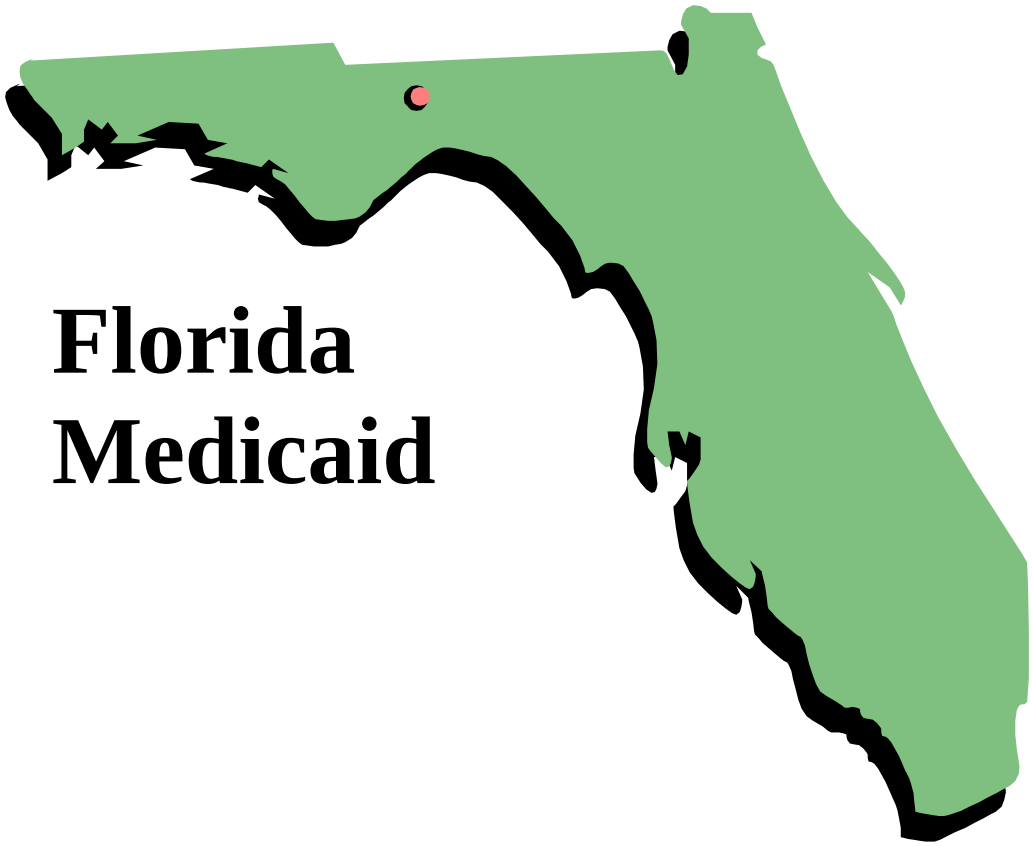

Florida Medicaid

AMBULANCE TRANSPORTATION SERVICES COVERAGE AND LIMITATIONS HANDBOOK

Agency for Health Care Administration

August 2013

FLORIDA AGENCY FOR HEALTH CARE ADMINISTRATION

UPDATE LOG

AMBULANCE TRANSPORTATION SERVICES COVERAGE AND LIMITATIONS HANDBOOK

How to Use the Update Log

Introduction

The current Medicaid provider handbooks are posted on the Medicaid fiscal agent's Web site at www.mymedicaid-florida.com. Select Public Information for Providers, then Provider Support, and then Provider Handbooks. Changes to a handbook are issued as handbook updates. An update can be a change, addition, or correction to policy. An update will be issued as a completely revised handbook.

It is very important that the provider read the updated material in the handbook. It is the provider's responsibility to follow correct policy to obtain Medicaid reimbursement.

Explanation of the Update Log

Providers can use the update log to determine if they have received all the updates to the handbook.

Update describes the change that was made.

Effective Date is the date that the update is effective.

Instructions

When a handbook is updated, the provider will be notified by a notice. The notification instructs the provider to obtain the updated handbook from the Medicaid fiscal agent's Web site at www.mymedicaid-florida.com. Select Public Information for Providers, then Provider Support, and then Provider Handbooks.

Providers who are unable to obtain an updated handbook from the Web site may request a paper copy from the Medicaid fiscal agent's Provider Support Contact Center at 1-800-289-7799.

