



Ambulance Services



Medicaid and Other Medical Assistance Programs



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Key Contacts and Websites

See the Contact Us link in the menu on the Montana Medicaid Provider Information website, <http://medicaidprovider.hhs.mt.gov/>, for a list of contacts and websites.

Covered Services

General Coverage Principles

Medicaid covers authorized ambulance transports with medical intervention by ground or air to the nearest appropriate facility. (See the Definitions and Acronyms page on the Provider Information [website](#).) This chapter provides covered services information that applies specifically to ambulance services. Like all healthcare services received by Medicaid members, the services, providers and members must also meet the general requirements listed in the *General Information for Providers* manual.

Services within Scope of Practice (ARM 37.85.401 and ARM 37.86.2602)

Services are covered only when provided by a licensed ambulance provider acting within the scope of the provider's license.

Vehicle Requirements (ARM 37.86.2601)

An ambulance is a vehicle designed and equipped to transport a sick or injured person by ground or air. Ground ambulances can operate on water or land. Air ambulances may be either fixed wing (airplane) or rotary wing (helicopter). The ambulance must contain a stretcher, linens, first aid supplies, oxygen equipment, and other lifesaving equipment required by state or local laws. The ambulance must also be staffed by licensed or certified personnel who provide first aid treatment.

Ambulance Coverage (ARM 37.86.2601 and ARM 37.86.2602)

Ambulance services are covered when the member's medical condition requires transportation by ambulance to the nearest appropriate facility. Each service provided to the member (e.g., transport, life support, oxygen) must be medically necessary to be covered by Medicaid. All scheduled ambulance transports require prior authorization, and all non-scheduled ambulance transports require authorization before the claim is submitted. The Authorization chapter in this manual covers medical necessity documentation tips and how to obtain authorization. Ambulance providers must submit documentation that supports medical necessity for each service. The service is then reviewed and authorized or denied for lack of medical necessity before the claim is submitted. Once a claim is submitted, it may be denied for reasons other than medical necessity. For tips on preventing claim denials, see the Billing Procedures chapter in this manual.



Coverage of ambulance transportation is based on the member's condition at the time of transport.

The following are examples of circumstances which may be considered in determining medical necessity for ambulance service. However, the presence of any one or more of the following does not necessarily establish medical necessity.

- The member is transported in an emergency situation (e.g., as a result of an accident or injury).
- The member must be restrained for medical (not law enforcement) purposes.
- The member is unconscious or in shock.
- The member requires oxygen as an emergency rather than a maintenance measure or requires other emergency treatment on the way to the destination.
- The member has to remain immobile because of a fracture (or possible fracture) that has not been set.
- The member sustains an acute stroke or myocardial infarction.
- The member is experiencing severe bleeding, neurological dysfunction, or respiratory distress.
- The member is bed confined before and after the ambulance transport.
- The member can be moved **only** by stretcher.

Air ambulance transportation is covered when medical necessity for ambulance transport is established (refer to previous list) and one of the following conditions are met:

- When the point of pick up is inaccessible by land or water ambulance.
- When the member's condition requires emergency admission to the nearest hospital with appropriate facilities, and distance or other obstacles (e.g., traffic) prevent rapid transport.
- When air transport would be less costly to the Medicaid program.

Noncovered Services (ARM 37.86.2602)

Some ambulance services are not covered by Medicaid, including:

- When the member can be transported by a mode other than ambulance without endangering the member's health, regardless of whether other transportation is available.
- Medicaid benefits cease at the time of death. When a member is pronounced dead after an ambulance is called but before transport, the ambulance services provided are covered at the base rate. If a member is pronounced dead by a legally authorized individual before the ambulance is called, no payment will be made.
- Medicaid will not pay ambulance providers for treatment of members who are not transported. An example of this situation is when an ambulance is dispatched to a member's home and the member refuses to be transported.

