NURSING HOME AMBULANCE TRANSPORTATION

Nursing facilities are required to provide medically necessary transportation services for Medicaid recipients residing in their facility. Any nursing home recipient needing non-emergency transportation services are the financial responsibility of the nursing facility. This means that any ambulance transportation provided to a nursing home recipient for a non-emergency service that does ***not include the physician's certification that an ambulance was required***, is not payable by Louisiana Medicaid; therefore, the nursing facility should be billed for such services.

Limits and Overrides

An override gives approval to perform a service that exceeds the given limitations. An override cannot be requested until the service has been performed.

Service Limits for Emergency Services

Payment will be made, without Medicaid approval, for one emergency trip per day to a hospital. Payment may also be made for a same day, second trip, when it is necessary for the recipient to be transferred from that hospital to another in order to receive the appropriate level of care.

When billing for additional emergency services, the provider must submit a hard copy claim with the Certification of Ambulance Transportation Form (105 Attachment) to the fiscal intermediary for consideration of an override of the service limit.

Services Limits for Non-Emergency Ambulance Services

Payment will be made for a maximum of two trips for one recipient on the same date of service. Additional services will require state office review and approval prior to reimbursement being made.

When billing for additional non-emergency services, the provider must submit a hard copy claim with the Certification of Ambulance Transportation Form (105 Attachment) stating that the transport was of a non-emergency nature, but an ambulance was required.

Medicaid /Medicare: Service Limits

Medicaid allows two trips on the same day. In certain situations, an override will be necessary in order to process the claims.

If Medicare pays on the second trip, same day, the Medicaid claim should be filed with the same procedure code as the Medicare claim, along with the Medicare Explanation of Benefit (EOB).

Providers may send the claims and the Medicare EOB to the fiscal intermediary's Correspondence Unit for forwarding to the Bureau of Health Services Financing (BHSF).

If Medicare denies the service as "not covered" (for example, hemodialysis transportation, a trip to the doctor's office, etc) and Medicaid will cover the service, the BHSF has given the fiscal intermediary the authority to override the 275 edit. ***Note that the Medicare EOB must be filed (attached) with the Medicaid claim.*** These requests should be sent to the fiscal intermediary. (See Appendix G for contact information.)

Medicaid and Medicare Part B

Services for Medicare Part B recipients should be billed to the Medicare carrier on the Medicare claim form. Medicare will make payment and cross the claim over to the fiscal intermediary for Title XIX payment. If the recipient has private insurance, the provider should bill the fiscal intermediary after the private insurer has been billed and has either paid or denied the claim.

Medicaid will not make payment on any claim denied by Medicare as not being medically necessary. Qualified Medicare Beneficiary (QMB) claims are included in this policy.

For trips that are not covered by Medicare but are covered by Medicaid, payment will not be made unless the claim is filed hardcopy with the Medicare EOB attached stating the reason for denial by Medicare.

For claims that fail to cross over via tape, a hard copy claim along with Certification of Ambulance Transportation Form (105 Attachment) may be filed up to six months after the date of the Medicare EOB, provided they were filed with Medicare within a year of the date of service.

Medicaid does a cost comparison of cross over claims to determine if Medicare paid more than Medicaid for the claim. If this occurs and Medicare has paid more than Medicaid pays for the service, the claim will be "zero" paid and the ambulance provider will be considered paid in full. No balance may be collected from the recipient.