All medically necessary transports to and from a nursing facility via ambulance must be billed by the ambulance provider.

- The Ambulance Program policies apply for both emergency and non-emergency transports. This includes transport of Medicaid beneficiaries to and from dialysis treatments via ambulance.

- The nursing facility is responsible for arranging both emergency and non-emergency ambulance transports. For non-emergency ambulance transports, the nursing facility is responsible for working with the ambulance providers to ensure that Certificate of Medical Necessity forms are completed by the physician and are forwarded to the ambulance provider in advance of the date that ambulance transportation is required so that appointments do not have to be canceled due to no access to transportation. Beneficiaries must not be denied access to medical care because the nursing facilities have not arranged transportation in advance.

  If the case does not qualify for the benefits through the Ambulance Program, the nursing facility must arrange transportation through the family, if available, the nursing facility vehicles, or outside resources.

- The nursing facility may not bill the patient or the family for ambulance transports.

Cost for all other forms of transports (excluding transports to and from dialysis) must be provided and arranged by the nursing facility and must be reported in the cost reports.

- A nursing facility may ask the family to transport the patient in personal vehicles if the condition of the patient allows such mode of transportation; however, if the family is not available or chooses not to transport the patient, the nursing facility is responsible for providing and arranging transportation by use of nursing facility vehicles or through outside resources.

- The nursing facility may not require the family to transport the beneficiary, and the nursing facility may not bill the family for transportation by any means.

  EXCEPTION: For cases requiring transportation other than by ambulance to and from dialysis, the nursing facility may make referrals to the NET Program on cases that do not require transportation via ambulance. The NET provider must, in these cases, submit claims to Mississippi Medicaid for direct reimbursement. Refer to NET, section ~~12.11~~ 12.03, Transport of Nursing Facility Residents, in this manual.

For beneficiaries covered under Medicare and Medicaid (dual eligibles), ambulance providers may file a claim with Medicaid for non-emergency ambulance services not covered by Medicare if the reason for the Medicare denial is other than for medical necessity. (Ex: transport to a physician's office)

To file a claim with Medicaid for non-emergency ambulance services, the ambulance provider must first file a claim with Medicare and obtain an Explanation of Benefits (EOB). The ambulance provider may then submit a hard copy of the CMS - 1500 using Medicaid specific codes, a copy of the Medicare EOB, a copy of the Ambulance Trip report, and the Certificate of Medical Necessity for Non-Emergency Ambulance Transportation that has been completed by the physician. This must be mailed to:

DIVISION OF MEDICAID
Ambulance Program
~~Suite 801, Robert E. Lee Building~~
~~239 North Lamar Street~~
550 High Street, Suite 1000
Jackson, MS 39201~~-1399~~

A retrospective review will be completed for the dual eligible cases, and the claim will be forwarded to the fiscal agent for processing.

For ambulance transport to and from dialysis treatments, Mississippi Medicaid will only pay the deductible and coinsurance based on Medicare's allowed charges on cases approved by Medicare if the patient is covered by both Medicare and Mississippi Medicaid. If Medicare benefits are denied because (1) the patient is being taken to a non-approved dialysis facility or (2) the medical necessity criteria for ambulance transport is not satisfied, Medicaid will not approve benefits for the ambulance transport.

The six (6) month timely filing limitation for filing crossover claims is applicable with no exceptions.