It also occurs in “paramedic intercept” calls. For example, a BLS ambulance may begin transporting a member with chest pain to a hospital some miles away. An ALS ambulance meets the basic life support (BLS) ambulance so that a paramedic can board the BLS ambulance and begin advanced life support (ALS) treatment. If the member remains on the BLS ambulance, no payment is made to the ALS ambulance provider.

- Air ambulance services are not covered to transport a member from a hospital capable of treating the member to another hospital simply because the member or family prefers a specific hospital or physician.

Importance of Fee Schedules

The easiest way to verify coverage for a specific service is to check the Department’s fee schedule for your provider type. In addition to being listed on the fee schedule, all services provided must meet the coverage criteria listed in the Provider Requirements chapter of the *General Information for Providers* manual and in this chapter. Use the fee schedule in conjunction with the more detailed coding descriptions listed in the CPT and HCPCS Level II coding books. Use the fee schedule and coding books that pertain to the date of service. Fee schedules are available on the Montana Healthcare Provider Information [website](#).

Coverage of Specific Services

The following are coverage rules for specific ambulance services.

Air Transfers

Medicaid covers air ambulance transfer of a member who is discharged from one inpatient facility and transferred and admitted to another inpatient facility when distance or urgency preclude the use of ground ambulance. If a member is an inpatient at a hospital, Medicaid does not pay separately for round trip ambulance transport for an outpatient service (e.g., x-ray or other procedure) at a different hospital. This type of transport is included in the Medicaid payment to the hospital for the inpatient stay.

Air Transport for Neonates and Pregnant Women

Medicaid covers emergency air transport to the nearest appropriate facility for neonates (infants age 0 to 28 days) and high-risk pregnant women. The neonate’s inpatient hospital services must be categorized within one of the diagnosis related group (DRG) codes 385 through 389. The high-risk pregnant women’s inpatient hospital services must be categorized within one of the DRG codes 370, 372, 375 or 383.

For authorization of these services, the provider should notify the authorizing agency within 180 days of transport. (See the Authorization chapter in this manual.) If the hospital does not meet the DRG requirements, the provider may submit the claim/trip report to Medicaid as long as he/she had notified the authorizing agency within 180 days of the transport.



All ambulance transports require authorization. (See the Authorization chapter in this manual.)

Ambulance Non-Scheduled Transport

Non-scheduled ambulance services may be emergencies or they may be non-emergent transports with special circumstances that prevent scheduling. Examples include:

- Emergency transports.
- Non-emergent transports when the need became known after regular business hours.
- Meeting flight teams at airports.
- Hospital to hospital transfers to a more acute level of care.
- One-way returns to nursing homes or residences following emergency transports to an emergency room.
- Urgent transports, which may include:
 - A fall in a nursing home or community care where there is no bleeding or obvious life threatening situation, but the member should be checked for possible fracture.
 - An elderly member with flu like symptoms (possible dehydration).
 - A member who has sustained an injury and needs medical evaluation but it is not an emergency.
 - A trauma member who has been stabilized at Critical Access Hospital A and must be transported to Critical Access Hospital B for further treatment diagnostic tests such as a computerized tomography (CT) scan.

Not all non-emergent ambulance transports can be anticipated during regular business hours. In these cases, prior authorization is not required. However, all non-scheduled ambulance transports must be authorized before the claim is submitted. (See the Authorization chapter in this manual.)

Ambulance Scheduled Transport

Scheduled ambulance transports may be round trip (loop trip) or one-way. Most scheduled ambulance use is arranged during regular business hours and requires prior authorization. (See the Authorization chapter in this manual.)

Examples include:

- Transport to a hospital for scheduled diagnostic tests such as CT scan or magnetic resonance imaging (MRI).
- Transport to a doctor's office or clinic for members who can only be transported by stretcher.
- Transport to a hospital or other facility for a planned admission.
- Transfer from one acute care hospital to a lower level acute setting, as in the case of premature infants being returned from a referral hospital to a smaller hospital.
- Transport from a hospital to another setting as part of a planned discharge.

