



Arkansas Department Of Health and Human Services

Division of Medical Services



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TO: Arkansas Medicaid Health Care Providers - Transportation

DATE: September 1, 2006

SUBJECT: Provider Manual Update Transmittal #82

REMOVE

Section	Date
201.100	3-1-05
201.200	3-1-05
203.000	10-13-03
203.100	10-13-03
204.000	10-13-03
—	—
211.000	10-13-03
212.000	10-13-03
212.100	10-13-03
213.000	10-13-03
216.000	10-13-03
220.000	10-13-03
242.000	10-13-03
251.000	7-1-05

INSERT

Section	Date
201.100	9-1-06
201.200	9-1-06
203.000	9-1-06
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204.000	9-1-06
205.000	9-1-06
211.000	9-1-06
212.000	9-1-06
212.100	9-1-06
213.000	9-1-06
216.000	9-1-06
220.000	9-1-06
242.000	9-1-06
251.000	9-1-06

Explanation of Updates

Sections 201.100 and 201.200 are included to revise the language regarding participation and enrollment requirements for ambulance providers. A statement has been added to comply with the Medicaid Fairness Act of 2005.

Section 203.000 is included to add language that sets forth Arkansas Medicaid participation requirements and enrollment procedures for ambulance providers in states not bordering Arkansas. The heading has also changed to "Ambulance Providers in States Not Bordering Arkansas".

Section 203.100 has been removed from the manual. The information in this section has been revised and included in section 203.000.

Section 204.000 is included to replace the word "recipient" or "recipients" with "beneficiary" or "beneficiaries". This has been done throughout most of this update including sections 211.000, 212.000, 212.100, 213.000, 216.000 and 251.000.

Section 205.000 is a new section number which takes the place of section 220.000. Section 220.000 has been removed from the manual. This section has been updated to add information concerning documentation that all ambulance providers are required to keep to comply with the Medicaid Fairness Act of 2005.

Section 242.000 is included to make some grammatical changes and to change the department name to the Department of Health and Human Services along with the abbreviation from DHS to DHHS.

Paper versions of this update transmittal have updated pages attached to file in your provider manual. See Section I for instructions on updating the paper version of the manual. For electronic versions, these changes will be automatically incorporated.

If you need this material in an alternative format, such as large print, please contact our Americans with Disabilities Act Coordinator at (501) 682-6789 (TDD only).

If you have questions regarding this transmittal, please contact the EDS Provider Assistance Center at 1-800-457-4454 (Toll-Free) within Arkansas or locally and Out-of-State at (501) 376-2211.

Arkansas Medicaid provider manuals (including update transmittals), official notices and remittance advice (RA) messages are available for downloading from the Arkansas Medicaid website:

www.medicaid.state.ar.us.

Thank you for your participation in the Arkansas Medicaid Program.



Roy Jeffus, Director

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201.100 Ground Ambulance Providers**9-1-06**

Providers of ground ambulance transportation must meet the following criteria in order to be eligible for participation in the Arkansas Medicaid Program:

- A.** Provider must complete a provider application (DMS-652), a Medicaid contract (DMS-653) and a Request for Taxpayer Identification Number and Certification (W-9) with the Arkansas Medicaid Program. [View or print a provider application \(Form DMS-652\), Medicaid contract \(Form DMS-653\) and Request for Taxpayer Identification Number and Certification \(Form W-9\).](#)
- B.** Enrollment as a Medicaid provider is conditioned upon approval of a completed provider application and the execution of a Medicaid provider contract. Persons and entities that are excluded or debarred under any state or federal law, regulation, or rule are not eligible to enroll, or to remain enrolled, as Medicaid providers.
- C.** A current copy of the ambulance license issued by the applicable State Ambulance Board must accompany the provider application and Medicaid contract. Subsequent license renewal must be provided when issued.
 - 1.** Subsequent license renewal must be forwarded to Provider Enrollment within 30 days of issuance.
 - 2.** Failure to ensure that current licensure and/or certification is on file with Provider Enrollment will result in termination from the Arkansas Medicaid Program.
- D.** Ambulance transportation providers who wish to be reimbursed for Advanced Life Support services must submit a written request and a current copy of the ambulance license that reflects paramedic, intermediate or EBLIS (Enhanced Basic Life Support). Please refer to Section 252.410 for special billing instructions regarding Advanced Life Support.
- E.** The ambulance company must be enrolled in the Title XVIII (Medicare) Program.
- F.** The ambulance transportation provider must adhere to all applicable professional standards of care and conduct.

