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## 1. Section Modifications

Version	Section/ Column	Modification Description	Publish Date	SME
12.0	All	Published version	5/31/2018	TQD
11.1	All	Reformatted, cleaned up language, added clarifications, and information about covered and non-covered services.	5/31/2018	W Deseron D Baker E Garibovic
11.0	All	Published version	2/20/18	TQD
10.2	2.3.2.3 Customary Fees	Updated ICF/IID acronym	2/20/18	D Baker E Garibovic
10.1	2.2.9 Non-Emergency Medical Transportation (NEMT)	Updated with new transportation vendor information	2/20/18	D Baker E Garibovic
10.0	All	Published version	3/9/17	TQD
9.4	2.4.3 Ambulance Procedure Codes	Minor updates for clarity	3/9/17	K Eidemiller E Garibovic
9.3	2.3.12 Request for Hearing	Removed section	3/9/17	K Eidemiller E Garibovic
9.2	2.3.2.8 Dates of Service	Removed section	3/9/17	K Eidemiller E Garibovic
9.1	2.3.1 Overview	Changed "Medicaid Ambulance Review" to "IDAPA"	3/9/17	K Eidemiller E Garibovic
9.0	All	Published version	2/27/17	TQD
8.9	2.4.4 Requests for Retrospective Review/Authorization	Removed section	2/27/17	K Eidemiller D Baker E Garibovic
8.8	2.4.1.1 Treat and Release 2.4.1.2 Respond and Evaluate	Changed "authorized" to "appropriate"; removed information about downgrading a claim	2/27/17	K Eidemiller D Baker E Garibovic
8.7	2.4.1 Overview	Various updates to verbiage	2/27/17	K Eidemiller D Baker E Garibovic
8.6	2.3.13.1 Obtaining Prior Authorization (PA)	Specified "non-emergent" transports	2/27/17	K Eidemiller D Baker E Garibovic
8.5	2.3.5.1 Levels of Service	Updated for clarity	2/27/17	K Eidemiller D Baker E Garibovic
8.4	2.3.2.9 Emergency Transportation Providers	Added information regarding emergency procedure codes and PA requirements effective 2/1/17	2/27/17	K Eidemiller D Baker E Garibovic
8.3	2.3.1 Overview 2.3.2.3 Customary Fees 2.3.2.6 Submitting Claims to Idaho Medicaid 2.3.4.1 Air Ambulance	Changed "Medicaid Ambulance Review" to "Medical Care Unit"	2/27/17	K Eidemiller D Baker E Garibovic
8.2	2.2.6 Critical Care Transport (CCT)	New section	2/27/17	K Eidemiller D Baker

Version	Section/ Column	Modification Description	Publish Date	SME
				E Garibovic
8.1	2.2.1 Emergency Services	Clarified definition of emergency	2/27/17	K Eidemiller D Baker E Garibovic
8.0	All	Published version	11/17/16	TQD
7.1	2.3.7 Multiple Runs in One Day	Updates regarding modifier 76	11/17/16	W Deseron E Garibovic
7.0	All	Published version	5/31/16	TQD
6.1	2.2.8 Non-Emergency Medical Transportation (NEMT)	Updated with new NEMT vendor information	5/31/16	D Baker
6.0	All	Published version	07/07/14	TQD
5.1	2.2.3. Basic Life Support; 2.2.4. Advanced Life Support	Updated reference to IDAPA rule	07/07/14	A Coppinger C Taylor
5.0	All	Published version	04/25/14	TQD
4.3	2.4.2 Co-Payment for Non-Emergency Use of Ambulance Transportation Services	Updated co-payment amount to \$3.65.	04/25/14	C Taylor
4.2	2.3.1 Overview	Spelled out prior authorization in first paragraph	04/25/14	C Taylor
4.1	2.2.8 Non-Emergency Medical Transportation	Updated link to AMR	04/25/14	A Coppinger C Taylor
4.0	All	Published version	10/25/13	TQD
3.1	2.3.2.3	Changed ICF/MR to ICF/ID	10/25/13	H McCain
3.0	All	Published version	10/20/11	TQD
2.1	2.3.2.9 Emergency Transportation Providers	Added section per DHW request	10/20/11	R Sosin
2.0	All	Published version	08/30/10	TQD
1.2	All	Updated sections for clarity and ease of use	08/30/10	T Kinzler
1.1	All	Updated numbering for sections to accommodate Section Modifications	08/30/10	C Stickney
1.0	All	Initial document – Published version	05/07/10	Molina/TQD