Disposable Supplies

Medicaid covers disposable and non-reusable supplies such as oxygen, gauze and dressings, defibrillation supplies, and IV drug therapy disposable supplies. When medically necessary, each service is allowed one time per transport in addition to the base rate.

Drugs

Drugs are covered in addition to the base rate only when medical necessity is clearly documented.

EKG Services

EKG monitoring is included in the base rate, but the technical component for obtaining tracing (no interpretation and report) is covered in addition to the base rate one time per transport.

Injectable Drugs and IV Solutions

Injectable drugs and IV solutions are covered in addition to the base rate when medical necessity is clearly documented.

Mileage

Although mileage is included in the base rate for ground transports (in the city, unless an airport transfer) it is also paid in addition to the base rate when the pickup point is outside city limits or when transporting to another community. Mileage is only paid for loaded miles (members on board) from pickup to destination. When transporting from one community to another, if odometer readings are not shown on the trip report, then the authorizing agency may use a map program to confirm mileage.

Mileage is covered in addition to the base rate for all air transports. Air mileage is calculated for actual loaded miles flown and is expressed in statute miles.

Mileage must be medically necessary, which typically means that mileage should equal the shortest route to the nearest appropriate facility. Exceptions may occur such as road construction or weather (for air ambulance).

Multiple Member Transportation

When more than one member is transported during the same trip, Medicaid will cover one base rate per **member** and one mileage charge per **transport**.

Oxygen and Oxygen Supplies

Medicaid covers oxygen and related disposable supplies only when the member's condition at the time of transport requires oxygen.

Medicaid does not cover oxygen when it is provided only on the basis of protocol or when the member requires oxygen on a regular basis (e.g., during trips to the grocery store).



Members are not candidates for ambulance transport solely because of their oxygen requirement.

The amount of oxygen provided to the member is prior authorized based on the duration of the transport and must be billed in half hour increments. (See the Billing Procedures chapter in this manual.)

Transports Outside Montana

Transports outside Montana are covered in most cases and require authorization.

Other Programs

The information in this chapter does not apply to the Mental Health Services Plan (MHSP) or Healthy Montana Kids (HMK). The MHSP manual is available on the Provider Information website. The HMK medical manual is available through Blue Cross and Blue Shield of Montana at 1-800-447-7828, Extension 8647.

Authorization

Authorization

Providers must obtain prior authorization for all scheduled ambulance services and authorization within 180 days for all non-scheduled ambulance services before submitting a claim. The only exception occurs when a member has both Medicare and Medicaid. For those members, authorization is not required for non-scheduled transport. Other authorizations that may apply to the transport (e.g., inpatient out-of-state admission authorization) do not replace the need for ambulance transport authorization.

For authorization, contact the authorizing agency by phone or fax. The following are instructions for obtaining authorization for scheduled and non-scheduled transports. References to the *trip report* refer to the medical record documented during the ambulance run.

Obtaining Prior Authorization for Scheduled Transport

Prior authorization is required for all scheduled transports. The following are steps to obtain prior authorization.

1. Verify Medicaid eligibility. (See the *General Information for Providers* manual, Member Eligibility and Responsibilities chapter.)
2. Prepare transport documentation:
 - Name of transportation provider
 - Member's name
 - Member's Medicaid ID number
 - Point of origin to the point of destination
 - Date and time of transport
 - Reason for transport
 - Level of services to be provided during transport (e.g., BLS, ALS, mileage, oxygen.)
3. Present the documentation to the authorizing agency by phone or fax before transport.
4. The nurse reviewer will interview the requestor by phone regarding the member's medical condition and need for ambulance transport. If another mode of transport is more appropriate, the nurse reviewer will suggest alternatives. In this step of the process, it is essential to provide accurate and up-to-date medical information about the member's condition and transport requirements.



Providers have 180 days from transport to notify the authorizing agency and submit paperwork (trip report), and 12 months from transport date of service to submit a clean claim.

