TIP RFP Grant Questions

November 9, 2026

1. Are responses involving a clinically meaningful assessment that results in a decision not to transport eligible for TIP grant reimbursement when no medication is administered and no additional procedure is performed? For example, would a patient suffering from a panic episode whose encounter involves an assessment, vital signs and therapeutic communication qualify if the assessment supports the non-transport decision?

    a. **Yes, an assessment only encounter is considered billable to the grant. The way that we define a treatment in place intervention is administering a medication OR performing a procedure OR providing a comprehensive medical assessment that leads to a documented decision not to transport the patient. Services should document the assessment in the applicable fields within their PCR such as eExam, eHistory, and eVitals elements.**

2. Are lift assists in which the patient has no apparent injury and no treatment is provided eligible for reimbursement under any circumstances, provided the required assessment and documentation are completed?

    a. A lift assist situation is potentially billable to the grant with a comprehensive assessment. There should be a documented assessment for why/how the patient fell, an evaluation for potential injuries, and could include an evaluation of the surrounding conditions of the patient and any intervention to make the surrounding area safer for the patient. If the situation only results in moving the patient from one place, say a chair to another and there is absolutely no mechanism of injury (ie fall) then that would likely not meet the intent of the grant.

3. Does the TIP grant recognize or distinguish between HCPCS codes A0999 and A0998 for reimbursement purposes, or is eligibility determined exclusively by the grant's clinical criteria and required patient care report documentation?

    a. It is important to note that when sending things to be billed to the grant you will not have to worry about ambulance billing codes, we will be evaluating solely against your patient care report documentation. If your treatment in place patient has Medicaid on the date of service, you will need to attempt to bill Medicaid as Minnesota Medicaid will pay a limited amount for

treatment in place services in limited circumstances. So, for Medicaid patients you will need to bill Medicaid and if they pay anything on the claim then that is what you will have to accept and you will not be able to submit against the grant. However, if Medicaid denies the claim in full then and only then, you can bill the grant for review.

4. For encounters to qualify under Section 4.2(C), what documentation is necessary to demonstrate that a clinically meaningful assessment led to a medical decision resulting in non-transport? (Our guideline criteria require vital signs, orientation, lung sounds, patient statements of feeling safety, etc.)

    a. **You must document a clinically meaningful assessment. The criteria and minimums must be approved by your medical director. Complete and accurate documentation in eExam, eHistory, and eVitals elements will help ensure that the documentation reflects the assessment performed.**

5. Is there a template for TIP protocols?

    a. **No, each service is to supply protocols that work for how their service operates. This must be done with the approval of your medical director.**

6. The documentation Guide references eDisposition.29 and eDisposition.31; however, these aren't referenced in the contract. Do we need to do these?

    a. **Yes, the guide for documentation adds additional requirements identified after the grant contract was developed. As this is a pilot project, we anticipate updates throughout the grant period.**

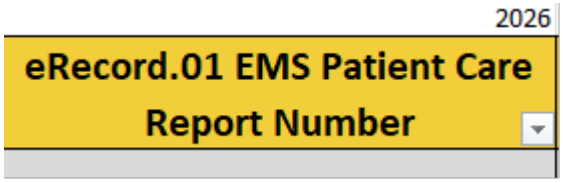
7. It looks like we would only be eligible for reimbursement from the grant if we bill Medicaid & Medicaid denies. The memo states that ambulance services must attempt to bill Minnesota Medicaid for Treatment in Place services provided to patients covered by Medicaid on the date of service before seeking reimbursement through the Treatment in Place. So, we would still want to bill these to Medicaid if the patient is eligible. All other payer sources would still follow the standard billing practices. Can you elaborate?

    a. **Yes, the guidance on billing has been updated since the webinar was posted. The updated guidance is that any TIP call for a Medicaid patient must be submitted to MN Medicaid for reimbursement first. If Medicaid denies payment, you can then submit the call for OEMS TIP reimbursement along with the denial information for that call. For patients not on Medicaid, you may include the TIP call in the OEMS TIP invoice submittal. Those runs cannot be billed through any other insurance or self-pay. This is a change because we received updated guidance for the proper use of these grant funds and the overall billing process. Calls can be submitted for TIP reimbursement throughout the grant period. We encourage prompt submittal, but understand if submittal is delayed, especially with this updated guidance on Medicaid billing.**

8. If we must first submit claims to Medicaid, wait for a denial, then submit to this grant program, we will not be able to meet the timeline set forth here. Are we still able to submit October calls at a later date? Also, should the progress report include calls that we are unsure of? For example, the nature of the response would qualify for the grant, but we need to determine if Medicaid pays first...

    a. **You are required to submit monthly progress reports regardless of having eligible runs. Please do submit October runs to Medicaid first as outlined in the memo and a denied response can be submitted later to the TIP grant. The progress report should only include the calls being submitted for reimbursement. Calls may be submitted for TIP reimbursement throughout the grant period. We encourage prompt submittal, but understand if submittal is delayed, especially with the updated Medicaid process.**

9. I wanted to double check what number is supposed to go in this box. We have the response number or incident number that I see on our reports:



    a. **The Patient Care Report Number (eRecord.01) It is the unique identifier automatically assigned by the EMS agency PCR system. This number should remain unique within the agency and should never be reused. The response number (eResponse.04) could be the same as the incident number(eResponse.03), depending on the agency's system. For reference, here is the [NEMSIS Data Dictionary](#).**

    This is an example from our Demo site:

