

**Distribution:** Ambulance 02-01  
Hospital 02-01  
Medicaid Health Plans 02-01

**Issued:** January 1, 2002

**Subject:** Ambulance Chapter III, Correction to Billing Instructions

**Effective:** Upon Receipt

**Programs Affected:** Medicaid, Children's Special Health Care Services

## Purpose

The attached Chapter III has been revised to incorporate changes due to the Uniform Billing Project and changes due to the new HCPCS ambulance procedure codes that have been previously issued in bulletins. The revised chapter also provides clarifications of existing ambulance policy.

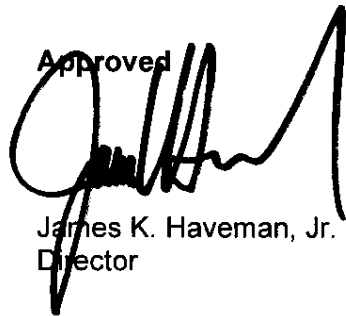
**NOTE:** MSA 01-04 "Uniform Billing Project for Ambulance Providers" erroneously referenced fields 43J or 43 K as the appropriate fields on the HCFA 1500 to enter modifiers. As stated in MSA 01-01 "Uniform Billing, Revised Chapter IV...", field 24D "Procedures, Services, or Supplies (CPT Codes plus Modifiers)," is the correct field on the HCFA 1500 to enter modifiers when they are necessary.

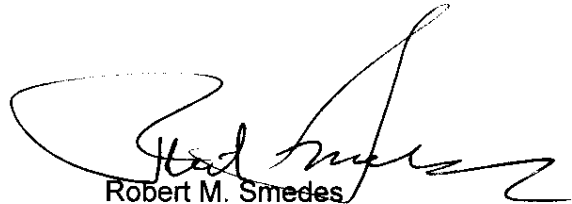
## Manual Maintenance

Discard your old Chapter III and insert the new Chapter III in your Ambulance Manual. Discard MSA 01-04 Uniform Billing Project for Ambulance Providers. The information in this bulletin has been incorporated into Chapters III and IV. Discard MSA 01-05, Revised List of Diagnosis Codes for Emergency Ambulance Transport. This list is being reissued along with Chapter III, as the Diagnosis Codes for Emergency Ambulance Transport Appendix.

**Questions**

Any questions regarding this bulletin should be directed to: Provider Inquiry, Medical Services Administration, P.O. Box 30479, Lansing, Michigan 48909-7979, or e-mail at [ProviderSupport@michigan.gov](mailto:ProviderSupport@michigan.gov). When you submit an e-mail, be sure to include your name, affiliation, and a phone number so you may be contacted if necessary. Providers may phone toll-free 1-800-292-2550.

Approved  
  
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**GENERAL:**

The primary objective of the Michigan Medicaid Program is to ensure that essential medical/health services are made available to those who would not otherwise have the financial resources to purchase them. The policies of the Program are aimed at minimizing the cost of medically necessary health care services provided to Medicaid beneficiaries.

Reimbursement for ambulance services is restricted to medically necessary and appropriate services when:

- Medical/surgical or psychiatric emergencies exist, or
- No other effective and less costly mode of transportation for medical treatment can be used because of the beneficiary's medical condition.

Services that have been excluded from direct reimbursement to ambulance providers are:

- Services which are not medically necessary.
- Services included as a part of the base rate.
- Services for beneficiaries in a LTC nursing facility that are reimbursed as part of the per diem or are billed separately by the facility.
- Services reimbursed as part of the DRG rate for beneficiaries who are inpatients at a hospital and are sent to another facility for services and returned to the originating hospital without being discharged from the originating hospital.
- Services to MHP enrollees, except for medically necessary ambulance transports related to dental, substance abuse and community mental health services.
- Non-ambulance, non-emergency medical transportation which is provided by a Medicaid health plan, or the Family Independence Agency reimburses the beneficiary or the transportation provider directly.