UPDATE	EFFECTIVE DATE
Jul2005 – New Handbook	July 2005
Feb2006 – Revised Handbook	February 2006
May 2013 – Revised Handbook	August 2013

AMBULANCE TRANSPORTATION SERVICES COVERAGE AND LIMITATIONS HANDBOOK

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INTRODUCTION TO THE HANDBOOK

Overview

Introduction

This chapter introduces the format used for the Florida Medicaid handbooks and tells the reader how to use the handbooks.

Background

There are three types of Florida Medicaid handbooks:

- Provider General Handbook describes the Florida Medicaid Program.
- Coverage and Limitations Handbooks explain covered services, their limits, who is eligible to receive them, and the fee schedules.
- Reimbursement Handbooks describe how to complete and file claims for reimbursement from Medicaid.

All Florida Medicaid Handbooks may be accessed via the internet at: www.mymedicaid-florida.com. Select Public Information for Providers, then Provider Support and then Handbooks.

Legal Authority

The following federal and state laws govern Florida Medicaid:

- Title XIX of the Social Security Act;
- Title 42 of the Code of Federal Regulations;
- Chapter 409, Florida Statutes; and
- Chapter 59G, Florida Administrative Code.

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This chapter contains:

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Handbook Use and Format

Purpose	The purpose of the Medicaid handbooks is to provide the Medicaid provider with the policies and procedures needed to receive reimbursement for covered services provided to eligible Florida Medicaid recipients. The handbooks provide descriptions and instructions on how and when to complete forms, letters or other documentation.
Provider	The term “provider” is used to describe any entity, facility, person or group who is enrolled in the Medicaid program and provides services to Medicaid recipients and bills Medicaid for services.
Recipient	The term “recipient” is used to describe an individual who is eligible for Medicaid.
General Handbook	General information for providers regarding the Florida Medicaid program, recipient eligibility, provider enrollment, fraud and abuse policy, and important resources are included in the Florida Medicaid Provider General Handbook. This general handbook is distributed to all enrolled Medicaid providers and is updated as needed.
Coverage and Limitations Handbook	Each coverage and limitations handbook is named for the service it describes. A provider who provides more than one type of service will have more than one coverage and limitations handbook.
Reimbursement Handbook	Each reimbursement handbook is named for the claim form that it describes.
Chapter Numbers	The chapter number appears as the first digit before the page number at the bottom of each page.
Page Numbers	Pages are numbered consecutively throughout the handbook. Page numbers follow the chapter number at the bottom of each page.
White Space	The "white space" found throughout a handbook enhances readability and allows space for writing notes.

Characteristics of the Handbook

Format	The format styles used in the handbooks represent a short and regular way of displaying difficult, technical material.
Information Block	Information blocks replace the traditional paragraph and may consist of one or more paragraphs about a portion of the subject. Blocks are separated by horizontal lines. Each block is identified or named with a label.
Label	Labels or names are located in the left margin of each information block. They identify the content of the block in order to help scanning and locating information quickly.
Note	Note is used most frequently to refer the user to important material located elsewhere in the handbook. Note also refers the user to other documents or policies contained in other handbooks.
Topic Roster	Each chapter contains a list of topics on the first page, which serves as a table of contents for the chapter, listing the subjects and the page number where the subject can be found.

Handbook Updates

Update Log	The first page of each handbook will contain the update log. Every update will contain a new updated log page with the most recent update information added to the log. The provider can use the update log to determine if all updates to the current handbook have been received. Each update will be designated by an “Update” and the “Effective Date.”

Handbook Updates, continued

How Changes Are Updated	The Medicaid handbooks will be updated as needed. Changes may be: 1. Replacement handbook-Major changes will result in the entire handbook being replaced with a new effective date throughout and it will be a clean copy. 2. Revised handbook-Changes will be highlighted in yellow and will be incorporated within the appropriate chapter. These revisions will have an effective date that corresponds to the effective date of the revised handbook.
Effective Date of New Material	The month and year that the new material is effective will appear at the bottom of each page. The provider can check this date to ensure that the material being used is the most current and up to date.
Identifying New Information	New material will be identified by yellow highlighting. The following information blocks give examples of how new labels, new information blocks, and new or changed material within an information block will be indicated.
New Label and New Information Block	A new label and a new information block will be identified with yellow highlight to the entire section.
New Material in an Existing Information Block or Paragraph	New or changed material within an existing information block or paragraph will be identified by yellow highlighting to the sentence and/or paragraph affected by the change.

