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2. Transportation Services (Ambulance)

2.1. Introduction

This document covers all ambulance transportation services. It also addresses the following processes.

- Co-payments
- Prior authorization (PA) procedures
- Reconsideration requests and the appeals process

2.2. Definitions

2.2.1. Emergency Services

Medical necessity is established when the participant’s condition is of such severity that use of any other mode of transport would endanger the participant’s life or health. An emergency is any event that puts the health and life of a Medicaid participant at serious risk without immediate treatment. Real emergencies occur when the medical needs of a participant are immediate and due to severe symptoms [Social Security Act 1932 (b)(2)(C)].

2.2.2. Non-Emergency Service

Medicaid defines a non-emergency ambulance service as ambulance transport, which is medically necessary due to the medical condition of the participant, when any other form of transportation will place the participant’s life or health in serious jeopardy. This includes inter-facility transfers, nursing home to hospital transfers, and transfers to the participant’s home from the hospital. All scheduled, non-emergency ambulance transports must be approved prior to the transport.

2.2.3. Basic Life Support (BLS)

BLS includes all acts and duties that may be performed by a certified Emergency Medical Technician - Basic (EMT-B). The care may be provided by personnel with a higher level of certification (e.g. advanced EMT-A, EMT-paramedic, registered nurse), but if the care provided falls within the scope of practice for the EMT-B, the level of reimbursement is BLS. Common examples include patient assessment, bleeding control, spinal immobilization, and the use of oxygen and splints. For a complete list of the skills and duties allowed for an EMT-B, refer to the Board of Medicine Rules for EMS personnel. For a complete list of the skills and duties allowed, refer to IDAPA 16.01.03 Emergency Medical Services (EMS) - Agency Licensing Requirements.

2.2.4. Advanced Life Support (ALS) Level I (Emergency and Non-Emergency)

ALS Level I emergency and non-emergency includes the transportation by ambulance and the provision of at least one medically necessary ALS intervention or treatment. An ALS intervention is a procedure that is beyond the scope of practice of an EMT-B. Common examples include peripheral venous puncture, electrocardiogram (EKG) rhythm interpretation, and administration of various medications used in medical, respiratory, or behavioral emergencies. For a complete list of the skills and duties allowed, refer to IDAPA 16.01.03 Emergency Medical Services (EMS) - Agency Licensing Requirements.
2.2.5. **Advanced Life Support (ALS) Level II**

ALS Level II includes the transportation by ambulance and the medically necessary administration of at least three separate administrations of one or more medications by intravenous push/bolus or continuous infusion or one of the following medically necessary treatments.

- Manual defibrillation/cardioversion
- Endotracheal intubation
- Central venous line
- Cardiac pacing
- Chest decompression
- Surgical airway
- Intraosseous line

2.2.6. **Critical Care Transport (CCT)**

Critical Care Transport (CCT) includes the provision of medically necessary supplies and services at a level of service beyond the scope of an EMT-Paramedic. CCT is the inter-facility transportation of a critically ill or injured participant that is necessary because the participant’s condition requires ongoing care furnished by one or more professionals in an appropriate specialty (such as emergency or critical care nursing, emergency medicine, respiratory or cardiovascular care, or a paramedic with additional training).

2.2.7. **Hospital Based**

Only ambulances that are owned or leased, and operated by a hospital are designated by Idaho Medicaid as hospital based.

2.2.8. **Non-Hospital Based**

Only ambulances that are NOT owned or leased, and operated by a hospital are considered non-hospital based.

2.2.9. **Non-Emergency Medical Transportation (NEMT)**

Effective July 1st, 2016, Idaho Medicaid has contracted with VEYO to handle all non-emergency medical transportation services. Please go to www.idahotransport.com or call 1 (877) 503-1261 for more information.

2.3. **General Information and Requirements**

2.3.1. **Overview**

Ambulance services are payable by Medicaid only if used in the event of a medical emergency or after prior authorization (PA) has been obtained from the Medical Care Unit. The Medical Care Unit manages ambulance transportation services, including PA of non-emergency ambulance transportation and medical review of emergency ambulance claims.

Ambulance services must be medically necessary, as determined by IDAPA, in order to be paid by Medicaid.

See the [Hospital](#) guidelines for more information.
2.3.2. Important Billing Instructions

2.3.2.1. Payment
Medicaid transportation providers will be reimbursed at the current rate established by DHW or the actual cost of the service, whichever is less.

