Ambulance Transportation

Health Resources Division

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DEPARTMENT OF
PUBLIC HEALTH &
HUMAN SERVICES

Definitions

DEPARTMENT OF PUBLIC HEALTH & HUMAN SERVICES

Definitions

Non-Emergency Services

Any scheduled transportation that is not an emergency.

Examples include:

- Hospital discharge trips
- Travel to and from dialysis (ESRD facilities)
- Trips for chemotherapy or radiation therapy
- Visits for diagnostic or therapeutic services

If it's planned and not urgent, it's non-emergency.

Emergency Services

Any non-scheduled transportation that results from an emergency.

Some examples include:

- Accident or injury patient
- Unconscious or in shock patient
- Acute stroke or myocardial infarction patient
- Hemorrhaging patient
- Patient requires oxygen as an emergency measure or other emergency treatment on the way to the destination.

Ambulance Service Requirements

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Service Requirements

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.

Ambulance Vehicle Requirements (ARM 37.86.2601)

- A specially equipped vehicle designed to transport sick or injured individuals by land, water, or air. It must carry essential medical equipment (such as a stretcher, oxygen, and first aid supplies) and be staffed by licensed or certified personnel who provide emergency care during transport.

Covered Services

General Coverage Principles

Ambulance Coverage (ARM 37.86.2601 and ARM 37.86.2602)

- **Medical Necessity**: Ambulance transport is covered only when the member's condition requires transport to the nearest appropriate facility. Each service (e.g., transport, oxygen, life support) must be medically necessary.
- **Documentation**: Providers must submit documentation supporting medical necessity for each service. Claims are reviewed and may be denied for reasons other than medical necessity.
- **Fee Schedule**: The easiest way to verify coverage for a specific service is to check the Ambulance fee schedule. https://medicaidprovider.mt.gov/25

General Coverage Principles

Noncovered Services (ARM 37.86.2602)

- No coverage if the member could be safely transported by another mode, regardless of availability.
- After Death: Medicaid benefits end at death. If death occurs after the ambulance is called but before transport, only the base rate is covered. No payment if death is pronounced before the call.
- No Transport Provided: No payment for treatment-only calls where the member is not transported.
- Air Ambulance Preference: Not covered for transfers between hospitals solely due to member or family preference for a specific hospital or physician.

Services-Ground

Transportation by an ambulance that operates on land or water. It includes several levels of care:

- **Basic Life Support (BLS):** non-invasive care by an EMT-Basic, following national or state standards.
  - BLS Emergency: same as BLS, but provided in response to an emergency.
- **Advanced Life Support Level 1 (ALS1):** care by an EMT-Intermediate or Paramedic, including at least one advanced procedure beyond BLS.
  - **ALS1 Emergency**: ALS1 care provided during an emergency.
- **Advanced Life Support Level 2 (ALS2):** intensive care that includes either: at least three medication administrations, or one advanced procedure (e.g., defibrillation, intubation, central line, pacing, chest decompression, surgical airway, intraosseous line).
- **Specialty Care Transport (SCT):** for critically ill or injured patients needing interfacility transport with ongoing care from specialized medical professionals (e.g., nurses, respiratory therapists).

Services-Air

Air covered only if:

1. Ground ambulance requirements are met, and one of these applies:
2. Pickup location cannot be reached by land vehicle, or distance or obstacles make land transport too slow and would endanger the patient's life or health.

Hospital Transfers:

- Allowed if the hospital cannot provide needed specialized care and the above conditions are met.
- Not covered for patient or family preference.
- Mileage is paid only to the nearest appropriate facility.

Specific Services-Air Transfers

Covered: Air ambulance transfer is covered when a member is discharged from one inpatient facility and admitted to another inpatient facility only if distance or urgency makes ground transport impractical.

Not Covered: Medicaid does not pay separately for round-trip ambulance transport for outpatient services (e.g., x-ray or procedure) at another hospital while the member is an inpatient. This transport is included in the hospital's inpatient payment.

Specific Services Non-Scheduled Transport

May include emergencies or non-emergent transports with special circumstances that prevent scheduling. Examples:

- Emergency transports.
- Non-emergent needs discovered after regular business hours.
- Meeting flight teams at airports.
- Hospital-to-hospital transfers for a higher level of care.
- One-way returns to nursing homes or residences after ER visits.

Urgent transports (not life-threatening but require prompt evaluation), such as:

- Nursing home fall (possible fracture).
- Elderly member with flu-like symptoms (possible dehydration).Injury requiring evaluation but not an emergency.
- Stabilized trauma patient needing transfer for advanced diagnostics (e.g., CT scan).

