

April 6, 2000

**SPECIALIZED NON-EMERGENCY
TRANSPORTATION, AMBULANCE, AND
NURSING HOME PROVIDERS
MONTANA MEDICAID NOTICE**

Non-emergency Ambulance Services for the Medicaid/Medicare Patient

All non-emergency ambulance services must be authorized by the Mountain-Pacific Quality Health Foundation (Foundation) to qualify for Medicaid reimbursement. This includes non-emergent transports for the patient with Medicaid and Medicare coverage. Non-emergent transports include, but are not limited to, scheduled doctor visits and return trips to the nursing home from the hospital.

Please note: For the patient who is in a nursing facility, non-emergency routine transportation is the responsibility of the nursing facility when such transportation is provided within 20 miles of the facility. The exception is when an individual is wheel-chair bound or subject to transport by stretcher and transported in a vehicle specifically equipped for the wheelchair or stretcher. This type of transportation is called Specialized Non-emergency Transportation.

For medical necessity review--Contact the Foundation by telephone at 1-800-292-7114 to request authorization for a non-emergency transport via ambulance. If transport via ambulance appears to be necessary based on the medical information provided over the telephone, the Foundation will assign a six-digit reference number and ask that the trip report be submitted within six months for full review. After review of the medical documentation, if the transport is determined medically necessary, the Foundation will assign a ten-digit authorization number and transmit the approval to Consultec. If determined not medically necessary, the Foundation will generate a denial notice.

If a non-emergency transport via ambulance becomes necessary "after hours" (after 5:00 p.m., on week-ends or holidays), the specific details of the transport must be left on voice mail message at the Foundation prior to transport. The Foundation needs, at minimum,

1. the name of the ambulance services provider and
2. the patient's name, Medicaid ID number, date of birth, date of service, time of transport, level of service, pick up point and destination, and medical reason for ambulance services.

You will receive notification from the Foundation on the next business day with a six-digit reference number. Submit the ambulance trip report with the reference number on it to the Foundation within six months for the medical necessity review.

The Foundation will not authorize payment for ambulance services in cases where some means of transportation other than ambulance could be utilized without endangering the patient's health, whether or not such other transportation is actually available.

For reimbursement--Submit the claim to Medicare. If you participate in the automatic electronic crossover process, the claim will "cross over" to Medicaid. It is the provider's responsibility to follow-up on crossover claims and ensure they are correctly billed to Medicaid within the timely filing limit.

If Medicare denies a claim for lack of medical necessity for non-emergency ambulance services in which prior authorization was obtained by the Foundation, the Department is requesting that the provider appeal the claim to Medicare. If Medicare denies the appeal, please submit a HCFA 1500 with the ten-digit prior authorization number from the Foundation, a copy of the Medicare EOB and a copy of the notice from Medicare which contains the results of the appeal **WITHIN 365 DAYS OF THE DATE OF SERVICE** to:

Ambulance Services Program Officer
Medicaid Services Bureau
PO Box 202951
Helena, Montana 59620-2951

Claims received by the Department or Consultec after 365 days will be denied.

If you have any questions or require additional information, please call Provider Relations at:

Helena and out-of-state: 406-442-1837
In-state toll-free: 800-624-3958