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8 Ambulance (Ground & Air)

Medicaid covers transportation costs to and from medical care facilities for eligible recipients. The approved plan includes the following services:

- Reimbursement of ambulance service for emergency and non-emergency situations
- Reimbursement of non-emergency transportation coordinated by the Alabama Medicaid Agency (See Appendix G, Non-Emergency Transportation (NET Program)

The policy provisions for transportation providers can be found in the *Alabama Medicaid Agency Administrative Code,* Chapter 18.

8.1 Enrollment

HPE enrolls transportation providers and issues provider contracts to applicants who meet the licensure and/or certification requirements of the state of Alabama, the Code of Federal Regulations, the *Alabama Medicaid Agency Administrative Code*, and the *Alabama Medicaid Provider Manual*.

For ambulance providers, Medicaid requires a new service contract in the following instances:

- Expiration of state license and issuance of new license
- Change of ownership

HPE is responsible for enrolling any qualified ambulance service that wishes to enroll in the Medicaid Transportation Program.

Refer to Chapter 2, Becoming a Medicaid Provider, for general enrollment instructions and information. Failure to provide accurate and truthful information or intentional misrepresentation might result in action ranging from denial of application to permanent exclusion.

Federal requirements mandate providers re-enroll periodically with the Alabama Medicaid program. Providers will be notified when they are scheduled to re-enroll. Failure to re-enroll and provide appropriate documentation to complete enrollment will result in an end-date being placed on the provider file. Once a provider file has been closed for failure to timely re-enroll, providers will have to submit a new application for enrollment.

National Provider Identifier, Type, and Specialty

A provider who contracts with Medicaid as a transportation provider is added to the Medicaid system with the National Provider Identifier provided at the time application is made. Appropriate provider specialty codes are assigned to enable the provider to submit requests and receive reimbursements for transportation-related claims.

NOTE:

The current 10 digit National Provider Identifier (NPI) is required when filing a claim.

Transportation providers are assigned a provider type of 26 (Transportation).

Valid specialties for transportation providers include the following:

- Emergency Ground Ambulance (260)
- Helicopter (261)
- Fixed Wing (268)

Enrollment Policy for Transportation Providers

To participate in the Alabama Medicaid Program, transportation providers must meet the following requirements:

- Must be certified for Medicare Title XVIII
- Must maintain a disclosure of the extent and cost of services, equipment, and supplies furnished to eligible recipients
- Must be licensed in the state of Alabama and/or the state in which services are provided
- The effective date of enrollment of an Ambulance Provider will be the date of Medicare certification. However, if a provider's request for enrollment is received more than 120 days after the date of their Medicare certification, then the effective date will be the first day of the month the enrollment is initially received by Medicaid's Fiscal Agent.

Added: **Change of Ownership (CHOW) and Closures** section

Change of Ownership (CHOW) and Closures

Medicaid will mirror Medicare's Change of Ownership (CHOW) policy. Refer to Chapter 19, Hospital for additional information on Change of Ownership.

8.2 Benefits and Limitations

This section describes program-specific benefits and limitations. Please refer to Chapter 3, Verifying Recipient Eligibility, for general benefit information and limitations. Refer to Chapter 7, Understanding Your Rights and Responsibilities as a Provider, for general criteria on Medical Necessity/ Medically Necessary Care.

Medicaid reimburses a maximum of one round trip per date of service per recipient. A round trip consists of the transport from home base (home, nursing home, etc.) to the destination (physician's office, hospital, etc.) and transport from the destination back to home base on the same date of service.

Medicaid requires that the recipient be taken to the nearest hospital that has appropriate facilities, physicians, or physician specialists needed to treat the recipient's condition. The hospital must have a bed or specialized treatment unit immediately available. If the recipient is not taken to the nearest appropriate hospital, payment will be limited to the rate for the distance from the pick-up point to the nearest appropriate hospital.

All transportation must be medically necessary and reasonable. Documentation must state the condition(s) that necessitate ambulance service and indicate why the recipient cannot be transported by another mode of transportation. Medicaid will not reimburse ambulance service if some other means of transportation could have been used without endangering the recipient's health.

Additional Information

Reasonableness of the Ambulance Trip

Payment is made according to the medically necessary services actually furnished. That is, payment is based on the level of service furnished (provided they were medically necessary), not simply on the vehicle used. Even if a local government requires an ALS response for all calls, payment under the Fee Schedule is made only for the level of service furnished, and then only when the service is medically necessary.