2.3.2.2. Claim Forms
Non-hospital based ambulance providers may bill electronically or on the CMS-1500 claim form. Hospital based ambulance providers may bill electronically or on the UB04 claim form. Forms are available from local form suppliers.

Required attachments include third party payer Explanation of Benefits (EOB) for payments or denials.

2.3.2.3. Customary Fees
Ambulance service charges to Medicaid cannot exceed the provider’s charges to the public for the same service (usual and customary fee). Reimbursement for non-hospital based ambulance service is at the rate established by Idaho Medicaid.

Transportation of nursing home or Intermediate Care Facility for the Intellectually Disabled (ICF/ID) residents is the responsibility of the facility unless the medical condition of the participant requires ambulance transport. All non-emergency ambulance transports must be prior authorized by Medical Care Unit

2.3.2.4. Payment in Full
The claimant’s certification (reverse side of the CMS claim form), signed on each claim submitted for payment, indicates the Medicaid payment for the charges on that claim will be accepted as payment in full for the services rendered. The participant is not responsible for the unpaid balance remaining on covered services, and should not be billed.

2.3.2.5. Medicare Participants
If a participant has Medicare coverage, the provider must first bill Medicare for services rendered. See General Billing Instructions, Third Party Recovery (TPR), for billing instructions.

2.3.2.6. Submitting Claims to Idaho Medicaid
The provider’s claim must match the authorized services on the Notice of Decision for Medical Benefits or the claim will be denied. Contact Medical Care Unit with questions, pertaining to the review of ambulance claims.

Medicaid Ambulance Review
PO Box 83720
Boise, ID 83720-0009
1 (208) 287-1157 or 1 (800) 362-7648

2.3.2.7. Covered Services
For non-hospital based ambulance services, see CMS 1500 Instructions for covered services. For hospital based ambulance services, see UB04 Instructions for covered services.
2.3.2.8. Emergency Transportation Providers

Effective for claims with dates of service on or after February 1, 2017, the following HCPCS codes no longer require prior authorization and are to be billed directly to Molina Medicaid Solutions with appropriate documentation*.

- A0429-Emergency BLS
- A0427-Emergency ALS I
- A0433-Emergency ALS II
- A0425-Emergency mileage (PA will be required if not billed in conjunction with one of the above three codes)

A0998 – Response without transport: The provider has the option to bill using modifier II and receive a flat fee payment without the need for prior authorization or documentation. The provider can bill A0998 and request a PA from the Department with appropriate documentation for payment different than the flat fee amount.

*These claims must be billed as a CMS 1500 and must include the Patient Care Report attached to the claim, and the EOB (if applicable). These claims will pay through the system according to rule, however, the Medical Care Unit will be targeting a random sample of claims to ensure rule compliance, accuracy, correct billing, and other quality measures. If a claim is selected during the retroactive review and it is determined that the claim does not meet the Idaho Medicaid requirements for emergency transport, then Idaho Medicaid will recoup the allocated funds for that claim. Idaho Medicaid will also conduct further research on similar claims to ensure accuracy and compliance.

Please ensure that claims submitted meet the Medical Necessary Guidelines for Emergency Ambulance Transportation according to CMS/IDAPA for the actual service performed. Idaho Medicaid reimburses for the level of service provided, not the level of licensure providing that service.

Effective for claims with dates of service on and after January 1, 2011, ambulance providers and suppliers must report mileage units rounded up to the nearest tenth of a mile for all claims (except hard copy billers that use the UB-04) for mileage totaling less than 100 covered miles. Providers and suppliers must submit fractional mileage using a decimal in the appropriate place (e.g., 99.9).

For trips totaling 100 miles and greater, suppliers must continue to report mileage rounded up to the nearest whole number mile (e.g., 999).

For mileage totaling less than one mile, providers and suppliers must include a “0” prior to the decimal point (e.g., 0.9).

2.3.3. Licensing Requirements

Medicaid ambulance service providers must hold a current license issued by the Emergency Medical Services (EMS) Bureau and must comply with the rules governing EMS services. Ambulance services based outside the State of Idaho must hold a current license issued by that state’s EMS licensing authority.

