

**TOC required**

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201.100 Ground Ambulance Providers

7-1-128-1-  
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Ground Ambulance Transportation providers must meet the Provider Participation and enrollment requirements contained within Section 140.000 of the Arkansas Medicaid provider manual of this manual as well as the following criteria in order to be eligible for participation in the Arkansas Medicaid Program:

- A. A current copy of the ambulance license issued by the Arkansas Department of Health (in-state providers) or the applicable licensing authority (out-of-state and bordering state providers) must accompany the provider application and Medicaid contract. Medicaid will accept approved electronic signatures provided the signatures comply with Arkansas Code § 25-31-103 et seq.
- B. 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 or Advanced Emergency Medical Technician (EMT) licensure from the Arkansas Department of Health (for in-state providers) or the applicable licensing authority (out-of-state providers) paramedic, intermediate or EBLS (Enhanced Basic Life Support). Please refer to Section 252.410 for special billing instructions regarding Advanced Life Support.
- C. The ambulance company must be enrolled in the Title XVIII (Medicare) Program.

204.000 Physician's Role in Non-Emergency Ambulance Services

8-1-2010-4-  
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- A. Non-emergency ambulance service for eligible Medicaid beneficiaries is covered by Medicaid when a physician certifies that non-emergency ambulance service is medically necessary. Physician certification is required for each non-emergency ambulance service event. It is the responsibility of the ambulance service provider to obtain and maintain the physician documentation verifying the medical necessity of each non-emergency ambulance service. The physician's signature must be legible.
- B. Ambulance service providers should obtain a signed and dated physician certification statement (PCS) within twenty one (21) calendar days of the provision of non-emergency ambulance service. The PCS should be signed by the attending physician, physician ordering the service or another physician with knowledge of the beneficiary's case. The physician's name should be printed below the signature and must be legible.

Physician certification statements (PCS) are required for patients who are under the direct care of a physician and are required for:

- A. Scheduled non-emergency ambulance transports
- B. Unscheduled non-emergency ambulance transports

Ambulance suppliers must obtain certification from the patient's attending physician verifying the medical necessity of ambulance transportation in certain circumstances. The physician certification must be accurate and timely as it enables billing Medicaid to receive payment.

The attending physician is responsible for supervising the medical care of the patient by:

- A. Reviewing the patient's program of care;
- B. Ordering medications;
- C. Monitoring changes in the patient's medical status; and

- D. Signing and dating all orders.

**NOTE: The signed PCS does not, by itself, demonstrate the transport was medically necessary and does not absolve the ambulance provider from meeting all other coverage criteria.**

### **Scheduled Repetitive Transports**

#### Definition of Repetitive Ambulance Service:

A repetitive ambulance service is defined as medically necessary ambulance transportation that is furnished three (3) or more times during a 10-day period, or at least once per week for at least three (3) weeks. For example, members receiving dialysis or cancer treatment may need repetitive ambulance services.

PCS requirements for non-emergency scheduled repetitive ambulance transportation include the following:

- A. The PCS for repetitive transports must be signed and dated by the attending physician before furnishing the services to the patient.
- B. The PCS must be dated no earlier than sixty (60) days in advance of the transport for those patients who require repetitive ambulance services and whose transportation is scheduled in advance.
- C. The PCS may include the expected length of time ambulance transport would be required not to exceed sixty (60) days.

### **Non-Repetitive Transports**

- A. PCS requirements for non-emergency (whether scheduled, or not) on a non-repetitive basis ambulance transportation include the following rules:

1. The PCS must be obtained from the attending physician within forty-eight (48) hours after the transport
2. If the ambulance provider is unable to obtain the PCS from the attending physician within forty-eight (48) hours of transport, the provider may submit a claim within twenty-one (21) days if a certification has been obtained from one (1) of the following who is knowledgeable about the patient's condition and who is employed by either the attending physician or the facility to which the patient is admitted:
  - a. Physician Assistant;
  - b. Nurse Practitioner;
  - c. Clinical Nurse Specialist;
  - d. Registered Nurse; or,
  - e. Discharge Planner.

- B. If the ambulance provider is unable to obtain the written order within the 48-hour limit, the supplier may submit the claim after twenty-one (21) days if there is documentation of attempts to obtain the order and certification. The provider may send a letter via U.S. Postal certified mail using the return and/or proof of mailing or other similar service demonstrating delivery of the letter as evidence of the attempt to obtain the PCS.