Medical Necessity

Medical Necessity is established when the recipient's condition is such that use of any other method of transportation is contraindicated. In other words, the recipient could not be transported by any other means of transportation without endangering their health. If the recipient could be transported by means other than ambulance, e.g. wheelchair van, car, taxi etc. without endangering the recipient's health, then medical necessity does not exist. It does not make a difference whether or not the other means of transportation are actually available in the locality.

Medical necessity is determined based on the conditions of the recipient at the time of service. Carriers are instructed to presume the requirement is met if the recipient:

- was transported in an emergency situation, e.g. as a result of an accident, injury or acute illness, or
- needed to be restrained to prevent injury to the patient or others, or
- was unconscious or in shock, or
- required oxygen or other emergency treatment on the way to his destination, or
- exhibited signs and symptoms of acute respiratory distress or cardiac distress, e.g. shortness of breath, chest pain, or
- had to remain immobile because of a fracture that had not been set or the possibility of a fracture, or
- exhibited signs and symptoms of a possible acute stroke, or
- was experiencing a severe hemorrhage, or
- was bed confined before and after the ambulance trip, or
- could only be moved by stretcher.

NOTE:

If the condition was one of the last two (2) listed above, i.e. bed confided or could only be moved by a stretcher, it is prudent to document the reasons why the recipient was bed confined or could only be moved by stretcher. Also, while "bed confined" is still listed as CMS in their manual as "before and after", they have clarified it refers to the time of transport.

Bed Confined

A national definition for bed confined has been established in the Regulations at 42 CFR 410.40(d) (1). A beneficiary will be considered bed confined only if they are:

- unable to get up from bed without assistance, and
- unable to ambulate, and
- unable to sit in a chair or wheelchair.

8.2.1 Non-Emergency Transportation (NET) Program Services

To eliminate transportation barriers for recipients, Medicaid operates the Non-Emergency Transportation Program (NET). The NET Program ensures that necessary non-ambulance transportation services are available to recipients. See Appendix G, Non-Emergency Transportation (NET) Program, for specifics about the program.

All payments for NET services require authorization.

8.2.2 Non-Emergency Ambulance Services

Medicaid reimburses non-emergency ambulance services provided to eligible recipients for the following origins and destinations:

- Hospital to home following hospital admission
- Home to hospitals or specialized clinics for diagnostic tests or procedures for non-ambulatory recipients
- Home to treatment facility for recipients designated on Home Health Care Program who are confined as "bedfast" recipients
- Nursing facility to hospital or specialized clinic for diagnostic tests within the state when medically necessary and out of state with Alabama Medicaid determined placement only.
- Nursing facility to nursing facility
- Hospital to hospital
- Hospital to nursing facility following hospital admission
- Physician’s Office

8.2.3 Emergency Ambulance Services

Medicaid reimburses emergency ambulance services provided to eligible recipients for the following origins and destinations:

- Location of emergency to a local hospital
- Nursing facility to a local hospital
- Hospital to hospital

Medicaid reimburses emergency ambulance services if the recipient expires during transport, but not if the recipient was pronounced dead by authorized medical personnel before transport.

If more than one recipient is transferred in the same ambulance at the same time, please file a separate claim form for each recipient.

8.2.4 Air Transportation Services

Medicaid reimburses air transportation services for all Medicaid recipients with prior authorization approval only. Air transportation for adults is reimbursed at the ground ambulance rate.

Air transportation may be rendered only when basic and advanced life support land ambulance services are not appropriate. Medical necessity applies when transport by land or the instability or inaccessibility to land transportation threatens survival or seriously endangers the recipient's health. Medicaid may authorize air transportation in certain cases when the time required to transport by land as opposed to air endangers the recipient's life or health. Medicaid will not reimburse air transportation when provided for convenience.

Medicaid requires that the recipient be taken to the nearest hospital that has appropriate facilities, physicians, or physician specialists needed to treat the recipient's condition. The hospital must have a bed or specialized treatment unit immediately available. If the recipient is not taken to the nearest appropriate hospital, payment will be limited to the rate for the distance from the pick-up point to the nearest appropriate hospital.

NOTE:

Medicaid does not consider trips of less than 75 loaded miles to be appropriate unless extreme, extenuating circumstances are present and documented.

NOTE:

If more than one recipient is transferred in the same air transport trip, only one recipients transport will be reimbursed.

If Medicaid determines that land ambulance service would have been more appropriate, payment for air transportation will be based on the amount payable for land transportation.

8.3 Prior Authorization and Referral Requirements

When filing claims for recipients enrolled in the Patient 1st Program, refer to Chapter 39, Patient 1st, to determine whether your services require a referral from the Primary Medical Provider (PMP).