The section on Covered Services (Section 3) describes, in alphabetical order, the coverages and limitations for payment of ambulance services by the Medicaid Program.

Billing instructions follow the various coverages, where applicable. These instructions will assist the ambulance provider in obtaining reimbursement and should be used along with the completion instructions in Chapter IV and the HCPCS coding for ambulance.

**AMBULANCE SERVICES:**

The Michigan Department of Community Health recognizes different levels of medical services provided by qualified ambulance staff according to the standards established by law and regulation through Michigan Public Act 368 of 1978, as amended. The standards established for each level of service are detailed in the Base Rate sub-section of Section 3.

The Ambulance Quick Reference Guide (Section 5) may be used as a guide to Medicaid coverage for ambulance services.



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All services identified as covered "if medically necessary" must be ordered by a physician, and a copy of the physician's order must be retained in the beneficiary's file. The physician's order must contain, at a minimum, the following information:

- Beneficiary's name and Medicaid I.D. number,
- Medical necessity of an ambulance transport, and
- Physician's signature and Medicaid Provider I.D. number.

Emergency services do not require a physician's order, but documentation must be kept by the ambulance provider in the beneficiary's file supporting the emergency nature of the service.

When a beneficiary who is an inpatient in a hospital is transported to another hospital or to another facility for testing or treatment not available at the originating hospital, and is returned to the originating hospital without being discharged, the originating hospital is responsible for the cost of the transport.

### MEDICAL NECESSITY:

Determination of medical necessity and appropriateness of service is the responsibility of the medical care personnel in attendance, including the emergency medical technician (EMT) at the scene of an emergency, within the scope of currently accepted medical practice and the limitations of the Program. Medical necessity for non-emergency transports must be substantiated by/with a physician's written order. Documentation of the medical necessity and appropriateness of service must be maintained by the ambulance provider in the beneficiary's file.

### DIAGNOSIS CODING:

Providers must enter the appropriate diagnosis code on all ambulance claims using the International Classification of Diseases, Ninth Edition, Clinical Modification (ICD-9-CM). Providers must report the most specific diagnosis code available that identifies the reason for the service. When billing for emergency transports providers should refer to the Diagnosis Codes for Emergency Ambulance Transports Appendix.

Documentation supporting the diagnosis code must be retained in the ambulance provider's records for audit purposes.

### USUAL AND CUSTOMARY CHARGES:

The Program must be billed the provider's usual and customary "fee" charged to the public. If the public receives a service without charge, an ambulance provider cannot bill the Program for the same service. If one charge is made to tax paying residents in a given township, and a higher charge is made to nonresidents, the same charge formula should be applied for Medicaid beneficiaries.

Refer to the Third Party Billing instructions located in Chapter IV when the beneficiary also has Medicare or other insurance.



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### MEDICARE/MEDICAID COVERAGES:

The Michigan Department of Community Health will reimburse the ambulance provider for the coinsurance and deductible amounts subject to the Program's reimbursement limitations on all Medicare approved claims, even if the Program does not normally cover the service.

The ambulance provider should refer to **Chapter IV** for instructions on completing the claim after Medicare has approved the services.



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**Ambulance:** A motor vehicle, watercraft, or aircraft that is primarily used or designated as available to provide transportation and basic life support or advanced life support.

**Continuous or Round Trip:** An ambulance service in which the patient is transported to the hospital, the physician deems it medically necessary for the ambulance to wait, and the beneficiary is then transported to a more appropriate facility for care or back to the place of origin.

**Cooperating Hospital:** A licensed hospital which supports an advanced mobile emergency care service as required by sections 20761(a) and 20763(b) of Public Act 368 of 1978, as amended.

**Emergency Medical Condition:** A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate attention to result in:

- Placing the health of the individual (or, with respect to pregnant women, the health of the woman or her unborn child) in serious jeopardy
- Serious impairment of bodily functions
- Serious dysfunction of any bodily organ or part.