**C. Non-emergency ambulance service claims are subject to review and recoupment by DHS or its designated representatives.**

- 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 Human Services:
1. The beneficiary's diagnosis, ICD code, if known, and/or the conditions or symptoms requiring non-emergency ambulance service. (Diagnosis is not required for emergency ground ambulance service.)
  2. Copy of the Physician Certification Statement (PCS) for non-emergency ambulance service to include the ICD diagnosis code, if known, and/or the conditions or symptoms establishing medical necessity.
  3. Documentation required by Medicare for ambulance services provided to dual-eligible beneficiaries.
  4. Number of miles traveled – Mileage at transport origin and mileage at transport destination, while loaded, must be documented. Mileage is paid only for that part of the trip the patient is a passenger in the ambulance. The loaded miles must be recorded on the Patient Care Report (PCR). The provider is still responsible for ensuring trip mileage is measured and reported accurately, even in cases where the ambulance personnel fail to reset the trip odometer at the beginning of the trip. Detailed explanation of what occurred must be documented. Acceptable tools used to measure mileage include: (Medicaid only reimburses patient loaded miles.)  
**Definition of rounding with decimals:** When rounding numbers involving decimals, there are two (2) rules to remember: **Rule One:** Determine what your rounding digit is and look to the right side of it. If that digit is 4, 3, 2, or 1, simply drop all digits to the right of it. **Rule Two:** Determine what your rounding digit is and look to the right side of it. If that digit is 5, 6, 7, 8, or 9, add one to the rounding digit and drop all digits to the right of it.
    - a. Odometer readings (both beginning and ending mileage must be documented);
    - b. Global Positioning Systems (GPS) (GPS printout must be included in documentation); and,
    - c. Map mileage documented by using an electronic mapping system (such as Google Maps or MapQuest)

The provider is responsible for ensuring any tools used to measure trip mileage are in working order. Ambulance providers are required to use the shortest route in time between point "A" to "B". If the shortest route cannot be used, the reason why must be documented.
  5. The Patient Care Report (PCR) is documentation used in both non-emergency and emergency transports and should contain at a minimum:
    - a. Origin of the call (i.e., 911, hospital, nursing home, private residence);<sub>1</sub>
    - b. Origin of transport or pick-up (on occasion the origin of the call and the pick-up location are different);<sub>1</sub>
    - c. Date and times inclusive of time call received, unit in route to scene, arrival on scene, en route to destination, arrival at destination;<sub>1</sub>
    - d. The Arkansas Department of Health (ADH) vehicle permit number or the unit call sign of the responding unit/ambulance (if licensed in Arkansas);<sub>1</sub>
    - e. The patient's name;<sub>1</sub>
    - f. Certification/licensure of all crew members responding, unit and the level of ambulance service provided;<sub>1</sub> and<sub>1</sub>
    - g. A complete subjective and objective assessment of patient being transported, monitoring of patient's condition,<sub>1</sub> and supplies used in transport.

- 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 assessments and aspects of care, including the response, interview, physical exam, any diagnostic procedures performed, any non-invasive or invasive procedures performed, diagnoses, supplies used, and any other activities performed in connection with any Medicaid beneficiary.
- E. At the time of an audit by the Office of Medicaid Inspector General, all documentation must be available at the provider's place of business during normal business hours. There will be no more than thirty (30) days allowed after the date of any recoupment notice in which additional documentation will be accepted.

**213.200 Exclusions**

**8-1-2010-  
13-03**

Ambulance service to a doctor's office or clinic is not covered, except as described in Section 204.000.

**214.000 Covered Ground Ambulance Services**

**8-1-2010-  
13-03**

The following services are covered by Medicaid during the trips listed in Sections 213.000 through 213.200:

- A. ~~Basic-Non-Emergency Pick Up Base Service;~~
- B. ~~Basic-Emergency Pick Up Base Service;~~
- C. ~~Mileage Rate - One Way (in addition to basic); and, Mileage outside the city limits must correspond to Arkansas map mileage.~~
- D. ~~Disposable Supplies and Drugs as described in Section 252.100. First Aid~~
- E. ~~Oxygen Charge~~

~~Mileage must be calculated in accordance with Section 205.000. Ground ambulance transportation is covered from the point of pick-up to the point of delivery. Mileage is paid only for that part of the trip the patient is a passenger in the ambulance.~~

~~Arkansas State Highway map mileage must be utilized for billing city to city mileage. When billing for intra-city/county mileage, providers may use the actual miles traveled according to the odometer from the point of pick-up to the point of delivery.~~

**216.000 Ambulance Trips with Multiple Medicaid Beneficiaries**

**8-1-2010-  
13-06**

There will be occasions when more than one (1) 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, except in situations when multiple patients are transported as a result of an emergency response. All documentation supporting the medical

necessity of transporting multiple patients in an ambulance must be kept for retrospective review.