When requesting prior authorization, please give the recipient's name, RID number, address, diagnosis, attending physician, reason for movement (from and to), and the name of the ambulance provider who will be used. Refer to Chapter 4, Obtaining Prior Authorization, for general guidelines.

In the case of Retroactive Eligibility, the provider has 90 days after the date on which the award of retroactive eligibility was made to submit their request for prior approval. It is the provider's responsibility to submit a copy of the retroactive eligibility determination along with the prior approval request to Medicaid.

NOTE:

"Clean" Prior Authorization (PA) requests must be received by our Fiscal Agent (HPE) within thirty (30) business days from the date of service. A "Clean" PA request is one where valid information is submitted on both the provider and the recipient regarding services that were rendered on a specific date of service and without any RTPs (Return To Provider) which would create a delay for your request.

Prior Authorization for Non-Emergency Transportation

All non-emergency ambulance services 100 miles or greater one way requires prior authorization. However, the provider has thirty (30) business days from the date the service was rendered to obtain the prior authorization (PA).

When submitting Prior Authorization requests for non-emergency ground ambulance transport >100 miles, the following condition codes are the only ones recognized by Alabama Medicaid:

Condition Code	***Description***
02	Bed confined before the ambulance service
04	Moved by stretcher
05	Unconscious or in shock
07	Physically restrained
08	Visible hemorrhaging

Authorization for Air Transportation

All payments for air transportation services require authorization from Medicaid.

The following steps must be followed for air ambulance providers to receive reimbursement:

1. Medicaid's Fiscal Agent must receive authorization requests no later than the thirtieth (30th) business day after the service was rendered. **Please include the following:**
   - Air versus ground time and/or distance
   - Age of recipient
   - Diagnosis and severity of condition
   - Any other pertinent medical data as deemed necessary to document air transportation
2. The provider must supply the above documentation for any service requiring immediate transportation. The documentation must also include a copy of the flight record, progress notes from institution that requested air transport, and documentation of reason why ground transport is not feasible.
3. Medicaid's Fiscal Agent assigns a prior authorization number and forwards the request to the Medicaid Prior Approval Program for review.
4. The Prior Approval Program reviews the request and forwards it to the contracted Medicaid designee reviewer for approval/denial.
5. If Medicaid or the contracted Medicaid designee reviewer determines that air transportation is not medically necessary and the criteria are met for ground transportation, the request is approved at the emergency ground rate. The

provider will bill authorized amount and be reimbursed at the emergency ground rate.

6. Providers who are dissatisfied with the decision of Medicaid or the contracted Medicaid designee reviewer must request an informal review of medical information. The request must be in writing and received by Medicaid within thirty days of the modified approval letter. If additional information is not submitted for review, the decision will be final and no further review will be available.
7. Provider is instructed to submit claim to Medicaid's Fiscal Agent for payment with the assigned prior authorization number.
8. Prior authorization requests will be accepted from newly enrolled providers for dates retroactive to the first day of the month preceding the month of the effective date provider is added to the Medicaid system.

NOTE:

In the event an air transport provider is unable to verify a recipient's eligibility prior to or at the time of the transport due to the patient being unconscious or disoriented and no family member being available, the provider's prior authorization request will be reviewed on a case by case basis. The request must include documentation detailing the reason eligibility was not verified prior to transport.

NOTE:

Prior authorization requests may be submitted to Medicaid's Fiscal Agent per FAX or regular mail. Providers are instructed to follow-up with the fiscal agent within four to five days to be certain request was received, and again in two weeks, if no reply has been received.

8.4 Cost Sharing (Copayment)

The copayment does not apply to services provided by transportation providers.

8.5 Billing Recipients

By filing a claim with the Medicaid Program, a provider is agreeing to accept assignment and by accepting assignment, the provider agrees to accept the Medicaid reimbursement, plus any cost-sharing amount (copay) to be paid by the recipient, as payment in full for those services covered under the Medicaid Program. The Medicaid recipient, or others on his behalf, must not be billed for the amount above that, if any, which is paid on an allowed service.

8.6 Completing the Claim Form

To enhance the effectiveness and efficiency of Medicaid processing, providers should bill Medicaid claims electronically.

Transportation providers who bill Medicaid claims electronically receive the following benefits:

- Quicker claim processing turnaround
- Immediate claim correction
- Enhanced online adjustment functions
- Improved access to eligibility information

Refer to Appendix B, Electronic Media Claims Guidelines, for more information about electronic filing.

NOTE:

When filing a claim on paper, a CMS-1500 claim form is required. Medicare-related claims must be filed using the Medical Medicaid/Medicare-related Claim Form.

This section describes program-specific claims information. Refer to Chapter 5, Filing Claims, for general claims filing information and instructions.