CHAPTER 1
AMBULANCE TRANSPORTATION SERVICES PROVIDER QUALIFICATIONS AND ENROLLMENT

Overview

Introduction

This chapter describes Medicaid ambulance transportation provider qualifications, enrollment, and responsibilities.

Legal Authority

Medicaid ambulance transportation services are authorized by Chapter 409, Florida Statutes (F.S.), and Chapter 59G, Florida Administrative Code (F.A.C.).

In This Chapter

This chapter contains:

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Purpose and Definitions

Purpose of This Handbook

This handbook is intended for use by providers of ambulance transportation services to Medicaid recipients. Ambulance providers must use this handbook in conjunction with the Florida Medicaid Provider General Handbook, which contains general information about the Medicaid program, and the Florida Medicaid Provider Reimbursement Handbook, CMS-1500, which contains procedures for submitting claims.

Purpose and Definitions, continued

Advanced Life Support (ALS)	The provision of medically necessary supplies and services during ground ambulance transportation, including the provision of at least one ALS intervention. The ALS intervention must be medically necessary and in accordance with state and local laws, required to be done by an emergency medical technician-intermediate (EMT-Intermediate) or EMT-Paramedic.
Advanced Life Support, Level 2 (ALS2)	The provision of medically necessary supplies and services during ground ambulance transportation, including (1) at least three separate administrations of one or more medications by intravenous push/bolus or by continuous infusion (excluding crystalloid fluids) or (2) medically necessary supplies and services, and the provision of at least one of the following ALS2 procedures: manual defibrillation/cardioversion; endotracheal intubation; central venous line; cardiac pacing; chest decompression; surgical airway; or intraosseous line. The medically necessary services must be provided by an emergency medical technician-intermediate (EMT-intermediate) or EMT-Paramedic.
Air Ambulance	An air ambulance is a fixed-wing or rotary-wing aircraft used for, or intended to be used for, air transportation of sick or injured persons who may require, or are likely to require, medical attention during transport.
Ambulance Transportation	Medicaid ambulance transportation services provide medically necessary ambulance transportation to Medicaid eligible recipients.
Basic Life Support (BLS)	The provision of medically necessary supplies and services during ground ambulance transportation. The ambulance must be staffed by an individual who is qualified in accordance with state and local laws as an emergency medical technician-basic (EMT-Basic).
Ground Ambulance	Ground ambulance is a privately or publicly owned land vehicle that is designed, constructed, reconstructed, maintained, equipped, operated for and used for, or intended to be used for, land transportation of sick and injured persons who are likely to require medical attention during transport.
Specialty Care Transport (SCT)	Interfacility transportation of a critically injured or ill beneficiary by a ground ambulance vehicle, including the provision of medically necessary supplies and services, at a level of service beyond the scope of the EMT-Paramedic. SCT is necessary when a beneficiary's condition requires ongoing care that must be furnished by one or more health professionals in an appropriate specialty area, for example, emergency or critical care nursing, emergency medicine, respiratory care, cardiovascular care, or a paramedic with additional training.

Ambulance Provider Enrollment and Qualifications

Introduction	To receive Medicaid reimbursement, an ambulance provider must enroll in Medicaid as an ambulance provider and meet the provider qualifications at the time the service is rendered. Note: See the Florida Medicaid Provider General Handbook for provider enrollment qualifications.
Provider Types Who May Enroll	Air and land ambulance companies are eligible to enroll as ambulance providers. If an ambulance company is also providing non-emergency stretcher van services, the company must be subcontracted with the Medicaid non-emergency transportation provider.
Air Ambulances	Air ambulances must be licensed by the Department of Health, Office of Emergency Medical Services, in accordance with section 401.251, F.S. and Chapter 64J-1.005, F.A.C.
Ground Ambulances	Ground ambulance services must be licensed in accordance with Chapter 401, F.S. Ground ambulance services can transport individuals on an emergency or non-emergency basis under the requirements of their ambulance services licenses.
Ambulance Companies	Ambulance companies are required to meet the insurance standards in section 401.25, F.S. and Chapter 64J-1, F.A.C.