- B. If there is a mileage charge, it must be charged on only one (1) of the eligible beneficiary's claims.
- C. ~~The basic pickup charge base service~~ and other procedures that are used and appropriately documented 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.

241.000 Method of Reimbursement 8-1-2010-  
43-03

Ambulance services are reimbursed based on the lesser of the amount billed or the Title XIX (Medicaid) charge allowed.

The Medicaid maximum for the intermediate transport is established at the average of the advance life support (ALS) and the basic life support transport (BLS) Medicaid rates.

251.000 Introduction to Billing 8-1-209-1-  
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 (1) beneficiary. For a date of service where more than one (1) ambulance service was provided, all service runs must be billed on one (1) claim.

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

252.100 Ambulance Procedure Codes 8-1-2014-1-  
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The covered ambulance procedure codes are listed below.

Drug procedure codes require National Drug Codes (NDC) billing protocol. See Section 252.110 below.

A0382	A0398	A0422	A0425	A0426	A0427	A0428	A0429
J0150*	J0171*	J0280*	J0461*	J1094*	J1100*	J1160*	J1200*
J1265	J1940*	J2060*	J2175*	J2270*	J2310*	J2550*	J2560*
J3360*	J3410*	J3475*	J3480*	J3490*	93041*		

\*Procedure code can be billed only in conjunction with procedure code A0426 and A0427 (please keep all documentation supporting the medical necessity of all codes billed for retrospective review of claims).

Arkansas Medicaid follows the billing protocol per the Federal Deficit Reduction Act of 2005 for drugs.

- A. Multiple units may be billed when applicable. Take-home drugs are not covered. Drugs loaded into an infusion pump are not classified as “take-home drugs.” Refer to payable CPT code ranges 96365 through 96379.
- B. When submitting Arkansas Medicaid drug claims, drug units should be reported in multiples of the dosage included in the HCPCS procedure code description. If the dosage given is not a multiple of the number provided in the HCPCS code description the provider shall round up to the nearest whole number in order to express the HCPCS description number as a multiple.
  - 1. **Single-Use Vials:** If the provider must discard the remainder of a **single-use vial** or other package after administering the prescribed dosage of any given drug, Arkansas Medicaid will cover the amount of the drug discarded along with the amount administered.
  - 2. **Multi-Use Vials:** Multi-use vials are not subject to payment for any discarded amounts of the drug. The units billed must correspond with the units administered to the beneficiary.
  - 3. **Documentation:** The provider must clearly document in the patient’s medical record the actual dose administered in addition to the exact amount wasted and the total amount the vial is labeled to contain.
  - 4. **Paper Billing:** For drug HCPCS/CPT codes requiring paper billing (i.e., for manual review), complete every field of the **DMS-664** “Procedure Code/NDC Detail Attachment Form.” Attach this form and any other required documents to your claim when submitting it for processing.

Remember to verify the milligrams given to the patient and then convert to the proper units for billing.

Follow the Centers for Disease Control (CDC) requirements for safe practices regarding expiration and sterility of multi-use vials.

Procedure Code	Required Modifier	Description
A0422	U1	Emergency, oxygen, helicopter air ambulance
A0425		Ground mileage per statute mile
A0428		Ambulance service, basic life support non-emergency transport
A0431		Ambulance service, emergency, basic pick-up, helicopter, one unit per day
A0434		Air Ventilator/Respiratory Therapist, one unit equals one hour (Round to the nearest hour)
A0435	U1, UB	Piston propelled fixed wing air ambulance per mile
	U2, UB	Turboprop fixed wing air ambulance per mile
	U3, UB	Jet (fixed wing) one unit equals one mile
	U4, UB	Piston propelled fixed wing air ambulance per hour (Round to the nearest hour)
	U5, UB	Turboprop fixed wing air ambulance per hour (Round to the nearest hour)
	U6, UB	Jet (fixed wing) one unit equals one hour (Round to the nearest hour)
A0436		Emergency, per mile, loaded, helicopter air ambulance

252.410

**Levels of Ambulance Life Support (ALS) ~~(ALS)~~ and Basic Life Support (BLS)**8-1-2010-  
43-03

Levels of ambulance life support are not applicable to transports by air ambulance and apply to ground ambulance transportation only. Ambulance transportation providers who bill advanced life support (ALS) services must be licensed as advanced emergency medical technicians (EMTs) or paramedics. All ambulance transports must be made and billed to Medicaid appropriately according to the licensure level of the provider. The level of services billed to Medicaid must be in compliance with the level of care provided and reflected by the license of the provider.