5. The nurse reviewer will give verbal authorization for qualifying transports and assign a reference number that is used in tracking the transport through the review process. This is not an authorization number.
6. Once the scheduled transport is complete, the provider mails or faxes a copy of the *trip report* and the charges to the authorizing agency with the reference number noted.
7. The authorizing agency reviews each transport to confirm that the medical record supports medical necessity for the same ambulance use which was communicated in the interview. (See step 4 above). The reviewer also evaluates level of service, oxygen use, and mileage.

Approvals

The provider receives an approval letter with the prior authorization number. This number is also transmitted to the claims processing system, which generates a report for the provider with notification that authorization has been received.

The provider then submits the CMS-1500 claim (paper or electronic) to the Claims Processing Unit. The prior authorization number must be reported on the claim form.

Denials

A scheduled ambulance transport for which verbal prior authorization was received from the authorizing agency may be denied if the medical record does not support the need for ambulance transport as reported to the authorizing agency before transport. If a claim is denied for medical necessity, the provider and the member are notified by letter. Providers have 30 days to appeal authorization decisions, and members have 90 days. Provider appeals are directed to the authorizing agency and instructions are given in the denial letter. Member appeals are directed to the Hearing Office and instructions are given in the denial letter.

Obtaining Authorization for Non-Scheduled Transport

Providers have 180 days following transport to notify the authorizing agency of non-scheduled transport.

When a member has Medicare and Medicaid, non-scheduled transports do not require authorization. Submit these claims directly to Medicare.



Granting of prior authorization does not guarantee payment. The claim may be denied for other reasons. (See the Billing Procedures chapter in this manual.)

Time Requirements

Providers have 180 days from a non-scheduled transport to notify the authorizing agency by submitting paperwork (trip report), and 12 months from transport to submit a clean claim. (See the Billing Procedures chapter in this manual.) The Department will not consider claims that have not been authorized or that are past any of these time limits, even if another payer is involved.

Retroactive Eligibility

When a member has retroactive Medicaid eligibility, the provider must obtain authorization and submit a clean claim within 180 days of the eligibility determination date. See the *General Information for Providers*, Member Eligibility and Responsibilities chapter for more information on retroactive eligibility.

Tips for Establishing Medical Necessity

- Coverage of ambulance transportation is based on the member's condition at the time of transport.
- Medical necessity must be demonstrated in the *trip report*. If documentation is not clear and complete, the transport will be denied for lack of medical necessity.
- The ambulance provider is responsible for making sure medical necessity is both valid and well documented. Providers must state objective findings such as respiratory rate 32 with diaphoresis, etc. These details are necessary to establish medical necessity for the transport.
- A doctor's or a hospital's order for ambulance transportation is not sufficient to guarantee that Medicaid will pay for the transport.
- A note indicating "stretcher patient" or "patient was moved by stretcher" does not indicate that the member could only be moved by stretcher.

Other Programs

The information in this chapter does not apply to the Mental Health Services Plan (MHSP) or Healthy Montana Kids (HMK). The MHSP manual is available on the Provider Information website. The HMK medical manual is available through Blue Cross and Blue Shield at 1-800-447-7828, Extension 8647.

Billing Procedures for Ambulance

Using Modifiers

Origin/destination modifiers are recommended when billing Medicaid but are not required. (See the Origin/Destination Modifiers table below.) Modifiers can help clarify transport information. The following are some tips for using modifiers.

- Review the guidelines for using modifiers in the most current CPT, HCPCS Level II, or other helpful resources.
- Always read the complete description for each modifier; some modifiers are described in the CPT manual while others are in the HCPCS Level II book.