8.6.1 Time Limit for Filing Claims

Medicaid requires all claims for transportation to be filed within one year of the date of service. Refer to Section 5.1.5, Filing Limits and Approved Exceptions, for more information regarding timely filing limits and exceptions.

8.6.2 Diagnosis Codes

The *International Classification of Diseases - 10th Revision - Clinical Modification* (ICD-10-CM) manual lists required diagnosis codes. These manuals may be obtained by contacting the American Medical Association, AMA Plaza 330 North Wabash Ave, Suite 39300 Chicago, IL 60611-5885, or 1-800-621-8335.

NOTE:

ICD-9 or ICD 10 diagnosis codes must be listed to the highest number of digits possible (3, 4, or 5 digits). Do not use decimal points in the diagnosis code field.

Ground transportation providers must use a valid diagnosis code. Ground transportation providers may use more than one diagnosis code from the approved list per claim.

NOTE:

Air transportation providers should only bill diagnosis code used on the prior authorization.

Covered Ambulance Diagnosis Codes

Refer to Appendix R: Ambulance (Ground and Air) Diagnosis Codes for the appropriate ICD-9 and ICD-10 diagnosis codes to use on claims.

8.6.3 Procedure Codes and Modifiers

Transportation providers use the following procedure codes and modifiers. The (837) Institutional electronic claim and the paper claim have been modified to accept up to four Procedure Code Modifiers.

Ambulance services billed will be commensurate with services actually performed. Services rendered are independent of the type of call received or the type staff / equipped ambulance service responding.

Procedure Codes for Basic Life Support (BLS) Services

Basic Life Support Service (BLS) is an ambulance service which includes equipment and staff to render basic services such as control of bleeding, splinting fractures, treating shock, performing cardiopulmonary resuscitation (CPR), delivery of babies, use of horizontal immobilizers, restraints for combative recipients, and use of gauze pads/bandages.

Procedure Code	***Description***
A0429	Ambulance Service, basic life support, emergency transport (BLS - Emergency)
A0425	Ground Mileage, per mile (100) miles or more requires prior authorization)

Procedure Codes for Advanced Life Support (ALS) Services

An ALS ambulance has similar equipment, crew, and certification requirements under Medicare as a basic ambulance, except the ALS ambulance has complex specialized life-sustaining equipment. It is ordinarily equipped for radio-telephone contact with a hospital or physician. A typical ALS ambulance may be a mobile coronary care unit or other vehicle appropriately equipped and staffed by personnel authorized to initiate and administer IV fluids, establish and maintain a recipient's airway, defibrillate the heart, relieve pneumothorax conditions, administer cardiopulmonary resuscitation (CPR), provide anti-shock therapy ,administer life sustaining drugs, venous blood draws, cardiac monitoring (EKG), administer pacing nebulizer and perform other advanced life support procedures or services to recipients during the transport. Documentation must support need for ALS services.

Procedure Code	***Description***
A0225	Neonatal Emergency Transport, transport of a critically ill neontate, a level of interfacility service provided beyond the scope of the Paramedic. This service should be billed only for the transport of a neonate.
A0427	Ambulance service, advanced life support, emergency transport, Level 1 (ALS1) Must provide medically necessary supplies and services, including the provision of an ALS assessment or at least one ALS intervention.
A0433	Advanced Life Support Level 2 (ALS2). The administration of at least three different medications and the provision of one or more of the following ALS procedures: Manual defibrillation/cardioversion, endotracheal intubation, central venous line, cardiac pacing, chest decompression, surgical airway, intraosseous line.
A0434	Specialty Care Transport (SCT), in a critically injured or ill patient, a level of interfacility service provided beyond the scope of the Paramedic. This service is necessary when a patient’s condition requires ongoing care that must be provided by one or more health professionals in an appropriate specialty area (for example, nursing, emergency medicine, respiratory care, cardiovascular

Procedure Code	Description
	care, or a paramedic with additional training).

