

## **AMBULANCE SERVICES**

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### **PURPOSE**

ND Medicaid covers services provided by ambulance providers that are licensed and enrolled with ND Medicaid.

Emergency transport by ambulance is a covered service. Nonemergency transport by ambulance is a covered service only when medically necessary and ordered by an attending practitioner.

### **AMBULANCE TRANSPORTATION**

To receive Medicaid payment on ambulance transportation, the member must receive medically necessary services before and/or during transport and the transportation must comply with the following conditions:

- The ambulance provider must be licensed per state requirements.
- The member's transportation must be in response to a 911 emergency call, a police or fire department call, or an emergency call received by the provider.
- Out-of-state ambulance transport for nonemergency medical services, including follow up visits, may be reimbursed only if the out of state medical services are approved by ND Medicaid and the member's medical condition substantiates transportation by ambulance.

### **AIR AMBULANCE**

Transportation by air ambulance is a covered Medicaid service if the member has a potentially life-threatening medical condition that prevents the use of another form of transportation. Claims submitted for air ambulance transport must include documentation of medical necessity, including the need for air transport.

For out of state air ambulance transport, the transferring facility must follow criteria for emergency out of state transportation. Air ambulance transportation originating outside of North Dakota or to a destination outside of North Dakota, must inform ND Medicaid within 48 hours of the transfer. Documentation to ND Medicaid must include:

- Destination and date of transfer;
- Mode of transportation;
- Discharge summary; and
- If trip is less than 50 miles, the facility must verify why air rather than ground ambulance was used.

## **TRANSPORTATION BETWEEN PROVIDERS**

Ambulance transportation of a member between providers is covered when medically necessary in these situations:

- Transportation between two long term care facilities when the member's plan of care requires a health service not available at the long-term care facility where the member resides.
- Transportation between two hospitals when a necessary service is not available at the hospital where the member is located when medical necessity is determined.
- Transportation between a hospital and long-term care.

## **BILLING INFORMATION**

### Multiple patients on one trip

Ambulance providers submitting a claim using the ASC X12 professional format or the CMS-1500 paper form for an ambulance transport with more than one patient onboard must use the "GM" modifier ("Multiple Patients on One Ambulance Trip") for each service line item. In addition, ambulance providers are required to submit documentation to specify the particulars of a multiple patient transport. The documentation must include the total number of patients transported in the vehicle at the same time and the Medicaid recipient identifiers for each Medicaid recipient.

If two patients are transported to the same destination simultaneously, for each Medicaid member, Medicaid will allow 75 percent of the payment allowance for the base rate applicable to the level of care furnished to that member plus 50 percent of the total mileage payment allowance for the entire trip. If three or more patients are transported to the same destination simultaneously, then the payment allowance for the Medicaid member (or each of them) is equal to 60 percent of the base rate applicable to the level of care furnished to the beneficiary. However, a single payment allowance for mileage will be prorated by the number of patients onboard. This policy applies to both ground and air transports.

### Modifiers

ND Medicaid requires that the ambulance supplier report a two-digit modifier for each ambulance trip. The first digit of the modifier indicates the origin of the trip, and the second digit indicates the destination. Some examples of ambulance modifiers include:

- **D:** Diagnostic or therapeutic site other than P or H
- **E:** Residential, domiciliary, or custodial facility

- **G:** Hospital-based ESRD facility
- **H:** Hospital
- **I:** Site of transfer, such as an airport or helicopter pad
- **J:** Freestanding ESRD facility
- **N:** Skilled nursing facility
- **P:** Physician's office
- **R:** Residence
- **S:** Scene of accident or acute event
- **X:** Intermediate stop at physician's office on way to hospital

When a member has two identical ambulance trips on the same calendar date, append modifier -76 to the second trip.

#### Date of Service

The date of service on the claim should be when the ambulance departs the point of pickup with the member on board.

### **COVERAGE LIMITATIONS**

A member's death is recognized when pronounced by a legally authorized individual in the state where the pronouncement is made.

Consistent with Medicare payment guidelines, if a member is pronounced dead after the ambulance is called but before the ambulance arrives at the scene, payment will be based on:

- Basic life support (BLS) level of service base rate only, for a ground vehicle.
- Fixed wing or rotary wing base rate only, as appropriate, for an air ambulance.

### **NONCOVERED SERVICES**

Noncovered services include:

- Transportation of a member to a hospital or other health care services ordered by a court or law enforcement agency - except when transportation via ambulance is medically necessary; or
- Transportation of a member pronounced dead prior to the time the ambulance was called or dispatched.

## **SUMMARY OF POLICY UPDATES**

January 2025

<b>Section</b>	<b>Updates</b>
Billing Information – Modifiers	Language added for the use of ambulance modifiers, modifier -76 and date of service specification.

August 2025

<b>Section</b>	<b>Updates</b>
Coverage Limitations	Removed requirement for emergent services to only be covered when taking a member to an ND Medicaid covered provider or service.