Origin/Destination Modifiers	
Modifier	Description
D	Diagnostic or therapeutic site other than “P” or “H” when these codes are used as origin codes.
E	Residential, domiciliary, custodial facility (other than an 1819 facility)
G	Hospital-based dialysis facility (hospital or hospital-related)
H	Hospital
I	Site of transfer (e.g., airport or helicopter pad) between types of ambulance
J	Non hospital-based dialysis facility
N	Skilled nursing facility (SNF) (1819 facility)
P	Physician’s office (includes HMO non-hospital facility, clinic, etc.)
R	Residence
S	Scene of accident or acute event
X	(Destination code only) intermediate stop at physician’s office on the way to the hospital (includes HMO non-hospital facility, clinic, etc.)



It is the provider's responsibility to follow up with all claims and make sure all problems are resolved within the twelve-month timely filing limit.

Billing Tips for Specific Services

Before billing Medicaid, all ambulance services must be authorized. The CMS-1500 claim form must contain a valid Montana Medicaid procedure code, a valid ICD diagnosis code, and an authorization code. (See the Authorization chapter in this manual.) A complete list of Montana Medicaid procedure codes for ambulance services is available on the ambulance fee schedule which may download from the Ambulance page of the Provider Information [website](#). The proper diagnosis code for the member being served can be obtained from the member’s physician.

Air Transfers

When billing Medicaid, use the appropriate life support code and mileage for either fixed or rotary wing aircraft. Medicaid will only pay for mileage to the nearest appropriate facility.

Air Transport for Neonates and Pregnant Women

Hospital flight teams may bill Medicaid for these transports on a UB-04 claim form and receive hospital outpatient payment. If the transport does not group to a qualifying DRG, the provider may bill Medicaid on a CMS-1500 claim form as long as all Medicaid authorization requirements have been met. See the Authorization chapter in this manual.

Ambulance Scheduled Transport

When a member is transported to a scheduled service and returned to the point of origin on the same day, it is considered a *loop trip*. Loop trips within a 10-mile radius of the provider's base are billed to Medicaid as one Basic Life Support (BLS) base rate (refer to the ambulance fee schedule). Loop trips beyond the 10-mile radius of the provider's base may be billed as two (BLS) base rates. Providers may bill for mileage in addition to the base rates when applicable. (See the Covered Services chapter in this manual.)

For example, an ambulance transports an outpatient from a hospital in Wolf Point to Glasgow and back for a CT (computerized axial tomographic) scan. This is considered a scheduled loop trip to a neighboring community 45 miles away (98 miles round trip) and would be billed like this:

24. A.	DATE(S) OF SERVICE						B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES			E. DIAGNOSIS POINTER	F. \$ CHARGES		G. BARS OR UNITS	H. (BLS) Family Ref	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
	From MM	DD	YY	To MM	DD	YY			CPT/HCPCS	MODIFIER								
1	11	12	14	11	12	14	41	A0428			1	441	40	2			NPI	
2	11	12	14	11	12	14	41	A0425			1	388	08	98			NPI	

Base Rates

Providers must bill using the following definitions, which are intended to be very similar to Medicare definitions. **In case of difference, however, the Medicaid definition prevails.** Providers should check the ambulance fee schedule for codes that correspond with the definitions below.

In the following definitions, *emergency transport* refers to the level of service required to respond to an emergency call. It does not require the use of lights and siren during the actual transport to the hospital. For example, a response to a chest pain call, whether it came through 911 or to the ambulance service itself, would be an emergency transport, even if the member's condition after assessment did not require the use of lights and siren during transport. A response to a request to transfer a member home from the hospital, even if it came through 911, would not be an emergency response.

If a provider bills Medicaid and the claim is denied because the member is not eligible, the provider may bill the member directly.

