



Commercial and Specialized Non-Emergency Transportation Services

*Medicaid and Other Medical
Assistance Programs*

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Key Contacts and Websites

In addition to the contacts listed below, see the Contact Us link in the menu on Provider Information [website](#). Unless otherwise stated, hours for the contacts are 8 a.m. to 5 p.m. Monday through Friday (Mountain Time).

Authorization

Mountain-Pacific Quality Health Medicaid Transportation Center is the Department's contractor that reviews transportation requests and grants authorization.

Send written inquiries to:

Medicaid Transportation Center
MPQH
P.O. Box 6488
Helena, MT 59604-6488

Phone
800-292-7114 In/Out of state
406-443-6100 Helena

Fax
800-291-7791 In/Out of state

Policy Questions

Address policy questions to:

Transportation Program Officer
Health Resources Division
P.O. Box 202951
Helena, MT 59620-2951

Phone
406-444-4189 In/Out of state

Fax
406-444-1861

E-Mail: jpaulsen@mt.gov

When a trip is canceled or rescheduled, return any travel funds to this address:

Health Resources Division
DPHHS
P.O. Box 202951
Helena, MT 59620-2951

Covered Services

General Coverage Principles

Medicaid covers authorized commercial transportation by ground or air to the Medicaid provider nearest the member. This chapter provides covered services information that applies specifically to **commercial and specialized non-emergency transportation 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.

Transportation services are available for members with Full or Basic Medicaid coverage. Transportation services are not available for members with the following coverage:

- Qualified Medicare Beneficiary (QMB). This member has a Medicaid ID card, but transportation is not covered for members who have “QMB Only” coverage.
- Special Low-Income Medicare Beneficiary Program (SLMB). This member is not issued a Medicaid ID card.
- Mental Health Services Plan (MHSP) and Healthy Montana Kids (HMK).

To verify member eligibility, refer to the Member Eligibility and Responsibilities chapter in the *General Information for Providers* manual.

When Medicaid covers transportation expenses to and from Medicaid members’ appointments, that type of transportation is considered non-emergency transportation and includes specialized non-emergency transportation, commercial transportation, and personal transportation.

Personal Transportation (ARM 37.86.2401–2402)

Personal transportation is for members who do not have special transportation needs. The member, friend, or relative transports the member in a privately owned vehicle. Personal transportation is covered when it is the least costly method of transportation. Member reimbursement is based on mileage. Members must obtain prior authorization from the Transportation Center for this service.

Notification of personal emergent transportation must be reported within 30 days of the emergency treatment.

Members should refer to the *Personal Transportation Services* manual for more information.



Specialized non-emergency transportation is covered only for those members who are wheelchair bound or require transportation by a stretcher.

Specialized Non-Emergency Transportation (ARM 37.86.2501–2502)

Specialized non-emergency transportation is for members who are wheelchair bound or must be transported by stretcher. Specialized non-emergency transportation providers must have a class B public service commission license or be an organization exempt from PSC licensing (5310/5311 funded organization or an IHS).

These providers have vehicles specially equipped to transport persons with disabilities such as wheelchair vans or stretcher vans. Members must obtain prior authorization from the Transportation Center for this service. (See the Passport and Prior Authorization chapter in this manual.)

Commercial Transportation (ARM 37.86.2401–2402)

Commercial transportation is for members who do not have special transportation requirements. Commercial transportation services are provided by air or ground commercial carrier, taxicab, or bus for a Medicaid member to receive medical care. Commercial transportation is covered only when it is the least costly form of transportation. Members must obtain prior authorization from the Transportation Center for this service. (See the Passport and Prior Authorization chapter in this manual.)

Services for Children (ARM 37.86.2201–2235)

The Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services program is a comprehensive approach to healthcare for Medicaid members ages 20 and under. It is designed to prevent, identify, and then treat health problems before they become disabling. Under EPSDT, Medicaid-eligible children may receive any medically necessary covered service, including transportation services described in this manual. All applicable Passport to Health and prior authorization requirements apply. Medicaid also covers an attendant for children. Attendant services must be prior authorized. (See the Passport to Health and Prior Authorization Requirements chapter in this manual.)

Non-Covered Services (ARM 37.86.2402)

Transportation services are not covered when:

- The appointment is within the member's community, and the member has access to public transportation, a personal vehicle, or a family member or friend with a personal vehicle. For example, if a member has routine access to a grocery store or pharmacy, Medicaid does not cover transportation.
- The member is determined retroactively eligible for Medicaid, and the transport occurred before retroactive eligibility was determined.
- The scheduled transport did not take place. (See When to Bill Medicaid Members in the Billing Procedures chapter of this manual).
- Transportation was provided in a state or government vehicle (except IHS).