**Emergency Patient:** An individual whose physical or mental condition is such that it meets the definition of "emergency medical condition".

**Emergency Response:** A response that, at the time the ambulance provider is called, is provided after the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity such that in the absence of immediate medical attention could reasonably be expected to result in placing the beneficiary's health in serious jeopardy; in impairment to bodily functions; or in serious dysfunction to any bodily organ or part.

**Emergency Transport:** An emergency, pre-hospital service in which no physician has yet seen the patient, e.g., a transport from the scene of an accident to an emergency department.

**Fixed Wing Air Ambulance:** Transportation by a fixed wing aircraft that is certified as a fixed wing air ambulance and such ancillary services as may be medically necessary.

**Helicopter (Rotary Wing) Air Ambulance:** Transportation by a helicopter that is certified as an ambulance and such ancillary services as may be medically necessary.

**Loaded Mileage:** The number of miles for which the Medicaid beneficiary is transported in the ambulance vehicle.

**Medically Necessary Transport:** An ambulance transport which is required because no other effective and less costly mode of transportation can be used due to the patient's medical condition. The transport is required to transfer the patient to and/or from a medically necessary service not available at the primary location.

**Psychiatric Emergency:** Any condition that must be treated to prevent the patient from inflicting injury to self or others.



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**Transfer:** A non-emergency transport in which the patient is moved from one facility to another for care that is not available at the originating facility.



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**AIR AMBULANCE:**

**FIXED WING AIR AMBULANCE SERVICES:**

Fixed wing air ambulance providers must be licensed by the Michigan Department of Consumer and Industry Services and be properly enrolled with the Michigan Department of Community Health. Providers must indicate on the application for enrollment that they are requesting fixed wing air ambulance status. Fixed wing providers are to submit a copy of their license as an Aircraft Transport Operation which shows their aircraft registered as an Aircraft Transport Vehicle. Since all equipment standards must equate to current Basic Life Support (BLS) or Advanced Life Support (ALS) criteria as appropriate for the transported patient, providers must also submit a copy of their Commission on Accreditation of Air Medical Services (CAAMS) accreditation or an affidavit of substantial CAAMS accreditation compliance to document the provider's fixed wing aircraft as suitable for air ambulance transport. The Medicaid provider enrollment file will then reflect enrollment in the Program as a fixed wing air ambulance provider.

**Prior Authorization:**

All air ambulance transport provided by fixed wing aircraft must first be prior authorized. For details regarding prior authorization or for out of state services, providers should refer to the Out of State Non-Borderland Transports sub-section of Section 4.

Ambulance transport in a fixed wing aircraft is a covered service if the following requirements are met:

- The transport, including ancillary services (e.g., flight nurse), is ordered by a physician,
- The written physician order is maintained in the beneficiary's file,
- Transport by a ground vehicle would endanger the beneficiary's life due to time and distance from the hospital,
- Necessary care and medical services for the beneficiary's condition cannot be provided by the local facility, and
- Transport is for medical or surgical procedures only and not for diagnostic purposes.

**NOTE:** Any ground ambulance transportation ordered to and from the airport must be billed by the ambulance company in the normal manner.

**HELICOPTER AIR AMBULANCES:**

Helicopter air ambulance providers must be licensed by the Michigan Department of Consumer and Industry Services and be properly enrolled with the Michigan Department of Community Health. Providers must indicate on the application for enrollment that they are requesting helicopter air ambulance status. Providers are to submit a copy of their license with their enrollment application. The Medicaid provider enrollment file will then reflect enrollment in the Program as a helicopter air ambulance provider.



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Helicopter air ambulance services are covered by the Program **only** under the following circumstances:

- Time and distance in a ground ambulance would be a hazard to the life of the patient,
- The reason for the service is that the necessary care and services for the beneficiary's needs are not available at the local hospital, and
- The transfer is for medical or surgical therapy, not for diagnosis only.