Ambulance Provider Responsibilities

General Responsibilities

Ambulance providers must comply with the provider responsibilities in this handbook and the provider responsibilities contained in the Florida Medicaid Provider General Handbook.

Health Insurance Portability and Accountability Act (HIPAA)

As trading partners with Florida Medicaid, all Medicaid providers, including their staff, contracted staff and volunteers, must comply with the confidentiality requirements related to protected health information contained in Title 45 of the Code of Federal Regulations (CFR), Part 160.

Providers who meet the definition of a covered entity according to HIPAA must comply with HIPAA and Health Information Technology for Economic and Clinical Health Act (HITECH) Security and Privacy rules, as well as HIPAA Electronic Data Interchange (EDI) requirements. In addition, providers must also maintain HIPAA/HITECH compliant Business Associate Agreements with all business associates. Providers must comply with the regulations pertaining to the safeguarding of information on Medicaid applicants and recipients [42 CFR Part 431, sections 431.300 – 431.307] to the same extent as the Agency for Health Care Administration (AHCA).

This handbook contains the information regarding changes in procedure codes mandated by HIPAA. The Florida Medicaid provider reimbursement handbooks contain the claims processing requirements for Florida Medicaid, including the necessary changes to comply with HIPAA.

Note: For more information regarding HIPAA privacy in Florida Medicaid, see the Florida Medicaid Provider General Handbook.

Note: For more information regarding claims processing changes in Florida Medicaid because of HIPAA, see the Florida Medicaid Provider Reimbursement Handbook, CMS-1500.

Note: For more information regarding changes in EDI requirements for Florida Medicaid because of HIPAA, contact the fiscal agent EDI help desk at 1-866-586-0961.

Providers Contracted with Medicaid Health Plans

The service-specific Medicaid coverage and limitations handbooks provide the minimum requirements for all providers. This includes providers who contract with Florida Medicaid health plans (e.g., provider service networks, health maintenance organizations, pre-paid mental health plans, etc.) Providers shall comply with all of the requirements outlined in this handbook, unless otherwise specified in their contract with the health plan. The provision of services to recipients enrolled in a Medicaid health plan shall not be more stringent than the limitations specified in this handbook.

CHAPTER 2
AMBULANCE TRANSPORTATION SERVICES
COVERED SERVICES LIMITATIONS AND EXCLUSIONS

Overview

Introduction

This chapter describes Medicaid ambulance transportation services, limitations, exclusions, and prior authorization process.

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Service Requirements

Introduction

Medicaid may only reimburse for medically necessary ambulance services provided to eligible Medicaid recipients.

Service Requirements, continued

Medical Necessity

Medicaid reimburses services that are determined medically necessary and do not duplicate another provider's service.

Rule 59G-1.010(166), Florida Administrative Code (F.A.C.) defines "medically necessary" or "medical necessity" as follows:

"[T]he medical or allied care, goods, or services furnished or ordered must:

(a) Meet the following conditions:

1. Be necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain;
2. Be individualized, specific, consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the recipient's needs;
3. Be consistent with generally accepted professional standards as determined by the Medicaid program, and not be experimental or investigational;
4. Reflect the level of services that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available statewide; and
5. Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider."

"(c) The fact that a provider has prescribed, recommended, or approved medical or allied care, goods, or services, does not, in itself, make such care, goods or services medically necessary or a covered service."