Procedure Codes for Non-emergency Services

Procedure Code	Description
A0426	Ambulance service, advanced life support, Level 1 (ALS1, Must provide medically necessary supplies and services including the provision of an ALS assessment or at least one ALS intervention), non-emergency transport, (cannot be billed with A0422)
A0428	Ambulance service, basic life support, (BLS), non-emergency transport
A0425	Ground Mileage, per mile (100) miles or more requires prior authorization)

Miscellaneous Procedure Codes

Procedure Code	Description
A0382	BLS routine disposable supplies
A0422	Ambulance (ALS or BLS) oxygen and oxygen supplies, life sustaining situation
A0425	Ground Mileage, per mile (100) miles or more requires prior authorization)

Services Not Covered by Medicare That Are Covered by Medicaid

- Some non-emergency ambulance services are non-covered by Medicare but are covered by Medicaid if billed in conjunction with the modifiers below. These claims should be filed on a medical claim electronically.
- Modifiers DD, DG, DJ, DN, DP, DR, ED, GD, GP,HD, HP, ND, JP,NP, PD, PE, PG, PH, PJ, PN, PP, PR, RD, or RP
- A0422, A0425, A0426, A0428, A0429

Procedure Codes for Medicare Crossovers Only

Medicaid will reimburse providers for only the coinsurance and deductible for the following procedure codes:

Procedure Code	Description
A0432	Paramedic ALS intercept (PI), rural area, transport furnished by a volunteer ambulance company which is prohibited by state law from billing third party payers

Procedure Codes for Air Transportation

Procedures not included in this list are not covered by Medicaid.

Procedure Code	Modifier	Description
A0435		Air mileage, fixed wing, per statute mile
A0436		Air mileage, rotary wing, per statute mile
A0430		Ambulance service, conventional air services, transport, one way (fixed wing)
A0431		Ambulance service, conventional air services, transport, one way (rotary wing)
A0215		Miscellaneous disposable supplies, limited to 1 unit per claim
A0422		Ambulance (ALS or BLS) oxygen and oxygen supplies, life sustaining situation

First Modifier

The first place alpha code is the origin; the second place alpha code is the destination. **The valid origin/destination modifiers and their explanations are listed below:**

Modifier	*Description*
D	Diagnosis or therapeutic site other than P or H when these are used as origin codes
E	Residential, domiciliary, custodial facility (other than 1819 facility)
G	Hospital-based dialysis facility (hospital or hospital related)
H	Hospital
I	Site of transfer (e.g., airport or helicopter pad) between modes of ambulance transport
J	Non-hospital based dialysis facility
N	Skilled nursing facility (SNF) (1819 facility)
P	Physician's office (includes HMO non-hospital facility, clinic, etc.) (Note: Bed-bound recipients only, NET Program prior authorization required)
R	Residence
S	Scene of accident or acute event

For example, when a recipient is picked up at the residence (origin code R) and taken to the hospital (destination code H) for an ALS emergency transport (procedure code A0427), the claim is coded as **A0427RH.**

The following are all of the valid combinations for the first modifier fields:

	DN	EH	GE	HG	HR	JH	NG	RD	RN
DD	DR	EJ	GH	HH	IH	JN	NH	RE	SH
DG	ED	EN	GN	HI	IN	JR	NJ	RG	SI
DH	EE	ER	GR	HJ	JD	ND	NN	RH	I I
DJ	EG	GD	HE	HN	JE	NE	NR	RJ	

NOTE:

For ground ambulance transport from a residence to an airport or helicopter site the ground provider should use the modifier combination “SI” since the reason for transport would be an accident or “acute event”.

Second Modifier **(These are not required by Medicaid)**

Modifier	*Description*
2A	Accidental injury home/nursing home
3A	Accidental injury
4A	Recipient in shock
6A	Transported by stretcher
8A	Hospital lacks facility (recipient admitted to second hospital)
9A	Rectal bleeding
5B	Dead on arrival (DOA) at hospital
6B	Died en route to hospital

Repeat Trip

Modifier TS (Follow up Service) is used in the second modifier position to indicate a repeat trip for the same recipient on the same day.

When a recipient is picked up at a hospital (origin code H), taken to another hospital (destination code H), and returned to the original hospital, bill the procedure code with a TS modifier for Follow-up Service.

8.6.4 Place of Service Codes

The following place of service codes apply when filing claims for transportation services:

POS	*Description*
41	Ambulance – Land
42	Ambulance – Air or Water

8.6.5 Required Attachments

To enhance the effectiveness and efficiency of Medicaid processing, your attachments should be limited to claims with third party denials.

NOTE:
When an attachment is required, a hard copy CMS-1500 claim form must be submitted.

Refer to Chapter 5, Section 5.8, Required Attachments, for more information on attachments.

8.7 For More Information

This section contains a cross-reference to other relevant sections in the manual.

Resource	Where to Find it
CMS-1500 Claim Filing Instructions	Chapter 5
Medical Medicaid/Medicare-related Claim Filing Instructions	Chapter 5
Medical Necessity/Medically Necessary Care	Chapter 7
Electronic Media Claims (EMC) Submission Guidelines	Appendix B
AVRS Quick Reference Guide	Appendix L
Alabama Medicaid Contact Information	Appendix N
NET Program	Appendix G