Basic Life Support (BLS) services are supportive and non-definitive in nature. BLS assessment includes brief and limited patient assessment and management procedures including evaluation of vital signs, mental and neurologic states, and hemodynamic stability.

To bill at the ALS level of service, the transportation event must include provision of an ALS assessment or at least one (1) ALS intervention. An ALS assessment is performed by an advanced EMT or paramedic as part of an emergency response that is necessary because the beneficiary's reported condition at the time of the service indicates only an advanced EMT or paramedic is qualified to perform the assessment. In the case of an appropriately dispatched ALS emergency service and if the ALS crew appropriately completes an ALS assessment, the services provided by the provider during that transportation event are covered at the ALS level of service.

MARKY-08

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT  
MEDICAL ASSISTANCE PROGRAM  
STATE ARKANSAS

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ATTACHMENT 4.19-B  
Page 8

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES -  
OTHER TYPES OF CARE

Revised: ~~March 1, 2009~~ July 1, 2020

23. Any other medical care and any other type of remedial care recognized under State law, specified by the Secretary.
- a. Transportation
- (1) The agency's ground transportation fee schedule rates are published on the agency's website ([www.medicaid.state.ar.us](http://www.medicaid.state.ar.us)). A uniform rate for these services is paid to all governmental and non-governmental providers unless otherwise indicated in the state plan.
- Ground Ambulance: Services are reimbursed based on the lesser of the amount billed or the Title XIX (Medicaid) charge allowed.
- Effective for claims with dates of service on or after March 1, 2009, the Arkansas Medicaid maximum mileage reimbursement rates are established for the Basic Life Support (BLS), Intermediate Life Support (ILS), and Advanced Life Support (ALS) ground ambulance services by using 86% of the Medicare rural base rate as of February 20, 2009, for the same services.
- Effective for claims with dates of service on or after July 1, 2020, the Arkansas Medicaid maximum reimbursement rate for covered ambulance procedure codes increased based upon a routine rate study performed by DHS and its actuary.
- (2) The agency's air transportation fee schedule rates were set as of July 1, 2008, and are effective for services on or after that date. All air transportation fee schedule rates are published on the agency's website ([www.medicaid.state.ar.us](http://www.medicaid.state.ar.us)). A uniform rate for these services is paid to all governmental and non-governmental providers unless otherwise indicated in the state plan.
- Air Ambulance: Reimbursement for jet fixed wing, turboprop fixed wing, piston fixed wing, and rotary wing air ambulance services is based on the lesser of the amount billed or the maximum Title XIX (Medicaid) charges allowed.
- The Air Ambulance service maximum reimbursement rates effective July 1, 2008, and after were developed as follows:
- Rotary wing, helicopter pick-up, and per mile rates were calculated by using 85% of Medicare Urban Rates as of 5/1/08 for the same services.
  - Piston fixed wing, Turbo Prop fixed wing, and Jet fixed wing mileage rates were calculated by using 85% of Medicare Urban Rates as of 5/1/08 for the same services.
  - Piston fixed wing, Turbo Prop fixed wing, and Jet fixed wing hourly rates were calculated by inflating the current rates by the change in the Consumer Price Index-All Urban Consumers (CPIU - not seasonally adjusted, U.S. city average-, all items) between December 1, 2000 and April 1, 2008. This hourly reimbursement rate of medical personnel and medical equipment is only for time while the aircraft is in the air, on the runway for takeoff and landing, boarding and disembarking patient and crew, and taxiing.
- Effective for dates of service occurring 7/1/2008 and after, reimbursement rate maximums for the turboprop fixed wing aircraft will be \$6.54 per mile and \$215.70 per hour, the maximums for piston propelled fixed wing aircraft will be \$6.54 per mile and \$50.32 per hour and the maximums for jet propelled aircraft will be \$6.54 per mile and \$215.70 per hour. Effective for 7/1/2008 and after, reimbursement rate maximums for helicopter rotary wing aircraft will be \$17.43 per mile and \$2,462.25 per pick up (one way).
- The hourly reimbursement rate is for medical personnel and medical equipment and is only for time while the aircraft is in the air, on the runway for takeoff and landing, boarding and disembarking patient and crew, and taxiing. The per mile rate is to cover the cost of transportation equipment, the



salary of the pilot, and non-medical supplies.

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