MO HealthNet Managed Care
(Medicaid)

Healthy Blue

Ambulance billing guide

Ambulance services for Healthy Blue members

The following is an overview of program-specific resources for emergent and non-emergent ambulance services:

- MTM is a transportation vendor for Healthy Blue that manages prior authorization (PA) and claim processing for all non-emergent ambulance services excluding non-emergent, hospital-to-hospital transfers.
- MTM was responsible for non-emergent, hospital-to-hospital transfers for dates of service from August 1, 2022, to October 31, 2023.
- Healthy Blue is responsible for claim processing for emergent ambulance services and non-emergent, hospital-to-hospital transfers.

Emergent ambulance claims

- Emergent ambulance services do not require PA and should be submitted to Healthy Blue.
- Follow the billing requirements outlined in the MO HealthNet ***Ambulance Manual*****.**

Emergent ambulance — claim filing

Paper claims
Healthy Blue
Claims Submission
P.O. Box 61010
Virginia Beach, VA 23466-1010

Note:
- Healthy Blue only accepts the original red claim form for claim submissions.
- Handwritten, faxed, or replicated claim forms are not accepted.

Electronic claims
- Healthy Blue Availity Essentials payer ID: 00541

Non-emergent, hospital-to-hospital transfers

- As of November 1, 2023, Healthy Blue accepts claims for non-emergent, hospital-to-hospital transfers.
- When submitting directly to Healthy Blue, no prior authorization is required.
- Claims should follow the billing requirements outlined in the MO HealthNet ***Ambulance Manual*** and be identified as a hospital-to-hospital transfer with the HH modifier.
- Reference slide 4 for claims filing information.

Non-emergent ambulance transport — PA process

PA process for non-emergent services other than non-emergent, hospital-to-hospital transfers:

1. The facility or member contacts MTM customer service.
   - Note: Advance notice of three hours is required.
2. Eligibility and covered services are verified.
3. The request is escalated to a specialist to locate available MTM in-network ambulance services.
4. The member's condition, special needs, and level of service are verified.
5. Once an in-network provider is located, MTM provides them with PA for the service(s).
6. MTM contacts the facility or member to inform them of the ambulance provider and expected pick-up time.

Non-emergent ambulance transport — claims process

Claims process for non-emergent services other than non-emergent, hospital-to-hospital transfers:

- Ambulance providers are required to submit a *CMS-1500* form, patient care report, and medical necessity form to MTM.
- Claim documents should be sent via fax, email, or mail to the attention of MTM Ambulance Claims:
  - **Fax**: **800-722-0129** or **866-463-0247**
  - **Email**: ambulanceclaims@mtm-inc.net
  - **Mail**: 16 Hawk Ridge Drive, Lake Saint Louis, MO 63367
- The MTM Ambulance Claims team validates against the PA.

Note: Non-emergent ambulance claims should follow the MO HealthNet *Billing Manual* guidelines.

Common denial reasons for ambulance claims

- Place of Service code billed do not follow MO HealthNet guidelines found in *Section 19.2* of the MO HealthNet ***Ambulance Manual***.
- Place of Service code 21 for inpatient hospital or 23 for emergency room not used.
- Claim was for non-emergent ambulance transport and was not directed to MTM for processing.
- Modifiers billed do not follow MO HealthNet guidelines found in *Section 19.1* of the MO HealthNet ***Ambulance Manual***. The only modifiers that should be used are:
  - EP: Healthy Children and Youth (HCY) service for participants under the age of 21
  - GM: Additional participants — hospital-to-hospital (HH) transfer
  - HD: Specialized testing and treatment
  - SC: Medically necessary service or supply

Joining the MTM network

To join the MTM network:

- Fill out an **application**.
- Follow-up can be conducted with the MTM Transportation Provider Help Desk at phelpdesk@mtm-inc.net or **888-828-1183**.

Rejected versus denied claims

There are two types of notices you may get in response to your claim submission — rejected or denied.

Rejected claims do not enter the adjudication system because they have missing or incorrect information.