Refer to Ambulance Services in Section 1 for documentation requirements for emergency and medically necessary services.

Coverage of helicopter air ambulance services includes the helicopter base rate, mileage, and waiting time.

**Base Rate:** Reimbursement for the helicopter air ambulance base rate includes oxygen, equipment and supplies essential for the provision of services and accompanying personnel.

**Mileage:** Mileage may only be billed for loaded air miles.

**Waiting time:** Waiting time which exceeds 30 minutes is reimbursable as detailed in the Waiting Time sub-section of this section.

## BASE RATE:

The ambulance provider should bill one base rate procedure code [e.g., Basic Life Support Non-Emergency (BLS), Basic Life Support Emergency (BLS), Advanced Life Support 1 Non-Emergency (ALS1), Advanced Life Support 1 Emergency (ALS1), Advanced Life Support 2 (ALS2), Neonatal Emergency Transport, Helicopter Air Ambulance, or Fixed Wing Air Ambulance Transport]. The base rate must reflect the level of service rendered, not the type of vehicle in which the beneficiary was transported, except in those localities where local ordinance requires ALS as the minimum standard of service. Ambulance providers in these localities may bill the ALS rate which most closely fits the services rendered for all emergency transports, regardless of the level of service rendered. For transfers in these localities, the base rate billed must reflect the level of service rendered, not the type of vehicle in which the beneficiary was transferred.

If an ambulance provider has only ALS vehicles, but operates in a locality where both BLS and ALS are available, the base rate billed must reflect the level of service rendered rather than the type of vehicle used.

Reimbursement for the base rate covers all services rendered except mileage which may be billed separately.

When treatment is rendered and no other care or transport is necessary, the ambulance provider may bill the base rate procedure code for the level of service performed but **not** for mileage. See Special Situations in Section 4 for instructions regarding intercept situations.



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**ADVANCED LIFE SUPPORT (ALS):**

Ambulance operations and ambulance staff must be licensed to render ALS services by the Michigan Department of Consumer and Industry Services (MDCIS) and properly enrolled with the Michigan Department of Community Health (MDCH). MDCH recognizes two levels: ALS1 and ALS2.

**ADVANCED LIFE SUPPORT 1 (ALS1) NON-EMERGENCY:**

When medically necessary, the ALS1 base rate may be billed when an advanced life support provider (minimum level of EMT-Intermediate or Paramedic) renders an assessment or furnishes one or more ALS interventions or in those localities where ALS has been mandated as the minimum level of service.

**ADVANCED LIFE SUPPORT 1 (ALS1) EMERGENCY:**

When medically necessary and ALS1 services, as specified above, are provided in the context of an emergency response.

**ADVANCED LIFE SUPPORT 2 (ALS2):**

When medically necessary, the ALS2 base rate may be billed when an advanced life support provider (minimum level of EMT-Intermediate or Paramedic) renders an assessment and the administration of at least three (3) different medications and furnishes one or more of the following ALS procedures:

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

Reimbursement for the ALS base rates includes those services listed under Basic Life Support (BLS).

Reimbursement is also the same whether special services were or were not performed.

**BASIC LIFE SUPPORT (BLS):**

Ambulance operations and ambulance staff must be licensed to render BLS services by the Michigan Department of Consumer and Industry Services and properly enrolled with the Michigan Department of Community Health. Medicaid coverage of the BLS base rate includes transportation and medical services which an Emergency Medical Technician is routinely trained to provide (e.g., the provision of oxygen, the establishment of a peripheral intravenous (IV) line, and resuscitation). Reimbursement for accompanying personnel, suctioning, delivery/labor, emergency first aid, emergency/night call services, oxygen, and resuscitation is included in the BLS base rate. BLS also includes equipment and supplies essential to the provision of such services (e.g., splints, backboards, obstetrical kits).



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### **BLS NON-EMERGENCY:**

When medically necessary, the BLS base rate may be billed when a BLS or ALS provider renders basic life support services as defined above.