201.200 Air Ambulance Providers**9-1-06**

Providers of air ambulance transportation must meet the following criteria in order to be eligible for participation in the Arkansas Medicaid Program:

- A.** Provider must complete a provider application (Form DMS-652), a Medicaid contract (Form DMS-653) and a Request for Taxpayer Identification Number and Certification (Form W-9) with the Arkansas Medicaid Program. [View or print a provider application \(Form DMS-652\), Medicaid contract \(Form DMS-653\) and Request for Taxpayer Identification Number and Certification \(Form W-9\).](#)
 - B.** Enrollment as a Medicaid provider is conditioned upon approval of a completed provider application and the execution of Medicaid provider contract. Persons and entities that are excluded or debarred under any state or federal law, regulation, or rule are not eligible to enroll, or to remain enrolled, as Medicaid providers.
 - C.** The ambulance company must be in enrolled in the Title XVIII (Medicare) Program.
 - D.** A current copy of the ambulance license issued by the applicable State Ambulance Board must accompany the provider application and Medicaid contract. Subsequent license renewal must be provided when issued.
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1. Subsequent license renewal must be forwarded to Provider Enrollment within 30 days of issuance.
 2. Failure to ensure that current licensure and/or certification is on file with Provider Enrollment will result in termination from the Arkansas Medicaid Program.
- E. The ambulance transportation provider must adhere to all applicable professional standards of care and conduct.

203.000 Ambulance Providers in States Not Bordering Arkansas**9-1-06**

- A. Ambulance providers in states not bordering Arkansas may enroll as closed-end providers after they have furnished services to an Arkansas Medicaid beneficiary and have a claim to file with Arkansas Medicaid.
1. A non-bordering state provider may send a claim to Provider Enrollment and Provider Enrollment will forward by return mail a provider manual and a provider application and contract. [View or print Provider Enrollment Unit Contact information.](#)
 2. Alternatively, a non-bordering state provider may download the provider manual and provider application materials from the Arkansas Medicaid website, www.medicaid.state.ar.us, and then submit its application and claim to the Medicaid Provider Enrollment Unit.
- B. Closed-end providers remain enrolled for one year.
1. If a closed-end provider treats another Arkansas Medicaid beneficiary during the year of enrollment and bills Medicaid, the enrollment may continue for one year past the newer claim's last date of service, if the provider keeps the enrollment file current.
 2. During the enrollment period the provider may file any subsequent claims directly to EDS.
 3. Closed-end providers are strongly encouraged to submit claims through the Arkansas Medicaid website because the front-end processing of web-based claims ensures prompt adjudication and facilitates reimbursement.

204.000 Physician's Role in Ambulance Services**9-1-06**

Ambulance service for eligible Medicaid beneficiaries is covered by Medicaid when a physician certifies that the ambulance transportation is medically necessary. It is the responsibility of the transportation provider to maintain physician documentation verifying the medical necessity of ambulance transportation.

205.000 Records Ambulance Providers Are Required to Keep**9-1-06**

- A. Ambulance providers are required to keep the following records and, upon request, to immediately furnish the records to authorized representatives of the Arkansas Division of Medical Services and the State Medicaid Fraud Control Unit and to representatives of the Department of Health and Human Services:
1. Verification of the diagnosis
 2. Copy of the certification of necessity by a physician
 3. Medicare documentation
 4. Record of place of origin, destination, date, who was transported
 5. Number of miles traveled one-way (Medicaid only reimburses one-way mileage to ambulance providers)

- B. All required records must be kept for a period of five (5) years from the ending date of service; or until all audit questions, appeal hearings, investigations or court cases are resolved, whichever period is longer.
- C. Furnishing medical records on request to authorized individuals and agencies listed above in subpart A is a contractual obligation of providers enrolled in the Medicaid Program. Failure to furnish medical records upon request may result in the imposition of sanctions.
- D. The provider must contemporaneously establish and maintain records that completely and accurately explain all evaluations, care, diagnoses and any other activities in connection with any Medicaid beneficiary.
- E. At the time of an audit by the Division of Medical Services, Medicaid Field Audit Unit, all documentation must be available at the provider's place of business during normal business hours. All documentation must be immediately made available to representatives of the Division of Medical Services at the time of an audit by the Medicaid Field Audit Unit. There will be no more than thirty days allowed after the date of the recoupment notice in which additional documentation will be accepted.

211.000 Introduction

9-1-06

The Medical Assistance (Medicaid) Program is designed to assist Medicaid beneficiaries in obtaining medical care within the guidelines specified in Section I of this manual. Reimbursement may be made for ambulance services within the Medicaid Program's limitations. Ambulance services must be certified as medically necessary by a physician.

212.000 Scope

9-1-06

Emergency ambulance services may be covered only when provided by an ambulance company that is licensed by the Arkansas State Ambulance Board and is an enrolled provider in the Arkansas Medicaid Program. Emergency ambulance services may be covered only when an emergency exists for the transported individual. (See the Glossary—Section IV of this manual—for a definition of “emergency services.”)

Ground ambulance services must be provided by a licensed ambulance service, even if the trip is a routine or non-emergency transfer.

Air ambulance services are covered for eligible Medicaid beneficiaries on an emergency basis or as deemed medically necessary by a physician.

When emergency ambulance services are provided as described above, and the beneficiary is transported to the hospital, the Arkansas Medicaid Program will cover the ambulance transportation only when the beneficiary is admitted to the hospital or when the patient's condition is an emergency. (See the Glossary—Section IV of this manual—for a definition of “emergency services.”)