Service Requirements, continued

Medical Conditions List	The Medical Conditions List contains ambulance codes for both emergency and non-emergency conditions. The condition code is based on the recipient's condition at the time of transport as observed and documented by the ambulance crew. Use of the condition codes will not guarantee payment of the claim or payment for a certain level of service. Ambulance providers and suppliers must retain adequate documentation of the patient's condition, other on-scene information, and details of the transport (e.g., medications administered, changes in the patient's condition, and miles traveled), all of which may be subject to medical review by Medicaid or Medicaid's authorized representative. Medicaid will rely on medical record documentation to justify coverage, not simply the condition codes by themselves. Note: To obtain a copy of the most updated Medical Conditions List codes, please view the Current Medicare Claims Processing Manual, Chapter 15, for Ambulance on the Centers for Medicare & Medicaid Services Web site, www.cms.gov. If the recipient's medical condition is not included on the Medical Conditions List, but appears to the ambulance provider to meet Medicaid's definition of medical necessity, the ambulance provider must obtain authorization from the Medicaid area office to be reimbursed for the trip.
Exceptions to the Limits (Special Services) Process	As required by federal law, Florida Medicaid provides services to eligible children under the age of 21, if such services are medically necessary to correct or ameliorate a defect, a condition, or a physical or mental illness. Included are diagnostic services, treatment, equipment, supplies, and other measures described in Section 1905(a) of the Social Security Act, codified in 42 USC 1396d(a). Services requested in excess of limitations described within this handbook or the associated fee schedule for children under the age of 21, may be approved if medically necessary through the prior authorization process described in Chapter 2 of this handbook.
Recipient Eligibility for Ambulance Services	The recipient must be eligible for Medicaid on the date the service is rendered. If the recipient was ineligible on the date of service, but subsequently became retroactively eligible for the date of service, Medicaid can reimburse the claim. If the service requires authorization, post authorization can be granted when the recipient was ineligible or pending an eligibility determination on the date of service and subsequently became retroactively eligible.
Nearest Facility	All ambulance transports should be to the nearest facility within the same locality that is capable of providing the appropriate service.

Covered Services

Levels of Life Support Services for Ground Ambulances

Medicaid will reimburse for ground ambulance services when the recipient's condition falls within one or more of the condition codes listed on the Medical Conditions List, pending Medicaid eligibility on the date of service.

Medicaid reimburses an all-inclusive fee for Advanced Life Support (ALS), Advanced Life Support Level 2 (ALS2), Basic Life Support (BLS), and Specialty Care Transport (SCT) service levels. Medicaid reimbursement for ALS, ALS2, BLS, or SCT is based on the recipient's medical condition at the time of transport as listed on the Medical Conditions List, as well as the level of life support service(s) provided for the recipient during transport. The Medical Conditions List indicates whether a condition requires ALS or BLS services.

Medicaid will not pay ALS rates when the recipient's condition, as listed on the Medical Conditions List, requires only BLS services, even if the vehicle is licensed and equipped for ALS services. Medicaid will also not pay ALS2 or SCT rates when the specific criteria defining those emergency services are not met or cannot be verified.

In-State Air Ambulance

Medicaid will reimburse an all-inclusive fee for air ambulance when the recipient's condition falls within one or more of the condition codes listed on the Medical Condition List on the date of service and the transport is:

- A critical emergency situation in which life, limb, or essential body or organ function is jeopardized;
- A medical situation in which time constraints make the use of ground ambulance impractical.

Emergency Transportation

Medicaid reimburses for emergency transportation (ALS or BLS) by ambulance, whether ground or air. Emergency transportation is necessary when the recipient has an emergency medical condition as defined in the Florida Medicaid Provider General Handbook.

Emergency transportation does not require prior authorization. However, the provider must document the medical necessity of the emergency and keep the documentation on file for five years for every Medicaid recipient transported by emergency vehicle.

Scheduled ambulance service (ALS or BLS) is not emergency transportation. All scheduled ambulance services must be authorized before providing the service.

Note: See Prior Authorization for Ambulance Services in this chapter for information on the procedures and services that require authorization.

Covered Services, continued

Closure or Decertification of a Nursing Facility	Medicaid reimburses for medically necessary ambulance transportation of a recipient from one nursing facility to another or to an alternate living arrangement when the Agency for Health Care Administration has begun a closure or decertification of a nursing facility. The Medicaid area office manager or designee can authorize transport on a one-time exception basis. The ambulance provider must send the claims to the Medicaid area office.
Nursing Facility Not Equipped to Provide Required Level of Care Services	Medicaid reimburses for ambulance transportation of a recipient from one nursing facility to another nursing facility when the recipient has a change in level of care that results in the facility not being certified or equipped to provide medically necessary or specialized services.
Baker Act Recipients	The Baker Act refers to action taken by the state to protect those individuals who are classified as being a danger to themselves or others. When a Baker Act recipient requires transportation to a facility or institution, the county's designated law enforcement agency is responsible for providing for the transportation. If a Medicaid eligible, Baker Act recipient requires Medicaid-compensable services such as medical assessments or diagnosis that cannot be furnished at the receiving facility prior to institutionalization, then Medicaid will reimburse for transportation to the medically necessary services while the individual is under Baker Act prior to institutionalization.
Out-of-County Ground Transport	If the recipient is transported out of the county in which the recipient was picked up, Medicaid reimburses $3.00 per mile plus the base rate. This rate begins at the point of pickup. Note: See Authorization for Ambulance Services in this chapter for information on negotiated rates for out-of-county transports greater than 30 miles.

