Fee Schedule Guidelines

Ambulance

WSI
North Dakota Workforce Safety & Insurance

January 2024

Notice

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The WSI Fee Schedule is not a guarantee of payment. The fact that WSI assigns a procedure or service a HCPCS code and a payment rate does not imply coverage by WSI but indicates the maximum allowable payment for approved services. Services represented are subject to provisions of WSI including: compensability, claim payment logic, applicable medical policy, benefit limitations and exclusions, bundling logic, and licensing scope of practice limitations.

Any changes made to Pricing Methodology are subject to the North Dakota Public Hearing process. WSI reserves the right to implement changes to the Payment Parameters, Billing Requirements, and Reimbursement Procedures as needed. WSI incorporates all applicable changes into the relevant Fee Schedule Guideline at the time of implementation, and communicates these changes in Medical Providers News, available on the WSI website at www.workforcesafety.com/news/medical-providers. WSI reviews and updates all Fee Schedule rates on an annual basis, with additional updates made on a quarterly basis when applicable.

For reference purposes, the sections of the North Dakota Administrative Code (N.D.A.C.) that regulate medical services are **92-01-02-27 through 92-01-02-46**. The complete N.D.A.C. is accessible on the North Dakota Legislative Council website: http://www.legis.nd.gov/agency-rules/north-dakota-administrative-code.

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Ambulance Pricing Methodology

Ambulance Pricing Methodology outlines the methods used by Workforce Safety and Insurance (WSI) to determine the final rates represented on the Ambulance Fee Schedule. The Ambulance Fee Schedule uses the applicable procedure codes and descriptions as defined by the Healthcare Common Procedure Coding System (HCPCS), their respective payment status indicators, and payment amounts. In accordance with North Dakota Administrative Code 92-01-02-29.2, any provider who renders treatment to a claimant under the jurisdiction of WSI is reimbursed according to the rates assigned in the Ambulance Fee Schedule. A provider may access the complete Ambulance Fee Schedule and other resources referenced within this document by visiting the Medical Provider section of the WSI website: www.workforcesafety.com.

Status Indicators

WSI assigns one of the following status indicators to each HCPCS code within the Ambulance Fee Schedule:

Indicator	Description	Pricing Methodology
A	Active Code	Service is payable under the applicable WSI Fee Schedule.
B	Packaged Code	Service is not separately payable. Payment is packaged into the payment for another service.
C	Custom Priced Code	Service is payable using usual and customary or WSI-negotiated rates.
D	Discontinued Code	Service is not payable. Code was discontinued effective beginning of the calendar year.
P	Excluded Code	Service is not payable under the WSI Fee Schedule.

Calculation of the Reimbursement Rate

For HCPCS codes assigned a status indicator “A”, WSI applies the following formula to determine the maximum allowable reimbursement rate:

Prior Year’s Rate	X	Consumer Price Index-Urban (CPI-U)	=	Reimbursement Rate

For 2024, the CPI-U is 3%

Annual Updates

WSI updates the Ambulance Fee Schedule annually based on the CPI-U published by The Centers for Medicare and Medicaid (CMS). WSI applies the increases to the prior year’s payment amount for both ground ambulance services and air ambulance services.

Limitations of the Ambulance Fee Schedule

The payment rates listed on the Ambulance Fee Schedule indicate the maximum allowable payment for approved services only. The fact that a procedure or service is assigned a HCPCS code and a payment rate does not imply coverage by WSI but indicates the maximum allowable payment for approved services. The final payment rate may be impacted by the payment parameters and billing requirements enforced by WSI. A provider is encouraged to carefully review WSI’s Payment Parameters, Billing Requirements, and Reimbursement Procedures to avoid unneccesary delays and denials of payment.

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Ambulance Payment Parameters

Ambulance Payment Parameters outline the rules for payment adopted by WSI. While WSI has adopted many of Medicare's rules for payment, WSI has developed a set of unique rules that are applied to the final payment of approved services. The complete payment parameters enforced by WSI are as follows:

Advanced Beneficiary Notice (ABN) – A provider may utilize the ABN form to notify an injured employee of the costs associated with a recommended procedure that is: statutorily excluded from coverage, statutorily limited in quantity, deemed by WSI as not medically necessary to treat the work injury. To identify a charge accompanied with a signed ABN, a provider should append modifier GA to each applicable bill line. A provider should then submit the signed ABN along with the bill and medical documentation to WSI.

Authorization – Emergency transportation does not require authorization. Non-emergent transportation, including hospital-to-hospital transfer, requires prior authorization. For non-emergent ground transportation, a provider should contact customer service at 800-777-5033 to initiate a request for prior authorization. For non-emergent air transportation, a provider must submit the Non-Emergent Air Ambulance Facility-to-Facility Request (M13) form to request prior authorization.

"Lesser of" Payments" – The rates listed on the Ambulance Fee Schedule represent the maximum amount payable for services rendered. WSI pays the "lesser of" the billed charge or the Fee Schedule amount. This is done at the line level rather than the bill level.

Mileage Adjustments – WSI does not incorporate the current Medicare payment adjustments for rural mileage vs. urban mileage or for extensive mileage.

Modifiers – WSI has adopted the following policy on ambulance modifiers:

- WSI requires the use of the GM and QL modifiers
- WSI accepts, but does not require, the use of origin and destination modifiers
- WSI accepts, but does not require, the use of "under arrangement" modifiers

Multiple Patient Reductions – WSI follows the Medicare payment reduction rules for ambulance runs with multiple patients on-board.

