Arkansas Department of Human Services
Division of Medical Services

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TO: **Arkansas Medicaid Health Care Providers - Transportation**

DATE: **July 1, 2005**

SUBJECT: **Provider Manual Update Transmittal #67**

REMOVE		**INSERT**	
Section	**Date**	**Section**	**Date**
251.000 – 252.100	varies	251.000 – 252.100	7-1-05
252.300 – 252.310	10-13-03	252.300 – 252.310	7-1-05

Explanation of Updates

Sections 251.000, 252.000 and 252.300 are included in this update to remove obsolete information.

Section 252.100 is included to show that procedure code A0435 which has a modifier of **52** is changing to modifier **UB**. Effective for claims with dates of service on or after July 1, 2005, modifier **UB** will replace modifier **52**. This section is also included to add procedure codes that are currently payable in the system for Transportation providers that were inadvertently omitted and to remove obsolete information.

Section 252.310 is included to remove information in Field 29 of the CMS-1500 claim form instructions regarding co-payments imposed by private insurance. The beneficiary is no longer responsible for insurance co-payments.

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 or 1-877-708-8191. Both telephone numbers are voice and TDD.

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.

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Roy Jeffus, Director

251.000 Introduction to Billing 7-1-05

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

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

252.000 CMS-1500 Billing Procedures 7-1-05

252.100 Ambulance Procedure Codes 7-1-05

93041*	A0380	A0382	A0390	A0398
A0422	A0426	A0427	A0429	J0150*
J1940	J2270*	J3490*	J0152*	J0170*
J0280*	J0460*	J1094*	J1100*	J1160*
J1200*	J2060*	J2175*	J2310*	J2550*
J2560*	J3360*	J3410*	J3475*	J3480*
Q4076*				

* Procedure code can be billed only in conjunction with procedure code A0427.

Procedure Code	Required Modifier	Description
A0436		Emergency, per mile, loaded, helicopter air ambulance
A0422	U1	Emergency, oxygen, helicopter air ambulance
A0431		Ambulance service, emergency, basic pick-up, helicopter, one unit per day
A0428		Ambulance service, ILS intermediate transport, mileage and disposable supplies billed separately
A0380	TF	ILS mileage (per mile)
T2002**		Non-emergency ground ambulance transportation, hospital to nursing facility
A0435	U1 UB U2 UB U3 UB U4 UB U5 UB U6 UB	Piston propelled fixed air ambulance per mile Turboprop fixed wing air ambulance per mile Jet (fixed wing) one unit equals one mile Piston propelled fixed wing air ambulance per hour Turboprop fixed wing air ambulance per hour Jet (fixed wing) one unit equals one hour
A0434		Air Ventilator/Respiratory Therapist, one unit equals one hour

** Procedure code must be billed on a paper CMS-1500 claim form with the supporting documentation listed in section 213.100.

252.300 Ambulance Transportation Billing Instructions—Paper Only 7-1-05

EDS offers providers several options for electronic billing. Therefore, claims submitted on paper are paid once a month. The only claims exempt from this process are those that require attachments or manual pricing.

To bill for ambulance transportation services, use the CMS-1500. **View a CMS-1500 sample form.**

The following instructions must be read and carefully adhered to, so that EDS can efficiently process claims. Accuracy, completeness and clarity are important. Claims cannot be processed if applicable information is not supplied or is illegible. Claims should be typed whenever possible.

Completed claim forms should be forwarded to the EDS Claims Department. **View or print the EDS Claims Department contact information.**

NOTE: A provider rendering services without verifying eligibility for each date of service does so at the risk of not being reimbursed for the services.