## **2. Transportation Services – Ambulance**

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

- Idaho Medicaid's general ambulance policy
- Service Limitations
- Co-payments
- Prior authorization (PA) procedures

### **2.1. Provider Qualifications**

Ambulance service providers in any state are eligible to participate in the Idaho Medicaid Program. They must be licensed in the state where they are based, and enroll as an Idaho Medicaid provider prior to submitting claims for services.

See [General Provider and Participant Information](#), Idaho Medicaid Provider Handbook for more information on enrolling as an Idaho Medicaid provider.

### **2.2. Eligible Participants**

All participants are eligible to receive ambulance services unless otherwise indicated.

#### **2.2.1. Hospice Participants**

Ambulance services related to the terminal illness that placed the participant on hospice are the responsibility of the hospice agency. Ambulance services unrelated to the terminal illness may be billed with a GW modifier directly to Idaho Medicaid without an authorization.

#### **2.2.2. Long Term Care Residents**

Residents of a Nursing Home or Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) are only covered in an emergency situation or when prior authorized by Medicaid Ambulance Review. Payment for any non-covered service is the responsibility of the facility and ambulance providers may not bill Medicaid or the participant.

### **2.3. Covered Services and Limitations**

Ambulance services must be medically necessary for coverage under either emergency or non-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.

#### **2.3.1. Emergency Services**

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)].

#### **2.3.2. Non-Emergency Services**

All non-emergency ambulance transports must receive a prior authorization before transport. This includes inter-facility transfers, nursing home to hospital transfers, trips to a

physician's office, and transfers to the participant's home from the hospital. See the [Post Authorization](#) and [Prior Authorization](#) section under Reimbursement for more information.

All non-emergency, non-ambulance medical transportation services are handled by MTM (Medical Transportation Management Inc.) effective March 6, 2018. Please go to [www.mtm-inc.net/idaho](http://www.mtm-inc.net/idaho) or call 1 (877) 503-1261 for more information.

### **2.3.3. Levels of Service**

Reimbursement is set by the level of service, which is determined by the lowest certification in Idaho with the service in their scope of practice. For a complete list of the skills and duties allowed, refer to the Board of Medicine Rules for EMS personnel, [IDAPA 16.01.03 Emergency Medical Services \(EMS\) - Agency Licensing Requirements](#). Care may be provided by personnel with a higher level of certification, but no additional payment will be made.

#### **2.3.3.1. Basic Life Support (BLS)**

BLS (HCPCS A0428 and A0429) includes all acts and duties that may be performed by a certified Emergency Medical Technician - Basic (EMT-B). Common examples include patient assessment, bleeding control, spinal immobilization, and the use of oxygen and splints. A0429 may be submitted as a claim without an authorization.

#### **2.3.3.2. Advanced Life Support (ALS) Level I**

ALS Level I (HCPCS A0426 and A0427) 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. A0427 may be submitted as a claim without an authorization.

#### **2.3.3.3. Advanced Life Support (ALS) Level II**

ALS Level II (HCPCS A0433) 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: manual defibrillation/cardioversion, endotracheal intubation, central venous line, cardiac pacing, chest decompression, surgical airway or intraosseous line. A0433 may be submitted as a claim without an authorization.

#### **2.3.3.4. Critical Care Transport (CCT)**

Critical Care Transport (CCT) (HCPCS A0434) 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). CCT always requires a prior authorization. See the [Post Authorization](#) and [Prior Authorization](#) section under Reimbursement for more information.

### **2.3.3.5. Respond and Evaluate**

A respond and evaluate (HCPCS A0998) may be appropriate if the ambulance responds to the scene and evaluates the participant, but treatment or transport is not necessary. Claims should be submitted with a Modifier II for a flat fee.

Providers may submit a PA request for higher levels of services that may have been provided. See the [Post Authorization](#) and [Prior Authorization](#) section under Reimbursement for more information.