Importance of Fee Schedules

The easiest way to verify coverage for a specific service is to check the Department's transportation fee schedule. 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. Take care to use the fee schedule that pertains to the date of service. Fee schedules are available on the Provider Information [website](#).

Coverage of Specific Services

The following are coverage rules for specific commercial and specialized non-emergency transportation services. Commercial transportation services do not include travel in a privately owned vehicle, an ambulance, or a specialized non-emergency transportation vehicle. Members must be wheelchair bound or subject to transport by stretcher to qualify for specialized non-emergency transportation. Commercial and specialized non-emergency transportation services may be covered when all of the following requirements are met:

- Other methods of transportation are not available or circumstances or disability prevent the use of such transportation.
- The Medicaid member obtains Medicaid covered services from the nearest in-state provider. Trips to out-of-state providers may be approved if it can be proven that total out-of-state expenses are less costly than in-state expenses.
- The medical services are determined medically necessary.
- The member selects the least expensive means of transportation suitable to his or her medical needs.
- No other financial resources are available. Members who are covered by IHS may receive Medicaid travel benefits.
- Applicable prior authorization, Passport to Health, and Team Care requirements are met. (See the Passport to Health and Prior Authorization Requirements chapter in this manual.)

In-Community Travel

Transportation to obtain medical care within the community is covered when:

- The Medicaid member has a disability or circumstance that prevents the use of public transportation.
- Transportation is not available from any other source.
- The service is the least costly means of transportation available.

Nursing Facility Residents

For members who reside in nursing facilities, non-emergency routine transportation (visits to physicians, pharmacy or other medical providers) is the responsibility of the nursing facility when the destination is within 20 miles of the facility. Medicaid may cover transportation costs in one of the following circumstances:

- If a member is wheelchair-bound or requires transport by stretcher.
- If a member must travel farther than 20 miles to a Medicaid covered appointment.



All transports require prior authorization. See the Passport and Prior Authorization chapter in this manual.

Personal emergent transportation must be reported within 30 days.

Presumptive Eligibility (Pregnant Women)

Assistance with transportation is available to pregnant women during the presumptive eligibility period. The member must provide a copy of her eligibility determination letter to indicate she qualifies for presumptive eligibility because her Medicaid eligibility information may not yet be available electronically.

Providers must call 1-406-655-7683 or 1-406-883-7848 to verify that the member has presumptive eligibility and Provider Relations, 1-800-624-3958 or 1-406-442-1837, to determine whether the services are covered. See the Presumptive Eligibility page on the Provider Information [website](#) for more information.

Deceased Member

If a member dies en route to or during treatment outside his/her community, the cost of the member's transportation to the medical service is allowed. The cost of returning a deceased person is not covered.

Attendant

Medicaid covers one attendant for a member for whom age or disability requires attendant services.

Other Programs

The services covered in this manual are not available for members enrolled in the Mental Health Services Plan (MHSP) or Healthy Montana Kids (HMK)/CHIP.

The MHSP manual is available on the Provider Information [website](#).

The HMK medical manual is available through Blue Cross and Blue Shield of Montana (BCBSMT) at 1-800-447-7828, Extension 8647.

Passport to Health and Prior Authorization Requirements

Members Enrolled in Passport to Health and Team Care

Most Medicaid members are enrolled in the Passport to Health primary care case management (PCCM) program. Financial assistance may be available when medical services are provided or authorized by the member's Passport or Team Care provider. The Transportation Center will contact the member's Team Care provider to verify that the service has been approved before the trip is allowed.

Prior Authorization (ARM 37.86.2401–2402)

Prior authorization is when the Department (or the Department's contractor) reviews and approves the medical necessity and coverage of a service prior to delivery of the service. The Transportation Center performs evaluation and authorization for all transportation requests.

The Medicaid member or his/her designee must call in or fax all non-emergent transportation requests to the Transportation Center before the services are provided. The Transportation Center completes the following procedures for each transportation request:

- Verifies current eligibility
- Confirms Team Care provider approval, if necessary
- Confirms individual appointments
- Confirms that Medicaid covers the service
- Determines the least expensive and most appropriate mode of travel
- Determines the closest site of service

When the Transportation Center approves commercial transport for a member, a list of approved transports is faxed to the transportation provider. The list contains member pick-up date, time, location, destination, a procedure code, and a prior authorization number to use when billing Medicaid. Each transport must be approved by the Transportation Center. Therefore, if a provider transports a member without this confirmation, the provider may not receive Medicaid payment.

If a member misses or cancels a scheduled transport, he/she must obtain approval for rescheduled transports.

If a member requests commercial transportation, and the provider has not received confirmation on the transport, refer the member to the Transportation Center.



If a provider transports a member without receiving a confirmation from the Transportation Center, Medicaid may not pay for the transport.