Covered Services, continued

Hospital to Hospital Transfer

Medicaid reimburses for ambulance transportation when a recipient is transferred from one hospital to another hospital if the level of care or availability of treatment cannot be met by the first hospital. In such cases, Medicaid will reimburse for medically necessary ambulance transportation to a hospital within the same locality that can provide the services the recipient needs.

If the recipient is in a Medicaid health plan and the transfer is at the request of the health plan due to non-participation in the health plan's network, reimbursement is the responsibility of the health plan.

Billing Ambulance vs. Stretcher Van

Ambulance transportation services are reimbursed according to the vehicle type and services used that are necessary for the recipient's physical and mental needs. When the recipient's condition is not listed on the Medical Conditions List, a stretcher van or other type of non-emergency transportation may be more appropriate than an ambulance.

In order to be reimbursed for stretcher van services, the ambulance provider must be subcontracted to provide stretcher van services. Ambulance providers may not bill Medicaid directly for stretcher van services.

Limitations and Exclusions

Recipient Traveling Out-of-State

Florida Medicaid reimburses emergency services for recipients traveling out-of-state without a prior authorization to receive medical treatment, but does not reimburse for emergency transportation services to return the recipient back to Florida.

Note: See the Florida Medicaid Provider General Handbook for information on out-of-state services.

Therapeutic Home Visits

Medicaid does not reimburse for ambulance transportation for therapeutic home visits to or from a hospital, hospice, nursing home, intermediate care facility for the developmentally disabled (ICF/DD), state or other private or public institution.

Transportation Due to Recipient Preference

Medicaid does not reimburse for ambulance transportation of a recipient from one hospital to another, one nursing facility to another, or from a hospital to a nursing facility based on the recipient, recipient's family, or recipient's preference.

Limitations and Exclusions, continued

Transportation of a Deceased Recipient	Medicaid does not reimburse for transportation of deceased recipients.

Authorization for Ambulance Services

Non-Emergency Ambulance Transportation Authorization	Non-emergency ground or air ambulance services require prior authorization if: • The recipient's medical condition is not included on the Medical Conditions List for non-emergency codes; • Due to unusual circumstances, the ambulance provider requests a negotiated rate; or • The ambulance transportation is to a destination outside of Florida. An exception is for transportation to a facility or a provider bordering Florida (Georgia or Alabama), if Florida Medicaid recipients normally go to that border facility or provider for medically necessary services.
Post Authorization	The ambulance provider must request post authorization from the Medicaid area office within 20 business days of providing the non-emergency ambulance transportation services. Authorization that is requested more than 20 business days from the date of service will be denied. Exceptions can be granted for recipients who become retroactively eligible for Medicaid.
Authorization for Negotiated Rates	Negotiated rates for ground or air ambulance transportation must be authorized as specified in this chapter by the Medicaid area office that has jurisdiction over the Medicaid recipient's county of residence. Providers must submit sufficient documentation to the Medicaid area office regarding the specific circumstance that necessitates a negotiated rate. Negotiated rates are based on: • Out-of-county transports greater than 30 miles from the point of pickup; or • Circumstances where the recipient's condition is not listed on the Medical Conditions List in effect at the time of service. If the Medicaid area office denies the authorization request for a negotiated rate, the Medicaid area office must provide the ambulance provider a written statement summarizing the reason for the denial. Note: The Medicaid area offices' phone numbers and addresses are available on AHCA's Web site at www.ahca.myflorida.com. Click on Medicaid, then on Area Offices. The phone numbers and addresses are also in the Florida Medicaid Provider General Handbook.

Authorization for Ambulance Services, continued

Authorization for Transportation from Florida to Another State

For non-emergency ambulance transportation from Florida to an out-of-state destination, except to a Georgia or Alabama facility or provider that recipients normally utilize for medically necessary services, the Medicaid area office must determine that, on the basis of medical recommendations and documentation, the medically necessary, services, or necessary supplementary resources are not available to a recipient in Florida. Once it is determined that services can only be rendered by a provider in another state, the non-emergency ambulance provider must follow the negotiated rate authorization instructions if requesting a negotiated rate for the trip.