Emergency Medical Services (EMS) Bureau
1 (208) 334-4000
Fax 1 (208) 334-4015
2.3.4. **Appropriate Transportation Service**

2.3.4.1. **Air Ambulance**

Medicaid covers air ambulance services when one of the following occurs:

- The point of pickup is inaccessible by a land vehicle.
- Great distances or other obstacles are involved in getting the participant to the nearest appropriate facility and urgent medical care is needed.
- The participant’s condition and other circumstances necessitate the use of air ambulance.
- If ground ambulance services would suffice and be less costly, payment is based on the amount that would be paid for a ground ambulance.

Air ambulance must be approved by the Medical Care Unit in advance, except in emergency situations. Non-hospital based air ambulance services must be billed on the CMS-1500 claim form, using HCPCS codes. Only air ambulances that are owned or leased, and operated by a hospital are designated by Idaho Medicaid as hospital based. The services must be billed on a UB-04 claim form using revenue codes from the Hospital guidelines.

2.3.4.2. **Ground Ambulance**

- Non hospital-based, ground ambulance services must be billed on a CMS-1500 claim form using HCPCS procedure codes.
- Ambulances that are owned or leased, and operated by a hospital are designated as hospital based. Those services must be billed on a UB-04 claim form using revenue codes found in the Hospital guidelines.

2.3.5. **Base Rate for Ambulances**

2.3.5.1. **Levels of Service**

Providers may report one of the following levels of service for transporting Medicaid participants. Providers may also request payment for treat and release or respond and evaluate if the patient is not transported. The three levels of service are:

- Basic Life Support (BLS) (emergency and non-emergency)
- Advanced Life Support (ALS) I (emergency and non-emergency)
- ALSII (emergency and non-emergency)
- Ground specialty (above the level of Paramedic)

When reviewing ambulance claims for quality assurance, the Medical Care Unit considers the following:

- The requested level of service is equal to or below the level of EMS certification of the personnel providing care in the patient compartment of the vehicle.
- The certification level of the provider is documented on the patient care record.
- The type of care provided corresponds with the level of service requested.

Each level of service corresponds with the Idaho Administrative Code acts and duties allowed for the pre-hospital care providers, as per IDAPA 16.02.03.325 Pre-Hospital Advanced Life Support (ALS) Standards.

Separate fees are not allowed for components of Basic Life Support (BLS) or Advanced Life Support (ALS) care, such as starting IVs and administering oxygen. This includes all non-disposable equipment used in the treatment such as backboards, scoop stretchers, and
cervical collars. Disposable (consumable) equipment and medications are included in the base rate payment for ground ambulance services and may not be billed separately.

2.3.6. Waiting Time and Extra Attendants
Waiting time and extra attendants are not paid unless medically necessary and authorized by Medicaid Ambulance Review. Waiting time must be physician ordered.

2.3.7. Multiple Runs in One Day
When the ambulance transports a participant, returns to the base station, and transports the participant a second time on the same date, two base rate payments and loaded mileage are allowed. Use modifier 76 on the second base rate procedure code to prevent denials for duplicate claims. Modifier 76 should not be included on either loaded mileage.

When the ambulance transports a participant, the participant is transferred to another facility, and the ambulance does not return to the base station, one base rate, waiting time, and loaded mileage are allowed.

2.3.8. Physician in Attendance
When a physician is in attendance, the documentation should justify the necessity and specialty type of the physician. The physician is responsible for the billing of their services.

2.3.9. Nursing Home Residents
Ambulance services are covered only in an emergency situation or when prior authorized by Medicaid Ambulance Review. Payment for any non-covered, non-emergency service is the responsibility of the facility and ambulance providers may not bill Medicaid.

2.3.10. Deceased Participants
Ambulance service for deceased participants is covered when documented in the run sheet as follows.

- If the participant was pronounced dead after the ambulance was called but before pickup, a base rate will be allowed.
- If the participant was pronounced dead while in route to or upon arrival at the hospital, a base rate and mileage will be allowed.
- If the participant was pronounced dead by an authorized person before the ambulance was called, no payment will be made.

2.3.11. Requests for Reconsideration of PA or Retrospective Review and Authorization Denial
Providers may request a reconsideration of a PA decision made by DHW, by following these steps.

**Step 1**
Carefully examine the Notice of Decision for Medical Benefits to ensure that the requested services and procedure codes were actually denied. Occasionally a requested service/procedure code has been denied and the appropriate service/procedure code was actually approved on the next line in the notice.

**Step 2**
If you disagree with the DHW decision, you can complete a written Request for Reconsideration, which is found on the second page of the Notice of Decision.
Include any additional extenuating circumstances and specific information that will assist the authorizing agent in the reconsideration review. Attach a copy (front and back) of the Notice of Decision for Medical Benefits.