Authorization: Prior authorization not required if transport cannot be anticipated during regular business hours. All non-scheduled transports must be authorized before claim submission.

Specific Services-Scheduled Transport

- May be round trip (loop) or one-way.
- Requires prior authorization.
- Typically arranged during regular business hours.

Examples:

- Transport to a hospital for scheduled diagnostic tests (e.g., CT scan, MRI).
- Transport to a doctor’s office or clinic for members who can only be transported by stretcher.
- Transport for a planned hospital admission.
- Transfer from one acute care hospital to a lower-level acute setting (e.g., premature infant returning to smaller hospital).
- Transport from a hospital to another setting as part of a planned discharge.

Specific Services-Miscellaneous

Drugs & Supplies

- Covered when medical necessity is documented.

EKG Services

- Covered one time 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.

Mileage

- Mileage is paid in addition to the base rate when the pickup point is outside city limits or when transporting to another community. 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.

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.

Authorization

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General Authorization Principles

- All ambulance transports require authorization from Mountain Pacific.
- The only exception occurs for non-scheduled transports of a member who has both Medicare and Medicaid.
- WWW.MPQH.ORG
  - Transportation Reimbursement
- Providers have **180** days from transport to notify the Mountain Pacific and submit paperwork (trip report), and 12 months from transport date of service to submit a claim.
- Mountain Pacific has 30 days to complete an authorization request. Average around 13 days.

Authorization for Scheduled Transport

Steps before the transport.

1. Verify eligibility.
2. Prepare transport documentation:
   - Name of transportation provider
   - Member's name
   - Member's 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).
   - Present the documentation to Mountain Pacific. Call 1-(877)362-5861.

Authorization Outcomes-Scheduled Transport

Approvals Before Transport

- The nurse reviewer will give verbal authorization and a case number.

Approvals After Transport

- Providers have 180 days from transport to submit paperwork (trip report) in the Mountain Pacific online portal, and 12 months from the transport date of service to submit a claim.
- The provider receives an approval letter with the prior authorization number. This number is also transmitted to the claims processing system.

Denials

Prior Authorization: Even if verbal prior authorization is received, the claim can still be denied if the medical record does not support the need for ambulance transport.

Notification: If denied for medical necessity, both the provider and the member receive a denial letter.

Appeal Timeframes: Providers: 30 days to appeal. Members: 90 days to appeal.

- Provider Appeals: Directed to the authorizing agency; instructions are in the denial letter.
- Member Appeals: Directed to the Hearing Office; instructions are in the denial letter.

Billing

Billing Procedures-Modifiers

Using Modifiers

- Origin/destination modifiers are recommended when billing Medicaid See Ambulance Manual for list of Origin/Destination modifiers list.
- Using the **U2** and **U3** modifiers after origin/destination modifiers when required when two or three transports are done for the same member on the same day. This helps reduce possible duplicate claims.

Billing Procedures-1500 Claim Form


HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

1. MEDICARE (Medicare#) MEDICAID (Medicaid#) TRICARE (ID#/DoD#) CHAMPVA (Member ID#) GROUP HEALTH PLAN (ID#) FECA BLK LUNG (ID#) OTHER (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. RESERVED FOR NUCC USE

CITY

ZIP CODE TELEPHONE (Include Area Code) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? YES

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT?

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. Claim Codes (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO If yes, complete items 9, 9a, and 9d.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY

15. OTHER DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate A-L to service line below (24E)) ICD Ind.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

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

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. Rsvd for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

a. NPI b.

NUCC Instruction Manual available at: www.nucc.org PLEASE PRINT OR TYPE APPROVED OMB-0938-1197 FORM 1500 (02-12)

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

SAMPLE

Billing-Mileage

Providers may bill for member-loaded miles using the mileage code in the fee schedule only if:

- Ground ambulance picks up a member outside the limits of the city where the ambulance is based.
- Ground ambulance transports a member between communities.
- Transport is by fixed wing or rotary wing air ambulance.

Billing Details:

- One unit = one statute mile (for both air and ground).
- 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.

Conclusion

DEPARTMENT OF PUBLIC HEALTH & HUMAN SERVICES

Contacts & References

Contacts

- Kial Leach, Ambulance Program Officer
  - (406)444-6868 or kleach@mt.gov

Mountain Pacific

- (877)362-5861 or ambulance@mpqh.org

References

Montana Medicaid Ambulance Services Manual

Ambulance Services Administrative Rules of Montana