Denied claims went through the adjudication process but payment has been denied.

- You can find claims status information on our **provider website** or by calling Provider Services at **833-405-9086**.
- If you need to appeal a claim decision, submit a copy of the *Explanation of Payment*, a letter of explanation, and supporting documentation.
- If your claim is administratively denied, you may file an appeal. As part of the appeal, you must demonstrate that you notified or attempted to notify us within the established time frame and that the services are medically necessary.

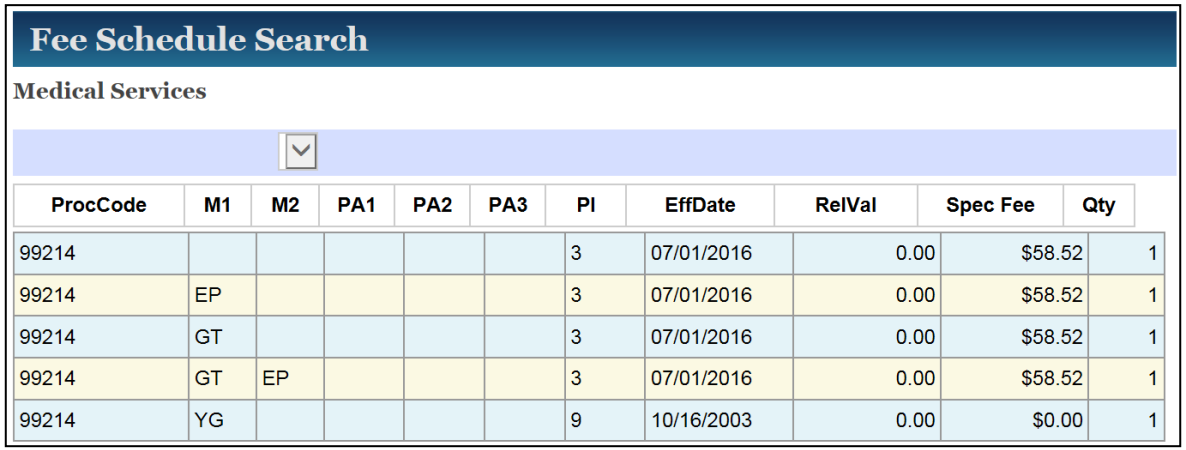
MO HealthNet *Billing Manual*

https://mydss.mo.gov/mhd/provider-manuals

MO HealthNet fee schedule search

MO HealthNet fee schedule:

- Select the link for the appropriate category for the CPT® code or modifier for which you want to view the allowed amount or modifier information.
- Next, select the radio button next to the *ProcCode* or *modifier*, and type in a procedure code or modifier.
- The search option will show you if the CPT code and/or modifier combination are payable.



Fee Schedule Search

Medical Services

ProcCode	M1	M2	PA1	PA2	PA3	PI	EffDate	RelVal	Spec Fee	Qty
99214						3	07/01/2016	0.00	$58.52	1
99214	EP					3	07/01/2016	0.00	$58.52	1
99214	GT					3	07/01/2016	0.00	$58.52	1
99214	GT	EP				3	07/01/2016	0.00	$58.52	1
99214	YG					9	10/16/2003	0.00	$0.00	1

Billing members

- Healthy Blue members should not be billed or reported to a collection agency for any *covered services* your office provides.
- Missouri Code of State Regulations, *Title 13 CSR 70-4.030* states in part,
  "When an enrolled Medicaid provider provides an item or service to a Medicaid recipient eligible for the item or service on the date provided, there shall be a presumption that the provider accepts the recipient's Medicaid benefits and seeks reimbursement from the Medicaid agency in accordance with all the applicable Medicaid rules."
- If a member receives a bill and contacts Healthy Blue, we may contact your office to confirm the member will no longer be charged for the service.
- The provider's office can file a claims dispute or an appeal if the service was paid incorrectly or denied. The provider must submit the claims dispute or appeal within appropriate time frames.

https://provider.healthybluemo.com

MOHB-CD-051500-24 March 2024