### **BLS EMERGENCY:**

When medically necessary, the BLS emergency transport base rate may be billed when a BLS or ALS provider renders basic life support services as defined above.

### **DRUGS AND SOLUTIONS:**

Drugs, intravenous solutions and needles, and hypodermic needles and syringes carried in ambulances require replacement by a cooperating hospital pharmacy and under the supervision of a licensed pharmacist, as detailed in Public Act 368 of 1978, as amended. Reimbursement will be made only to the hospital for these items.

### **EMERGENCY:**

Claims may be made to the Program for emergency transports which meet the criteria specified in the definitions of BLS Emergency, ALS1 Emergency and ALS2 transports in this section.

Claims for emergency ambulance transports must be coded with both an emergency procedure code and an appropriate ICD-9-CM diagnosis code whenever the service results in transport to an emergency department, or assessment and treatment/stabilization determines that no further transport is necessary. Claims for emergency transports without this information will be rejected.

Documentation supporting the emergency diagnosis code must be retained in the ambulance provider's records for audit purposes.

### **MILEAGE:**

Mileage is a benefit of the Program :

- Only when a transport occurs.
- Only when the beneficiary is in the vehicle (Loaded mileage only).
- When billed with the appropriate origin and destination modifier combination.
  - Refer to Chapter IV for list of origin and destination modifiers.
  - Modifier 22 is not an appropriate origin and destination modifier.

When billing for mileage greater than 100 miles, enter the origin and destination addresses in the Remarks.

**Note:** A charge may be made for the loaded mileage only.



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### NEONATAL:

Coverage of neonatal transport includes neonatal base rate, loaded mileage, transfer isolette, and waiting time.

The intensive care transport of critically ill neonates (i.e., newborns) to approved, designated neonatal intensive care units (regional centers) is covered, providing the designated carrier is approved by the regional center to which the provider renders service.

A hospital medical team must accompany the newborn on the newborn run for ambulance services to be reimbursed by the Medicaid Program. The hospital team usually consists of a physician, nurse, and respiratory therapist. The primary care of the newborn is the hospital team's responsibility, and reimbursement of these services is made to the hospital. The designated ambulance provider bills **the neonatal base rate and mileage for the transport.**

A return trip of a newborn from a regional center to a community hospital (after the newborn's condition is stabilized) is covered. A physician's order indicating the medical necessity of the return trip must be retained in the beneficiary's file as detailed in the Ambulance Services in Section 1.

The cost of the isolette use is included in the neonatal base rate.

**Waiting time** which exceeds 30 minutes is reimbursable and must be billed as detailed in the WAITING TIME sub-section of this section.

### NON-EMERGENCY:

A claim may be made to the Program for medically necessary non-emergency transport **only** when it is provided in a licensed BLS or ALS vehicle. Ambulance providers must obtain appropriate documentation of the medical necessity of the transport (a copy of the physician's written order or signed certification statement from the attending physician) and retain it in their files. **NOTE:** A copy of the physician's order for non-emergency ambulance transport in the patient's chart is acceptable documentation. A physician may write a single prescription for non-emergency ambulance transport of a beneficiary with a chronic condition to a planned treatment that will cover up to one month of treatment. The prescription must contain information that would indicate the type of transport necessary, why other means of transport could not be used, frequency of needed transport, origin, destination, diagnosis, and medical necessity. For all other non-emergency transport, a separate physician's order is required for each individual transport.

If the ambulance provider is unable to obtain the required written documentation of medical necessity within 21 days following the date of service, the ambulance provider must document a minimum of two (2) attempts to obtain the physician's order/documentation of medical necessity. Acceptable documentation must include a signed return receipt from the U.S. Postal Service, or other similar delivery service, as well as a copy of the request itself. Such a return receipt will serve as proof that the ambulance provider attempted to obtain the required documentation of medical necessity from the attending physician.