212.100 Subscription Plans for Ambulance Services

9-1-06

When ambulance subscription plans operate as insurance policies, Medicaid considers them third party resources. Federal regulations define private insurer, in part, to be “any...prepaid plan offering either medical services or full or partial payment...” As long as the membership fee paid by a Medicaid beneficiary is treated by the ambulance subscription plan as an insurance premium and the ambulance company does not then bill Medicaid for ambulance services provided to the Medicaid beneficiary, the ambulance company will not be in violation of Medicaid regulations. If, on the other hand, the ambulance provider collects a membership fee from Medicaid beneficiaries and then bills Medicaid for ambulance services provided to those Medicaid beneficiaries, the provider will be in violation of the Medicaid regulations by soliciting and/or accepting the membership fee.

Any ambulance company that markets a subscription plan must make it very clear in its marketing materials that Medicaid beneficiaries are not required to pay an enrollment fee to the subscription plan or make voluntary contribution to the subscription plan provider in order to avoid charges for medically necessary ambulance transportation.

213.000 Pick-Up and Delivery Locations**9-1-06**

Medicaid will cover ambulance services for Medicaid beneficiaries to and/or from the following locations when certified by the physician that transportation by ambulance is medically necessary:

- A. From the location a beneficiary has an accident or becomes ill to a hospital.
- B. From the patient's home or place of residence to a hospital.
- C. From a nursing home to a hospital.
- D. From a hospital (after receiving emergency outpatient treatment) to a nursing home if the patient is bedridden.
- E. From a hospital (after being discharged from an inpatient stay) to a nursing home when the beneficiary is being admitted to the nursing home.
- F. From a hospital to a hospital for inpatient services. However, if a patient is transported from a hospital to receive services on an outpatient basis, the cost of the ambulance is included in the hospital reimbursement amount. The ambulance company may not bill Medicaid or the beneficiary for the service.
- G. From the patient's home or place of residence to a nursing home when the beneficiary is being admitted to the nursing home.
- H. From a nursing home (after being discharged) to a patient's home or place of residence.
- I. From a hospital to the patient's home or place of residence following an inpatient hospital stay.
- J. From a nursing home to a nursing home when the original nursing home has been decertified by Medicaid and the transportation is determined necessary by the Office of Long Term Care, Arkansas Division of Medical Services. In these instances, the Arkansas Medicaid Program will contact the Ambulance Transportation provider who is rendering the service to provide special billing instructions.

216.000 Ambulance Trips with Multiple Medicaid Beneficiaries**9-1-06**

There will be occasions when more than one eligible Medicaid beneficiary is picked up and transported in an ambulance at the same time. When this situation exists, the procedures listed below must be followed:

- A. A separate claim must be filed for each eligible Medicaid beneficiary. Each claim must have a physician certification.
- B. If there is a mileage charge, it must be charged on only one of the eligible beneficiary's claims.
- C. The basic pickup charge and other procedures that are used may be charged on each eligible beneficiary's claim.

NOTE: If an eligible beneficiary and her newborn child are transported at the same time, the above procedures will apply. However, if the newborn has not been certified Medicaid eligible, it will be the responsibility of the parent(s) to apply and meet

the eligibility requirements for the newborn to be certified as Medicaid eligible. If the newborn is not certified as Medicaid eligible, the parent(s) will be responsible for the charges incurred by the newborn.

242.000**Rate Appeal Process****9-1-06**

A provider may request reconsideration of a Program decision by writing to the Assistant Director, Division of Medical Services. This request must be received within 20 calendar days following the application of policy and/or procedure or the notification of the provider of its rate. Upon receipt of the request for review, the Assistant Director will determine the need for a program/provider conference and will contact the provider to arrange a conference if needed. Regardless of the program decision, the provider will be afforded the opportunity for a conference, if he or she so wishes, for a full explanation of the factors involved and the program decision. Following review of the matter, the Assistant Director will notify the provider of the action to be taken by the Division within 20 calendar days of receipt of the request for review or the date of the program/provider conference.

If the decision of the Assistant Director, Division of Medical Services is unsatisfactory, the provider may then appeal the question to a standing Rate Review Panel established by the Director of the Division of Medical Services which will include one member of the Division of Medical Services, a representative of the provider association and a member of the Department of Health and Human Services (DHHS) Management Staff, who will serve as chairman.

The request for review by the Rate Review Panel must be postmarked within 15 calendar days following the notification of the initial decision by the Assistant Director, Division of Medical Services. The Rate Review Panel will meet to consider the question(s) within 15 calendar days after receipt of a request for such appeal. The question(s) will be heard by the panel and a recommendation will be submitted to the Director of the Division of Medical Services.

251.000**Introduction to Billing****9-1-06**

Ambulance transportation providers use the CMS-1500 claim format to bill the Arkansas Medicaid Program for services provided to eligible Medicaid beneficiaries. Each claim must contain charges for only one beneficiary.

Section III of this manual contains information about Provider Electronic Solutions (PES) and other available options.