252.310 Completion of CMS-1500 Claim Form 7-1-05

Field Name and Number		Instructions for Completion
1.	Type of Coverage	This field is not required for Medicaid.
1a.	Insured's I.D. Number	Enter the patient's 10-digit Medicaid identification number.
2.	Patient's Name	Enter the patient's last name and first name.
3.	Patient's Birth Date	Enter the patient's date of birth in MM/DD/YY format as it appears on the Medicaid identification card.
	Sex	Check "M" for male or "F" for female.
4.	Insured's Name	Required if there is insurance affecting this claim. Enter the insured's last name, first name and middle initial.
5.	Patient's Address	Optional entry. Enter the patient's full mailing address, including street number and name, (post office box or RFD), city name, state name and ZIP code.
6.	Patient Relationship to Insured	Check the appropriate box indicating the patient's relationship to the insured if there is insurance affecting this claim.
7.	Insured's Address	Required if insured's address is different from the patient's address.
8.	Patient Status	This field is not required for Medicaid.
9.	Other Insured's Name	If patient has other insurance coverage as indicated in Field 11D, enter the other insured's last name, first name and middle initial.
	a. Other Insured's Policy or Group Number	Enter the policy or group number of the other insured.
	b. Other Insured's Date of Birth	This field is not required for Medicaid.
	Sex	This field is not required for Medicaid.

	c. Employer's Name or School Name	Enter the employer's name or school name.
	d. Insurance Plan Name or Program Name	Enter the name of the insurance company.
10.	Is Patient's Condition Related to:	
	a. Employment	Check "YES" if the patient's condition was employment related (current or previous). If the condition was not employment related, check "NO."
	b. Auto Accident	Check the appropriate box if the patient's condition was auto accident related. If "YES," enter the place (two letter State postal abbreviation) where the accident took place. Check "NO" if not auto accident related.
	c. Other Accident	Check "YES" if the patient's condition was other accident related. Check "NO" if not other accident related.
10d.	Reserved for Local Use	This field is not required for Medicaid.
11.	Insured's Policy Group or FECA Number	Enter the insured's policy group or FECA number.
	a. Insured's Date of Birth	This field is not required for Medicaid.
	Sex	This field is not required for Medicaid.
	b. Employer's Name or School Name	Enter the insured's employer's name or school name.
	c. Insurance Plan Name or Program Name	Enter the name of the insurance company.
	d. Is There Another Health Benefit Plan?	Check the appropriate box indicating whether there is another health benefit plan.
12.	Patient's or Authorized Person's Signature	This field is not required for Medicaid.
13.	Insured's or Authorized Person's Signature	This field is not required for Medicaid.
14.	Date of Current: Illness Injury Pregnancy	Required only if medical care being billed is related to an accident. Enter the date of the accident.
15.	If Patient Has Had Same or Similar Illness, Give First Date	This field is not required for Medicaid.
16.	Dates Patient Unable to Work in Current Occupation	This field is not required for Medicaid.
17.	Name of Referring Physician or Other Source	Primary Care Physician (PCP) referral is not required for Ambulance Transportation services. If services are the result of a Child Health Services (EPSDT) screening/ referral, enter the referral source, including name and title.
17a.	I.D. Number of Referring Physician	Enter the 9-digit Medicaid provider number of the referring physician.
18.	Hospitalization Dates Related to Current Services	For services related to hospitalization, enter hospital admission and discharge dates in MM/DD/YY format.