Other Programs

The services covered in this manual are not available for members enrolled in the Mental Health Services Plan (MHSP) or Healthy Montana Kids (HMK)/CHIP.

The MHSP manual is available on the Provider Information [website](#). The HMK medical manual is available through Blue Cross and Blue Shield of Montana (BCBSMT) at 1-800-447-7828, Extension 8647.

Billing Procedures

Claim Forms

Services provided by the healthcare professionals covered in this manual must be billed to Medicaid either electronically or on a CMS-1500 claim form. CMS-1500 forms are available from various publishing companies; they are not available from the Department, the authorizing agency, or Provider Relations.

Timely Filing Limits (ARM 37.85.406)

Providers must submit clean claims to Medicaid within:

- Twelve months from whichever is later:
 - the date of service
 - the date retroactive eligibility or disability is determined
- **Medicare crossover claims:** Six months from the date on the Medicare explanation of benefits approving the service (if the Medicare claim was timely filed and the member was eligible for Medicare at the time the Medicare claim was filed).
- **Claims involving other third party payers (excluding Medicare):** Six months from the date on an adjustment notice from a third party payer who has previously processed the claim for the same service, and the adjustment notice is dated after the periods described above.

Clean claims are claims that can be processed without additional information or action from the provider. The submission date is defined as the date that the claim was received by the Department or the claims processing contractor. All errors and problems with claims must be resolved within this 12-month period.

Tips to Avoid Timely Filing Denials

- Correct and resubmit denied claims promptly. (See the Remittance Advices and Adjustments chapter in the *General Information for Providers* manual.)
- If a claim submitted to Medicaid does not appear on the remittance advice within 30 days, contact Provider Relations for claim status.

When to Bill Medicaid Members (ARM 37.85.406)

In most circumstances, providers may not bill Medicaid members for services covered under Medicaid. However, providers may bill the member if Medicaid denies a claim because the member is not enrolled in Medicaid.



It is the provider's responsibility to follow up with all claims and make sure all problems are resolved within the 12-month timely filing

More specifically, providers cannot bill members directly:

- For the difference between charges and the amount Medicaid paid.
- When the provider bills Medicaid for a covered service, and Medicaid denies the claim because of billing errors.
- When a member cancels or fails to arrive for a scheduled transport. Medicaid may not be billed for cancellations or no-show appointments either.
- When Medicaid covers the service, providers must accept Medicaid rates as payment in full.

Usual and Customary Charge (ARM 37.85.406)

Providers should bill Medicaid their usual and customary charge for each service; that is, the same charge that is made to others for that service.

Coding

Standard use of medical coding conventions is required when billing Medicaid. When the Transportation Center faxes the provider a list of approved transports, that list will contain important billing information. The following are some coding tips for billing Medicaid.

Procedure Codes

A procedure code is required for billing Medicaid. This code is provided by the Transportation Center on the dispatch log. Procedure codes are also listed in the Non-Emergency Transportation Codes table below, in the transportation fee schedule on the Provider Information [website](#), and in coding manuals. The following are valid transportation codes and require prior authorization. (See the Passport to Health and Prior Authorization Requirements chapter in this manual.)

Non-Emergency Transportation Codes			
Commercial Transportation – Taxicab – Provider Type 23			
Code	Use	Reimbursement	Prior Auth
A0100	Taxicab – over 16 miles	Transport per mile	Y
A0140	Taxicab – under 16 miles	One way flat fee	Y
Specialized Non-Emergency Transportation – Taxicab – Provider Type 24			
A0100	Wheelchair van – over 16 miles	Transport per mile	Y
A0130	Wheelchair van – under 16 miles	One way flat fee	Y

Diagnosis Code

A diagnosis code is also required for billing Medicaid.

For dates of service on or before September 30, 2015, transportation providers are instructed to use diagnosis code 799.9 (unspecified or unknown cause).

For dates of service on or after October 1, 2015, transportation providers are instructed to use diagnosis code Z02.9 for in-town trips to medical appointments and Z75.3 for out-of-town medical appointments.

Place of Service

The required place of service code for taxis and wheelchair vans is 41.

Prior Authorization Number

A prior authorization number is also required for billing Medicaid. This code is also provided by the Transportation Center on the dispatch log.

Additional Billing Tips

These suggestions may help reduce coding errors and unnecessary claim denials:

- Bill only for the trips or miles approved by the Transportation Center.
- Attend classes on coding offered by certified coding specialists.
- Use the correct units measurement on CMS-1500 claims. Unless otherwise specified, one unit equals one transport or one statute mile.

Using the Medicaid Fee Schedule

When billing Medicaid, providers should use the Department's fee schedule for transportation providers. In addition to covered services and payment rates, fee schedules contain helpful information such as authorization requirements and other information. Department fee schedules are usually updated each January and July. Fee schedules are available on the Provider Information [website](#).