NCCI Edits – WSI incorporates all applicable NCCI edits.

Origin Adjustments – WSI does not incorporate the Medicare adjustments for rural origin vs. urban origin.

Patient Death – WSI follows the Medicare payment provisions for a patient who is pronounced dead after the ambulance has been called, but before the ambulance arrives.

Payment Packaging – WSI issues payment for the base service and loaded mileage only. Payment for ambulance supplies, drugs, oxygen, waiting time charges, and miscellaneous services are packaged into the payment for the base service. WSI identifies these services with status indicator "B".

ZIP Code Reporting – WSI accepts, but does not require, ZIP code reporting.

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Ambulance Billing Requirements

Ambulance Billing Requirements outline the rules for billing adopted by WSI. WSI returns or denies inappropriately submitted bills. WSI notifies a provider of inappropriately submitted bills via a return letter or remittance advice. A provider must correct any returned bills prior to resubmission.

Bill Form – A provider must submit a medical bill for ambulance services on a standard CMS-1500 form or via EDI. WSI excludes hospital-owned ambulance charges from this requirement, in which case a provider may bill these charges on the UB-04 form or via EDI.

Bill Form Submission – WSI offers the following options for bill submission:

Electronic Billing – A provider submitting more than 50 bills per year to WSI must send charges electronically through Carisk Intelligent Clearinghouse. This option allows for the electronic submission of professional (837p) and institutional (837i) charges along with supporting medical documentation. Contact Carisk at 888-238-4792 for additional information.

Paper Billing – A provider submitting less than 50 bills per year to WSI may send charges in red and white paper format with supporting medical documentation at the following address:

Workforce Safety & Insurance
PO Box 5585
Bismarck, ND 58506

Coding – A provider is required to bill using only current and appropriate HCPCS Level II codes for ambulance services.

Fractional Mileage Billing – WSI accepts, but does not require, fractional mileage billing.

Medical Documentation – A provider must submit medical documentation to support all billed charges. WSI's Documentation Policies are available for detailed information on documentation requirements.

Medical Necessity – A provider is required to bill using the same medical necessity guidelines used for Medicare.

National Provider Identification (NPI) – WSI requires entities who are eligible for NPI to be registered with National Plan & Provider Enumeration System. When applicable, WSI requires a provider to include the NPI at both the rendering provider and billing provider levels.

Non-Emergent Transports – A provider may bill non-emergent transportation, which is not provided via an ambulance (e.g. taxi, wheel chair van, stretcher van), on an invoice.

Timely Filing – A provider must submit bills to WSI within 365 days of the date of service.

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Ambulance Reimbursement Procedures

Ambulance Reimbursement Procedures outline how WSI communicates bill processing information and issues payment to a medical provider. In addition, it outlines the WSI's requirements for reimbursement. A provider is encouraged to follow WSI Reimbursement Procedures to prevent delays in the payment processing of medical charges submitted to WSI.

Provider Registration – Prior to reimbursement for treatment, a provider is required to register the applicable Billing NPIs with WSI by completing the Medical Provider Payee Registration form. For additional information, visit the Provider Registration section of WSI's website.

Payment Address – WSI issues payment to the Pay-to Address registered on the Medical Provider Payee Registration form, regardless of the address submitted on the bill form. To update a payment address, a provider must resubmit the registration form for each applicable Billing NPI.

Remittance Advice – WSI issues remittance advices for processed medical bills each Friday. The remittance advice includes important information about a medical charge, including: patient name, date of service, procedure billed, billed amount, paid amount, and remittance advice reason codes. A provider should refer to the How to Read the WSI Remittance Advice document for assistance with interpretation of the remittance advice. This reference includes a sample remittance advice, along with definitions for significant fields within the remittance advice. Contact customer service at 1-800-777-5033 with questions or to obtain a duplicate remittance advice.

> **Reason Codes** – The WSI Remittance Advice Reason Codes document provides a comprehensive listing and description of the reason codes utilized by WSI. Each reason code identifies a cause for the adjudication of a medical charge and specifies whether a provider may bill a patient. When a reason code specifies a provider may bill a patient, WSI sends a "Notice of Non-Payment" letter to the patient informing them of their responsibility for the charge. In accordance with North Dakota Administrative Code 92-01-02-45.1, if a reason code does not state that a provider may bill a patient, the provider cannot bill the charge for the reduced or denied service to the patient, the employer, or another insurer.
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> **Bill Status Inquiries** – Bill status information is available 24/7 via myWSI. The Provider Bill Status application permits a registered user to view bill receipt status and processing details as well as export results. For access, a practice must submit a myWSI Portal Registration (M14) form for each group/billing NPI. With the availability of this resource, a provider or their TPA will not need to contact WSI via phone or email to inquire on the status of a billed charge.

Overpayments – When an overpayment occurs on a medical bill, WSI will notify the provider of the overpayment in a letter. WSI allows 30 days from the date of the letter for a provider to issue the requested refund. If a provider does not issue the refund within 30 days of the date of the letter, WSI will withhold the overpayment from future payments.

Medical Services Disputes – North Dakota Administrative Code 92-01-02-46 provides the procedures followed for managed care disputes. A provider who wishes to dispute a denial or reduction of a service charge must submit the Medical Bill Appeal (M6) form, along with supporting documentation, within 30 days of the remittance advice issue date. WSI will not address a provider dispute submitted without the M6 form.

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