19. Reserved for Local Use	Not applicable to Ambulance Transportation Services.
20. Outside Lab?	Not applicable to Ambulance Transportation Services.
21. Diagnosis or Nature of Illness or Injury	Enter the diagnosis code from the ICD-9-CM. Up to four diagnoses may be listed. Arkansas Medicaid requires providers to comply with HCFA diagnosis coding requirements found in the ICD-9-CM edition current for the claim dates of service.
22. Medicaid Resubmission Code	Reserved for future use.
Original Ref No.	Reserved for future use.
23. Prior Authorization Number	Enter the prior authorization number, for ground ambulance service to facilities outside the 50-mile radius in states bordering Arkansas.
24. A. Dates of Service	Enter the "from" and "to" dates of service, in MM/DD/YY format, for each billed service. 1. On a single claim detail (one charge on one line), bill only for services within a single calendar month. 2. Providers may bill, on the same claim detail, for two (2) or more *sequential* dates of service within the same calendar month when the provider furnished equal amounts of service on each day of the span.
B. Place of Service	Enter the appropriate place of service code. See Section 252.200 for codes.
C. Type of Service	Enter the appropriate type of service code. See Section 252.200 for codes.
D. Procedures, Services or Supplies	
CPT/HCPCS	Enter the correct CPT or HCPCS procedure code.
Modifier	Enter the applicable modifier
E. Diagnosis Code	Enter a diagnosis code that corresponds to the diagnosis in Field 21. If preferred, simply enter the corresponding line number ("1," "2," "3," "4") from Field 21 on the appropriate line in Field 24E instead of reentering the actual corresponding diagnosis code. Enter only <u>one</u> diagnosis code or one diagnosis code line number on each line of the claim. If two or more diagnosis codes apply to a service, use the code most appropriate to that service. The diagnosis codes are found in the ICD-9-CM.
F. $ Charges	Enter the charge for the service. This charge should be the provider's usual charge to private clients. If more than one unit of service is being billed, enter the charge for the total number of units billed.
G. Days or Units	Enter the units (in whole numbers) of service rendered within the time frame indicated in Field 24A.
H. EPSDT/Family Plan	Not applicable to Ambulance Transportation Services.
I. EMG	Emergency - This field is not required for Medicaid.
J. COB	Coordination of Benefit - This field is not required for Medicaid.

K. Reserved for Local Use	Not applicable to Ambulance Transportation Services.
25. Federal Tax I.D. Number	This field is not required for Medicaid. This information is carried in the provider's Medicaid file. If it changes, please contact Provider Enrollment.
26. Patient's Account No.	This is an optional entry that may be used for accounting purposes. Enter the patient's account number, if applicable. Up to 16 numeric or alphabetic characters will be accepted.
27. Accept Assignment	This field is not required for Medicaid. Assignment is automatically accepted by the provider when billing Medicaid.
28. Total Charge	Enter the total of Column 24F. This field should contain a sum of charges for all services indicated on the claim form. (See NOTE below Field 30.)
29. Amount Paid	Enter the total amount of funds received from other sources. The source of payment should be indicated in Field 11 and/or Field 9. Do not enter any amount previously paid by Medicaid. (See NOTE below Field 30.)
30. Balance Due	Enter the net charge. This amount is obtained by subtracting the amount received from other sources from the total charge. **NOTE: For Fields 28, 29 and 30, up to 26 lines may be billed per claim. To bill a continued claim, enter the page number of the continued claim here (e.g., page 1 of 3, page 2 of 3). On the last page of the claim, enter the total charges due.**
31. Signature of Physician or Supplier, Including Degrees or Credentials	The provider or designated authorized individual must sign and date the claim certifying that the services were personally rendered by the provider or under the provider's direction. "Provider's signature" is defined as the provider's actual signature, a rubber stamp of the provider's signature, an automated signature, a typewritten signature or the signature of an individual authorized by the provider rendering the service. The name of a clinic or group is not acceptable.
32. Name and Address of Facility Where Services Were Rendered (If Other Than Home or Office)	If other than home or office, enter the name and address, specifying the street, city, state and ZIP code of the facility where services were performed.
33. Physician's/Supplier's Billing Name, Address, ZIP Code & Phone #	Enter the billing provider's name and complete address. Telephone number is requested but not required.
PIN #	This field is not required for Medicaid.
GRP #	Clinic or Group Providers: Enter the 9-digit pay-to provider number in Field 33 after "GRP#" and the individual practitioner's number in Field 24K. Individual Providers: Enter the 9-digit pay-to provider number in Field 33 after "GRP#."