Non-emergency transport in a Medi-Van or other wheelchair-equipped vehicle is not a covered service for ambulance providers. However, Medicaid beneficiaries or transportation providers may receive reimbursement for this type of transport directly from their Family Independence Agency (FIA) caseworker or if the beneficiary is an enrollee in a health plan, the health plan may provide or reimburse for this service.



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**NOTE:** MDCH will pay on a fee-for-service basis for health plan enrollees only if the non-emergency transport was medically necessary and was for Community Mental Health Services Program (CMHSP) related services. When submitting claims, providers are to enter in the Remarks section that the ambulance transport was to receive CMHSP services.

### UNLISTED AMBULANCE SERVICE:

If a service is rendered which is not included in the coverages defined under the existing procedure codes, the ambulance provider may bill the procedure under the "Unlisted Ambulance Service" procedure code. The claim will pend for manual review to determine whether the service is reimbursable under Program guidelines.

- NOTE:**
1. Items included in the base rate are not separately reimbursable.
  2. If no transport was provided, refer to the base rate billing instructions.
  3. The Remarks section, or an attachment to the claim, must include a complete description of the service.

### WAITING TIME:

Waiting time is reimbursable after the first 30 minutes when a physician deems it medically necessary for the ambulance provider to wait at a hospital while the patient is being stabilized, with the intent of continuing the **beneficiary's** transport to a more appropriate hospital for care or back to the point of origin.

The maximum number of hours allowed for waiting time is 4 hours. If more than 4 hours of waiting time is involved, request Individual Consideration and provide documentation. Providers should refer to Chapter IV for instructions regarding requesting Individual Consideration.

The appropriate number of time units must be reflected in the Quantity box. One time unit represents each 30 minutes of waiting time **after the first 30 minutes** (e.g., total waiting time of 1 hour, 30 minutes = 2 time units),

The usual and customary charge must be entered.

The Remarks section, or attachment to the claim, must include the following documentation:

1. Total length of waiting time **including** the first 30 minutes,
2. The physician's name who ordered the wait, and
3. The reason for the wait.

### WATER AMBULANCE:

Water ambulance services are a benefit of the program. Non-emergency ambulance services provided by marine craft must be prior authorized. Refer to the Prior Authorization instructions in Chapter I for details on the Prior Authorization process.

Emergency ambulance services provided by marine craft do not require prior authorization.



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Claims are to be submitted to:

Michigan Department of Community Health  
Miscellaneous Transaction Unit  
P.O. Box 30239  
Lansing, MI 48909



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**INTERCEPTS:**

In situations where a BLS vehicle intercepts with an ALS vehicle, each provider may bill for the appropriate base rate and for the loaded mileage they provided (if any).

**BRIDGE TOLL:**

Bridge toll charges are reimbursable to the ambulance provider. Coverage includes both loaded and return trip charges.

**Billing Instructions:**

- The Unlisted Ambulance Service Code must be used.
- All toll charges must be combined on one claim line.
- The Remarks section must contain the bridge or tunnel name and the number of times used.

**CONTINUOUS OR ROUND TRIP TRANSPORT:**

This type of transport is considered to be **one** run.

The base rate code for the highest level of service performed during transport is billed on one claim line.

The loaded mileage is billed on one claim line with the total number of whole (loaded) miles indicated in the quantity item.

The Waiting Time sub-section in Section 3 should be referred to in cases where waiting time exceeds 30 minutes.

**LTC NURSING FACILITIES:**

Routine, non-emergency medical transportation provided for LTC nursing facility residents in a van or other non-emergency vehicle is included in the facility's per diem rate or are billed separately by the facility. This includes transportation for medical appointments, dialysis, therapies or other treatments not available in the facility but located in the county or in the normal service delivery area. When non-emergency transportation by ambulance is ordered by a LTC nursing facility resident's personal physician, due to the need for a stretcher or other emergency equipment, the ambulance provider may bill the Program directly. The ambulance provider must maintain the physician's written order as documentation of medical necessity. If the non-emergency ambulance transport is not ordered by the resident's personal physician, arrangements for payment must be between the facility and the ambulance provider, and cannot be charged to the resident, the resident's family, or used to offset the patient pay amount. This cost may not be claimed as a routine cost on Michigan's Medicaid cost report. The cost of non-emergency ambulance transports not ordered by the resident's physician must be identified and removed on Worksheet 1-B by the LTC nursing facility.