- **Basic Life Support (BLS).** This level of service is transportation by ground ambulance and provision of medically necessary supplies and BLS service. The ambulance and its crew must meet Montana standards for BLS care (or the equivalent in another state, if a Medicaid member requires ambulance transport outside Montana). Provision of care by an EMT-intermediate or paramedic does not turn a BLS call into ALS.
- **Basic Life Support Emergency (BLS Emergency).** This is the same BLS (above) but in emergency circumstances. Provision of care by an EMT-intermediate or paramedic does not turn a BLS call into ALS. For example, the transport of a football player with an isolated ankle fracture would be a BLS call even if a paramedic assessed the member.
- **Advanced Life Support Level 1 (ALS1).** This level of service is transportation by ground ambulance and provision of medically necessary supplies and at least one ALS intervention. The ambulance and its crew must meet Montana standards for ALS care (or the equivalent in another state, if a Medicaid member requires ambulance transport outside Montana). An ALS intervention refers to the provision of care outside the scope of an EMT-Basic and must be medically necessary (e.g., medically necessary EKG monitoring, drug administration). An ALS intervention or ALS assessment does not necessarily result in a determination that the member requires an ALS level of service.
- **Advanced Life Support Level 1 Emergency (ALS1 Emergency).** This is the same as ALS1 except in emergency circumstances.
- **Advanced Life Support Level 2 (ALS2).** This level of care requires one of the following:
 - At least three separate administrations of one or more different medications by intravenous push/bolus or by continuous infusion (excluding crystalloid fluids). The use of three separate administrations must be medically necessary and appropriate; an example would be three doses of 1 mg epinephrine to a member in ventricular fibrillation. Splitting doses (e.g., giving the member 0.4 mg, 0.3 mg and 0.3 mg IV) to meet the definition for this level of care would be inappropriate. Crystalloid fluids include normal saline, D5W, and Lactated Ringer's. A continuous infusion of dopamine, lidocaine or another drug, on the other hand, would count as one of the three separate administrations.
 - Provision of at least one of the following procedures:
 - Manual defibrillation/cardioversion (not merely EKG monitoring)
 - Endotracheal intubation (includes monitoring an ET tube inserted before transport)
 - Central venous line
 - Cardiac pacing
 - Chest decompression
 - Surgical airway
 - Intraosseous line (this level of care need not be provided under emergency circumstances, though in practice that is most common)



Always refer to the long descriptions in coding books.

- **Specialty Care Transport (SCT).** This level of service refers to hospital-to-hospital transportation of a critically injured or ill member by ground ambulance, including the provision of medically necessary supplies and services, at a level of service beyond the scope of a paramedic. SCT is necessary when a member’s condition requires ongoing care that must be furnished by one or more health professionals in an appropriate specialty area. Examples are emergency or critical care nursing, emergency medicine, respiratory care, cardiovascular care or a paramedic with additional training (as recognized by the State).
- **Fixed Wing Air Transport.** This level of service is one-way transport by air ambulance, regardless of whether BLS or ALS care is provided.
- **Rotary Wing Transport.** This level of service is one-way transport by helicopter, regardless of whether BLS or ALS care is provided.

Mileage

Providers may bill for member-loaded miles using a mileage code shown in the fee schedule only if one of the following circumstances applies:

- A ground ambulance picks up a member outside the limits of the city in which the ambulance is based.
- A ground ambulance transports a member between communities.
- The transport is by fixed wing or rotary wing air ambulance.

When billing for mileage, one unit is equal to one statute mile for both air and ground transport. Mileage must be rounded to the nearest mile.

Multiple Member Transportation

When more than one member is transported during the same transport, providers may bill Medicaid for one base rate per member but only one mileage charge per transport.

Oxygen

When billing Medicaid for oxygen, one unit is equal to one half hour of oxygen usage. For example, if the authorizing agency approves oxygen for a one-hour transport, it would be billed like this:

	24. A. DATE(S) OF SERVICE						B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES			E. DIAGNOSIS POINTER	F. \$ CHARGES	G. DAYS OF UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
	From MM DD YY	To MM DD YY	(Explain Unusual Circumstances)			CPT/HCPCS			MODIFIER								
1	01	12	15	01	12	15	41	A0428			1	32 0	2		NPI		
2															NPI		

Separately Billable Services and Supplies

Providers may bill for these services and supplies using applicable codes in the fee schedule. Each of these codes is billable only once per transport.

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