Note: See Out-of-State Enrollment in the Florida Medicaid Provider General Handbook for information on when Florida Medicaid can reimburse an out-of-state provider and the process for filing a claim. The out-of-state services must be coordinated with the Medicaid area office.

Approved Requests

If the authorization request is approved, the Medicaid area office notifies the ambulance provider.

An approved authorization is not a guarantee that Medicaid will reimburse for the service. The recipient must be eligible and the ambulance provider must be enrolled on the date of service, and the ambulance provider must submit a clean claim within the time limit for submitting claims.

Note: See the Florida Medicaid Provider Reimbursement Handbook, CMS-1500, for instructions on completing and submitting claims and the definition of a clean claim.

Denied Requests

If the prior or post authorization is denied, the Medicaid area office will notify the provider in writing within 10 business days.

The recipient may request a Medicaid fair hearing of the denial to:

Department of Children and Families
Office of Appeals Hearings
1317 Winewood Boulevard, Building 15, Room 203
Tallahassee, Florida 32399-0700

CHAPTER 3
AMBULANCE TRANSPORTATION SERVICES PROCEDURE CODES AND FEE SCHEDULE

Overview

Introduction

This chapter describes the procedure codes, fees, and modifiers for Medicaid reimbursable ambulance transportation services.

In This Chapter

This chapter contains:

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Reimbursement Information

Procedure Codes

The procedure codes listed in this handbook are Healthcare Common Procedure Coding System (HCPCS) Level II, which is part of the nationally standardized code set. Level II of the HCPCS is used primarily to identify products, supplies, and services not included in the Current Procedural Terminology codes. HCPCS Level II codes are also referred to as alpha-numeric codes because they consist of a single alphabetical letter (A-V) followed by four numeric digits. Please refer to the current HCPCS Level II Expert code book for complete descriptions of the standard codes. The HCPCS Level II Expert © code book is copyrighted by Ingenix, Inc. All rights reserved.

How to Read the Fee Schedule

Code	The number in this column identifies the procedure being billed.
Modifier	A modifier is an alpha or numeric code that is added to a procedure code to adapt or add to the procedure code description. Note: See the Florida Medicaid Provider Reimbursement Handbook, CMS-1500, for additional information on entering modifiers on the claim form.
Description of Service	The information in this column describes the service or procedure associated with the procedure code.
Standard Fee	The fee in this column is the standard amount Medicaid will pay for the procedure.
SPEC	An alphabetic code in this column indicates special requirements for submission of a claim for that procedure. A “PA” in the SPEC column identifies a procedure code that must be prior authorized before the provider renders the service. Note: See Chapter 2 in this handbook, Prior Authorization for Ambulance Services, for the prior authorization procedures.

APPENDIX A
AMBULANCE TRANSPORTATION SERVICES
PROCEDURE CODES AND STANDARD FEE SCHEDULE

APPENDIX A
AMBULANCE TRANSPORTATION SERVICES
PROCEDURE CODES AND STANDARD FEE SCHEDULE

Ground Ambulance Emergency Codes

CODE	MODIFIER	DESCRIPTION OF SERVICE	STANDARD FEE	SPEC
A0429		Ambulance Service, Basic Life Support	$136.00	
A0427		Ambulance Service, Advanced Life Support	$190.00	
A0999	QN	Negotiated Transportation Service	As Negotiated	PA
A0433		Advanced Life Support, Level 2 (ALS2)	$250.00	
A0434		Specialty Care Transport (SCT)	$295.00	

Ground Ambulance Non-Emergency Codes

CODE	MODIFIER	DESCRIPTION OF SERVICE	STANDARD FEE	SPEC
A0428		Ambulance Service, Basic Life Support	$136.00	
A0426		Ambulance Service, Advanced Life Support	$190.00	
A0999	QN	Negotiated Transportation Service	As Negotiated	PA

Air Ambulance Codes

CODE	MODIFIER	DESCRIPTION OF SERVICE	STANDARD FEE	SPEC
A0430		Air Ambulance Fixed Wing	$1,000.00	
A0431		Air Ambulance Rotary Wing	$1,000.00	
A0435		Ambulance Service, Service Mileage, Fixed Wing	$4.00 per air mile	
A0436		Ambulance Service, Service Mileage, Rotary Wing	$4.00 per air mile	
A0999	QN	Negotiated Transportation Service	As Negotiated	PA