical characters. Not required for SMV claims billed with POS 41, 42,99. The Medicaid provider must be certified as a billing provider.
33b	Taxonomy code and prefix	Must be present here or in Box 24i/24j. Not required for SMV, personal care attendant, Blood bank or Community Care Organization. Prefix of PXC is required for all 5010 electronic submission, for paper submission either ZZ or blank is accepted. For electronic submission: Loop Number 2310A-BILLING PROVIDER NAME, Segment PRV, ElementPRV02 =PXC, ElementPRZ03=value populated taxonomy code

Claims Address

- Medicare/Medicaid Covered Services

  Independent Care Health Plan

  PO Box 660346

  Dallas, TX 75222-0346

- Long-Term Care Services

  Independent Care Health Plan

  PO Box 224255

  Dallas, TX 75222-4255

Provider Portal

- Providers are encouraged to check the current claim status through our Provider Portal.
  - https://www.icarehealthplan.org/Providers/TrizettoAccess.aspx
- Providers may request access to the Provider Portal by completing the **Portal Access Request Form** at the above website
- You will also find the Provider Portal Guide on the iCare Provider Portal website.

Frequently Asked Questions

- When Medicare is primary which HCPCS code is used for ground ambulance services?
  - A0425 – BLS mileage (per mile) or ALS mileage (per mile)
- When Medicare is primary, should the provider submit claims using the trip modifiers for multiple transports on the same day?
  - No, Medicare will only submit using providers and suppliers must report an origin and destination modifier for each ambulance trip provided in HCPCS/Rates.
- Will *i*Care cover Hospital to Hospital transport.
  - Yes
- Multiple ambulance providers respond to a 911 call, will *i*Care pay the ambulance provider if there was not provide the transport.
  - No, payment is made only if you actually transport the member to the nearest hospital
- Will *i*Care pay the ambulance provider if Member is pronounced dead on arrival.
  - Yes, payment your BLS base rate; No mileage or rural adjustment; and Use QL modifier, "Patient pronounced dead after ambulance called," on claim .