**Step 3**
Submit the written request directly to Medicaid Transportation (MT) within 28 calendar days of the mailing date, on the Notice of Decision for Medical Benefits. Medicaid transportation will review the additional information and return a second Notice of Decision for Medical Benefits to the requestor within five working days of receipt of the provider’s Request for Reconsideration. If the reconsidered decision is still contested, the provider may then submit a written request for a contested case hearing. Medicaid participants may request a fair hearing. The Notice of Decision for Medical Benefits includes instructions for providers and participants to file a contested case or fair hearing.

**Step 4**
Maintain copies (front and back) of all documents in your records for a period of five years.

### 2.3.12. Prior Authorization (PA)

#### 2.3.12.1. Obtaining Prior Authorization (PA)
Please note that ALL non-emergent transports must receive prior authorization BEFORE the actual transport.

To obtain prior authorization for non-emergency ambulance services:
- Make the request a minimum of 24 hours before any scheduled appointment time.
  - Allow for weekends and state holidays.
- Call our Medical Program Specialist toll free at 1 (800) 362-7648 or in the Boise area at 1 (208) 287-1157. You will need to provide the following information.
  - Participant name, date of birth, and Medicaid ID number
  - Whether or not the participant has Medicare or other insurance
  - Transfer date and time
  - Level of service – BLS, ALS, Spec/Neo
  - Pick up point and destination
  - Discharging physician and receiving physician
  - Admit date and diagnosis
  - Medical reason for transport
- FAX the following to 1 (877) 314-8781
  - History and physical
  - Progress reports
  - Discharge summary (if available)
  - Other information that may be needed for physician review of medical necessity
- After hours, if there are any questions or further information that may be needed, please call and leave all the information on the voicemail, along with a return name and phone number.

After a request for PA has been submitted to DHW’s authorizing agent or designee, DHW will initiate a Notice of Decision for Medical Benefits to the participant and the transportation
provider indicating which procedures are authorized or denied. The procedure codes authorized on the notice must match the procedure codes billed on the claim form.

2.3.13. **Round Trip**

Medicaid places restrictions on round-trip charges, depending on whether the ambulance returns to the base station between trips. When the ambulance does not return to base station, bill for one base rate, round-trip loaded miles, and waiting time (limited to one and one-half hours). When the ambulance does not wait but returns to the base station between trips, bill for two base rates and loaded round-trip mileage.

2.3.14. **Trips to Physician’s Office**

Ambulance service from a participant’s home to a physician’s office is not covered unless prior authorized by Medicaid Ambulance Review.

2.4. **Emergency Transportation**

2.4.1. **Overview**

Provider claims for ambulance services may be reviewed to determine medical necessity and appropriate billing.

2.4.1.1. **Treat and Release**

A treat and release payment may be appropriate if the participant is treated at the scene and not transported. Disposable supplies are included in the treat and release payment. Treat and release may be requested at the BLS or ALS level, depending on the treatment provided. See section 2.3.5 *Base Rate for Ambulances* for details on determining the appropriate level of service.

2.4.1.2. **Respond and Evaluate**

A respond and evaluate payment may be appropriate if the ambulance responds to the scene and evaluates the participant, but treatment or transport is not necessary.

2.4.2. **Co-Payment for Non-Emergency Use of Ambulance Transportation Services**

Idaho Medicaid implemented co-payment provisions of House Bill #663 passed by the 2006 Idaho legislature. Ambulance providers may bill Medicaid participants a $3.65 (three dollar and sixty-five cent) co-payment for inappropriate ambulance service utilization when the following conditions are met.

- The Department of Health and Welfare (DHW) determines that the Medicaid participant’s medical condition did not require emergency ambulance transportation.
- DHW determines the Medicaid participant is not exempt from making co-payments according to Federal statute.
- DHW will notify both the ambulance provider and the Medicaid participant on the Notice of Decision letter when a participant may be billed for a co-payment.

**Note:** Collection of the co-payment is at the discretion of the provider and is not required by Idaho Medicaid.
2.4.3. **Ambulance Procedure Codes**

All ambulance services by a non-hospital based ambulance should be billed on a CMS-1500 claim form or submitted electronically. It is necessary to attach the run sheet to the claim. Payment for ambulance transport is for a one way trip in which the participant is in the patient compartment of the vehicle, except when a round trip is authorized by Medicaid Ambulance Review.