For direct reimbursement by the Medicaid Program to an enrolled ambulance provider for services provided to a LTC nursing facility resident who is a Medicaid beneficiary, refer to the Ambulance Quick Reference Guide (Section 5) of this chapter.



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**MULTIPLE ARRIVALS:**

When multiple units respond to a call for services, only the entity which actually provides services for the beneficiary may bill and be paid. The entity which rendered service/care would bill for all services furnished.

**MULTIPLE BENEFICIARIES PER TRANSPORT:**

When more than one eligible beneficiary is transported at the same time, the only acceptable duplication of charges is half of the base rate.

Separate claims must be submitted for each beneficiary. The first claim is completed in the usual manner and the base rate billed must reflect the highest level of service performed.

Claims for additional beneficiaries must indicate the usual and customary base rate charge. The appropriate modifier must be reported. Provider should refer to Chapter IV for a list of modifiers. Payment will be made at 50% of Medicaid's reimbursement rate or 50% of the provider's charge, whichever is less.

**NOTE:** No mileage or waiting time is to be charged for additional beneficiaries. These services are included in the reimbursement of the first claim.

**MULTIPLE TRANSPORTS PER BENEFICIARY:**

More than one transport per beneficiary on the same date of service is covered when the following conditions apply:

- The beneficiary received a different level of service on each transport (e.g., Advanced Life Support 1 and Basic Life Support), enter the appropriate code for each base rate on the claim.
- The beneficiary received the same level of service on each transport, enter the appropriate code for each base rate on one claim line with the appropriate combined base rate charge. A quantity of one (1) must be reported and individual consideration (Modifier 22) requested.
- Other services duplicated from the multiple transports must be combined and billed on one claim line (e.g., the total loaded mileage is combined and billed on one claim line).
- Other services not duplicated are billed on separate claim lines.
- The Remarks section of the claim, or an attachment to the claim, must detail the following information:
  - Number of transports
  - Originating and terminating locations
  - Ambulance requestor's name(s)
  - Reason for multiple transports on the same day, and
  - Number of times each base rate was provided.
  - If transport is for any reason other than further treatment, the reason for the transport must be provided in addition to the diagnosis

**NOTE:** Return trips are multiple transports **if** a break in service has occurred, i.e., the ambulance is available to respond to other requests for service.

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## OUT OF STATE NON-BORDERLAND TRANSPORTS:

Except for emergencies, out of state, non-borderland transports require prior authorization. The ambulance provider should refer to Chapter I, Delivery of Services, Prior Authorization, for details regarding prior authorization (PA).

The ambulance provider, home health agency, hospital, LTC nursing facility, physician, or social worker may request this authorization. The ambulance provider must retain documentation of medical necessity (physician's order) in the beneficiary's file to support the need for ambulance transportation. To request authorization, the requestor must submit a letter to the Michigan Department of Community Health. The requestor is responsible for requesting prior authorization before services are rendered.

**NOTE:** The request must include:

- Point of pickup,
- Beneficiary's name and ID number,
- Diagnosis,
- Service to be provided,
- Destination point,
- Reason why the ambulance transport was medically necessary,
- Reason why the beneficiary cannot be transported by any other means,
- Name and address of the ambulance provider, and
- Requestor's name.

