Ambulance transportation—Noncovered services.

(1) The medicaid agency does not cover ambulance services when the transportation is:

(a) Not medically necessary based on the client's condition at the time of service (see exception at WAC 182-546-1000);

(b) Refused by the client (see exception for ITA clients in WAC 182-546-4100 through 182-546-4300);

(c) For a client who is deceased at the time the ambulance arrives at the scene;

(d) For a client who dies after the ambulance arrives at the scene but prior to transport and the ambulance crew provided minimal to no medical interventions/supplies at the scene (see WAC 182-546-0500(2));

(e) Requested for the convenience of the client or the client's family;

(f) More expensive than bringing the necessary medical service(s) to the client's location in nonemergency situations;

(g) To transfer a client from a medical facility to the client's residence (except when the residence is a nursing facility);

(h) Requested solely because a client has no other means of transportation;

(i) Provided by other than licensed ambulance providers (e.g., wheelchair vans, cabulance, stretcher cars); or

(j) Not to the nearest appropriate medical facility.

(2) If transport does not occur, the agency does not cover the ambulance service, except as provided in WAC 182-546-0500(2) and 182-531-1740 Treat and refer services.

(3) The agency evaluates requests for services that are listed as noncovered in this chapter under the provisions of WAC 182-501-0160.

(4) For ambulance services that are otherwise covered under this chapter but are subject to one or more limitations or other restrictions, the agency evaluates, on a case-by-case basis, requests to exceed the specified limits or restrictions. The agency approves such requests when medically necessary, according to the provisions of WAC 182-501-0165 and 182-501-0169.

(5) An ambulance provider may bill a client for noncovered services as described in this section, if the requirements of WAC 182-502-0160 are met.