Using Modifiers

Two modifiers are available for use with transportation services:

- U2 is used when billing for a second trip for the same member on the same day.
- U3 is used when billing for a third trip for the same member on the same day.

Billing Tips

Before billing Medicaid, all transportation services must be authorized. (See the Passport to Health and Prior Authorization chapter in this manual.) The CMS-1500 claim form must contain a valid Montana Medicaid procedure code, diagnosis code, and a prior authorization code. Montana Medicaid procedure codes for transportation services are listed in the Non-Emergency Transportation Codes table earlier in this chapter and in the transportation fee schedule on the Provider Information [website](#).

Billing for Trips with a Blanket Authorization

When a provider has one prior authorization number for multiple services during a certain period of time, it is considered a blanket authorization. When billing with a blanket authorization, bill for the actual date the service was provided, with each date of service on a separate line. Span billing is not authorized.

For example, a provider has a blanket authorization for July 1–17 for six round trips to take the member to therapy appointments every Tuesday and Thursday morning. The services for these dates would be billed like this:

24.	A DATE(S) OF SERVICE						B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES		E DIAGNOSIS CODE	F \$ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
	From MM DD YY	To MM DD YY	PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)		CPT/HCPCS	MODIFIER											
1	07	01	14	07	01	14	41	0	A0140		1	\$20:00	2				
2	07	03	14	07	03	14	41	0	A0140		1	\$20:00	2				
3	07	08	14	07	08	14	41	0	A0140		1	\$20:00	2				
4	07	10	14	07	10	14	41	0	A0140		1	\$20:00	2				
5	07	15	03	07	15	14	41	0	A0140		1	\$20:00	2				
6	07	17	03	07	17	14	41	0	A0140		1	\$20:00	2				

Billing for More than One Trip on the Same Date

When two round trips have been authorized on the same date, use modifier U2; when three trips have been authorized on the same date, use modifier U3. If you have a separate prior authorization number for each trip, bill each trip on a separate claim form. For example, if the same member as shown above has also been approved for a round trip to the dentist on July 17, it would be billed like this.

A	DATE(S) OF SERVICE						B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES		E DIAGNOSIS CODE	F \$ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
	From MM DD YY	To MM DD YY	PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)		CPT/HCPCS	MODIFIER											
1	07	17	14	07	17	14	41	0	A0140	U2	1	\$20:00	2				

In-Community Travel

Transportation services can be billed for member loaded miles only. Ground trips under 16 miles are billed using the all-inclusive transportation code (located on the authorization list from the Transportation Center) with 1 unit for one-way trips or 2 units for round trips. Trips over 16 miles are billed using the *per mileage* code, with one 1 unit per mile. Bill for only the number of trips/miles actually provided, and up to the number of trips/miles authorized by the Transportation Center.

Submitting a Claim

Paper Claims

Unless otherwise stated, all paper claims must be mailed to:

Claims Processing
P.O. Box 8000
Helena, MT 59604

Electronic Claims

Providers who submit claims electronically experience fewer errors and quicker payment. Claims may be submitted electronically using:

- WINASAP 5010 (available on the Electronic Billing page of the [website](#)) or other HIPAA-compliant software.
- A claims clearinghouse.

Electronic claims submission changed with the implementation of the electronic transaction standards under the Health Insurance Portability and Accountability Act (HIPAA). For more information on electronic claims submission, see the *General Information for Providers* manual or call Provider Relations and follow the instructions for reaching EDI.

Claim Inquiries

Contact Provider Relations for questions regarding member eligibility, payments, denials, and general claim questions. Denied claims include an explanation of the denial and steps to follow for payment (if the claim is payable).

Other Programs

The billing procedures in this chapter apply to those services covered under the Mental Health Services Plan (MHSP).

Definitions and Acronyms

In addition to the terminology below, see the Definitions and Acronyms page of the Provider Information [website](#) for definitions and acronyms used in this manual.

Attendant

A person who accompanies the Medicaid member to Medicaid covered medical appointments. The Medicaid member's age or disability determine the necessity of attendant services. Attendant services must be prior authorized.

Mileage

The distance traveled by a Medicaid member in a privately owned vehicle from once community to another in order to receive Medicaid-covered medical care. This service must be prior authorized.

Personal Transportation

Transportation provided in a privately owned vehicle by the Medicaid member or the member's friend or relative.

Specialized Non-Emergency Transportation

Transport in a van designed for wheelchair or stretcher bound members, which is operated by a provider with a class B public service commission license. This type of service does not require the same level of care as an ambulance, and members using this service may have a disability or physical limitation that prevents them from using other forms of transportation to obtain medical services. Medicaid does not cover specialized non-emergency transports when another mode of transportation is appropriate and less costly.

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