The authorization may be obtained by writing to:

Michigan Department of Community Health  
Medical Services Administration  
Review and Evaluation Division  
P.O. Box 30170  
Lansing, Michigan 48909

Or by calling 1-800-622-0276

Based on the authorization request, the Department will approve or disapprove the request. The ambulance provider may render the service upon receipt of verbal approval. A copy of the approval authorization letter will be mailed to the ambulance provider following the verbal authorization. The ambulance provider may not bill the Program until he/she has received the authorization letter. The ambulance provider must keep a copy of the authorization letter in the beneficiary's file. Documentation of medical necessity (physician's order) must also be retained in the beneficiary's file to support the need for ambulance transportation.

**NOTE:** The requestor must notify the Review and Evaluation Division of any changes to the approved PA (e.g., change in service date or ambulance provider, etc).

When seeking reimbursement for out of state transports, Modifier AS must be reported and the prior authorization number must be entered on the claim, except in the case of emergency transports.



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Claims are to be submitted to:

Michigan Department of Community Health  
Miscellaneous Transaction Unit  
P.O. Box 30239  
Lansing, MI 48909

**PRONOUNCEMENT OF DEATH:**

There are three (3) rules that apply to ambulance services and the pronouncement of death:

1. If the beneficiary was pronounced dead by an individual who is licensed to pronounce death (coroner/physician) prior to the time that the ambulance is called, no payment will be made.
2. If the beneficiary is pronounced dead after the ambulance is called but before the ambulance arrives at the scene, payment for an ambulance trip will be made at the BLS rate, but no mileage will be paid.
3. If the beneficiary is pronounced dead after being loaded into the ambulance, payment will be made following the usual rules (that is, the same level of payment would be made as if the beneficiary had not died).



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Transports rendered in an emergency situation are covered in ALL settings.

The ambulance provider should use the "FROM" column to indicate the location where the beneficiary is picked up. The "TO" column is used to indicate the destination of the beneficiary. The point where the columns meet will indicate if the service is covered, not covered or if covered but to be billed to another facility/entity.

TO FROM	INPATIENT	EMERGENCY ROOM OUTPATIENT	LTC NURSING FACILITY	AMBULATORY SETTING (i.e., lab, office, clinic, therapy, dialysis)	HOME
INPATIENT	IF MEDICALLY NECESSARY	EMERGENCY ONLY	IF MEDICALLY NECESSARY	IF MEDICALLY NECESSARY	IF MEDICALLY NECESSARY
EMERGENCY ROOM OUTPATIENT	IF MEDICALLY NECESSARY	EMERGENCY ONLY	IF MEDICALLY NECESSARY	IF MEDICALLY NECESSARY	IF MEDICALLY NECESSARY
LTC NURSING FACILITY	IF MEDICALLY NECESSARY	EMERGENCY ONLY	IF MEDICALLY NECESSARY	IF MEDICALLY NECESSARY	IF MEDICALLY NECESSARY
AMBULATORY SETTING (i.e., lab, office, clinic, therapy, dialysis)	IF MEDICALLY NECESSARY	EMERGENCY ONLY	IF MEDICALLY NECESSARY	IF MEDICALLY NECESSARY	IF MEDICALLY NECESSARY
HOME	EMERGENCY ONLY	EMERGENCY ONLY	IF MEDICALLY NECESSARY	IF MEDICALLY NECESSARY	NOT COVERED
AT LARGE (example: Scene of accident)	EMERGENCY ONLY	EMERGENCY ONLY	NOT COVERED	EMERGENCY ONLY	NOT COVERED

### AMBULANCE COVERAGE EXCLUSIONS:

Circumstances under which Medicaid does not pay for ambulance transportation include, but are not limited to,:

- Medi-Car, Medi-Van, or wheelchair transports.
- Transport to a funeral home.
- Trips made for services such as drawing blood and catherization which could have been provided at the beneficiary's location.
- Transportation of a beneficiary pronounced dead before the ambulance was called.
- Round trips when a beneficiary is taken from a hospital to another facility and returned to the same hospital. As long as the beneficiary is an inpatient, all ancillary services are the responsibility of the hospital.
- Transport of inmates of correctional facilities to and from the correctional facility.
- Transports which are not medically necessary.



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