### **2.3.4. Air Ambulance**

Air ambulance (HCPCS A0430 and A0431) must be authorized by the Medical Care Unit in advance, except in emergency situations. If ground ambulance services would suffice and be less costly, payment is based on the amount that would be paid for a ground ambulance. See the [Post Authorization](#) and [Prior Authorization](#) section under Reimbursement for more information.

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.

### **2.3.5. 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 respond and evaluate payment may be authorized. See the [Post Authorization](#) section under Reimbursement for more information.
- 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.

### **2.3.6. Extra Attendants**

Extra attendants (HCPCS A0424) are not paid unless medically necessary and authorized by Medicaid. See the [Post Authorization](#) and [Prior Authorization](#) section under Reimbursement for more information.

### **2.3.7. Mileage**

Ambulance providers and suppliers must report mileage units (HCPCS A0425, A0435 and A0436) rounded up to the nearest tenth of a mile for all claims totaling less than 100 miles. For trips totaling 100 miles and greater, mileage should be rounded up to the nearest whole number.

If the level of service provided requires an authorization so does the mileage. See the [Post Authorization](#) and [Prior Authorization](#) section under Reimbursement for more information.

### **2.3.8. Multiple Runs in a 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, only one base rate, waiting time, and loaded mileage are allowed.

### **2.3.9. 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.

### **2.3.10. Round Trip**

A round trip is billed when the ambulance does not return to base station. Round trips are only allowed to transport inpatient participants between facilities for specialized treatment. The treatment must not be available at the facility the participant is inpatient, and only transportation to the nearest capable facility is permitted. Claims should be billed 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 see the Multiple Runs in a Day section.

### **2.3.11. Treat and Release**

A treat and release payment may be appropriate at the BLS or ALS level if the participant is treated at the scene and not transported. A prior authorization request is necessary for reimbursement. See the [Post Authorization](#) and [Prior Authorization](#) section under Reimbursement for more information.

### **2.3.12. Waiting Time**

Waiting time (HCPCS A0420) is not paid unless ordered by a physician, medically necessary and authorized by Medicaid. See the [Post Authorization](#) and [Prior Authorization](#) section under Reimbursement for more information.

## **2.4. Reimbursement**

Idaho Medicaid reimburses transportation providers on a fee-for-service basis set by the level of service provided. Usual and customary fees are paid up to the Medicaid maximum allowance. Components of Basic Life Support (BLS) or Advanced Life Support (ALS) care are included in the level of service, and are not separately billable. This includes services such as starting an IV or administering oxygen, non-disposable equipment, disposable equipment and medications.

See the [General Billing Instructions](#), Idaho Medicaid Provider Handbook regarding reconsideration and appeals, billing, co-pays, prior authorization, and requirements for billing all other third party resources before submitting claims to Medicaid.

See the General Provider and Participant Information, Idaho Medicaid Provider Handbook for information on when billing a participant is allowable.

### **2.4.1. Claim Submission**

All ambulance claims must be submitted with appropriate documentation, including the Patient Care Report (PCR), and an EOB if applicable. Ambulances are categorized as either hospital based, or non-hospital based. Idaho Medicaid only considers ambulances that are owned or leased, and operated by a hospital as hospital based.

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 using revenue codes **540-549**. Claims must include an invoice of charges. See the [Hospital](#), Idaho Medicaid Provider Handbook *Appendix B.2* for additional information.

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

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. Collection of the co-payment is at the discretion of the provider and is not required by Idaho Medicaid.

### **2.4.3. Post Authorizations**

If extenuating circumstances do not permit a prior authorization request before a service is rendered, a post authorization request may be submitted. Fax the following to 1 (877) 314-8781:

- Claim Form: CMS-1500 or UB-04 as appropriate
- Patient Care Report (PCR)
- EOB, if applicable
- Other information that may be needed for physician review of medical necessity
- Hospital based ambulances must also submit an invoice

After a request has been processed, 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 submitted on claims.

### **2.4.4. Prior Authorizations**

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 has been processed, 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 submitted on claims.

#### **2.4.5. Retrospective Review**

The Medical Care Unit will regularly review a random sample of claims to ensure rule compliance, accuracy, correct billing, and other quality measures. Claims will be recouped that are determined not to meet Idaho Medicaid requirements.

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.