Medi-Cal 2017
(think of a happy place!)

Medi-Cal 2017
• The end of the X codes
• Name change to Conduent
• The beginning of Claim Audits
  • ECS
  • Paper
• Change to Emergency Certification Statement

The X codes are gone!
• Last X codes allowed June 2016
• One year to bill Medi-Cal
• Medi-Cal HMOs appear to have transitioned
Medi-Cal
Carrier Name Change
Xerox is now Conduent
(April 2017 bulletin)

Medi-Cal is Auditing Claims

Probable Implementation of Audits

<table>
<thead>
<tr>
<th>Date/Type</th>
<th>Audit</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>July 2016 / ECS</td>
<td>Emergency Cart For Mls and Oxygen</td>
<td>0369</td>
</tr>
<tr>
<td>Oct 2016 / ECS</td>
<td>Start/End Time for UT (Night)</td>
<td>0076</td>
</tr>
<tr>
<td>April 2016 / 08er</td>
<td>Above audits added to paper</td>
<td>0369 and 0076</td>
</tr>
</tbody>
</table>
Emergency Cert Audit

- 0369 Denial Code
- For Miles, Oxygen, Wait time
- "Billing Comments" review checks the Emergency Certification Statement.
- "Why the line item not the claim?"

Non Abbreviated Destination

- Official Statement (Nov 1, 2016)
  "Claims submitted with an acronym in place of a hospital name (for example, VMC) will be denied. Abbreviations are acceptable (for example Valley Med. Ctr.)."

Non Abbreviated Destination, My Rules

- RMC is BAD
- Reg Med Ctr is not great
- Reg Med Ctr HOSP is better
- Reg Med Center HOSPITAL is best
The Attending Physician

- "Billing Comments" review checks the attending physician is listed
- Conduent will also verify the NPI of the physician

The Attending Physician Official Statement

"Providers are reminded that on the emergency statement the physician accepting responsibility for the recipient must be "a Doctor of Medicine (M.D.) (Nov 1, 2016)"

The Attending Physician Update

- Update clarifies physician requirements.
  "Additionally, the emergency department physician or medical director can now accept responsibility for the recipient." (April 2017)
The Attending Physician,
My Rules

- Staff MD is bad
- Non Transports: use County Medical Director
- Transports: TRY to get the physician name and NPI when possible
  - Alternately, use the head of the ER
  - Don’t forget to verify the NPI

The Emergency Cert Statement prior to April 2017
- The “old rules” (prior to April 2017)
  - Name of the person or agency (911)
  - Nature of the Emergency (diagnosis)
  - The name of the Hospital (no acronym)
  - Clinical Information (treatments)
  - Why services considered immediately necessary
  - The name of the accepting physician

The Emergency Cert Statement after April 2017
The “new” rules (mc gnd trans pg. 3)
- Nature of the Emergency (diagnosis)
- The name of the hospital (no acronym)
- The name of the accepting physician
My Rules Location / Keywords (not listed but helps!)

• Include the location of the call
• (medi-cal can check mileage)
• Try to include Keywords
• words EMERGENCY or HLOC
• (along with emergency check box)
• The word AMBULANCE
• (vs littervan or wheelchair)

Night charge Audit

• Confusion about night charge standards
  • DHCS clarified Night Charge Pays if either time occurs at night
  • Clarification was around June 2017
  • Began requiring Start and End Time to validate night charge (Oct 2016)
  • Use Unit Alert for Start
  • Use Unit At Destination for End

Night charge Audit My Rules (not listed but helps!)

• Do not need the date
• Include the word NIGHT
• Designate the time type (start/end)
• The time format is important
• Use standard time not military
  • GOOD Start 1:05 am, End 1:42 am
  • BAD 01:05, 01:42
The Paper Certification

If you are billing on Paper

• You may include the PCR
• Put “see attached” in box 3-
• Use a separate piece of paper
• Titled “Emergency Certification” at the top and include the Certification pieces

The Paper Cert Example

EMERGENCY CERTIFICATION / ADDITIONAL COMMENTS

PATIENT NAME: [FIRST LAST]
INSURANCE ID: [MEDICAL ID]
PATIENT ACCOUNT: [OUR TICKET ID]

START TIME: 12:42 AM, END TIME: 1:32 AM NIGHT TRAN.
EMERG AMBUL, PM RESIDENCE: 1333 6TH ST, MENDOTA, CA
REG. MED. HOSP. 3220 FRESNO ST, FRESNO, CA
PT ACUTE CONDITION REQUIRED: ECG.

The ECS Certification

If you are billing Electronically

• 80 characters per claim
• 80 characters per line item (depending on software)
• 160 (non transport) to
• 400 (base, miles, O2, ecg) could be available
The ECS Certification

• Check with software vendor to utilize the 80 characters per line item
• The vendor will need to “tweak” ECS settings to open up additional comments.

The Zoll Solution

• Begin narrative in narrative field, tab 2, (this field allows 80 characters).
• Each charge line item you can add up to 80 characters
  • Base rate, mileage, EKG, Oxygen and then wait time
  • you cannot add to a narrative for the night charge.

The Zoll Screen
Medi-Cal Summary

- 0369 Denial, fix destination and physician and rebill (or appeal)
  - A0425 (Mile)
  - A0432 (Oxygen)
  - A0432 (O不了)
- 0076 Denial, fix end time, time format and rebill (or appeal)
  - A0427/A0429 with UJ Modifier

Logisticare 2017

In California:
- Anthem Blue Cross Medi-Cal
- Alameda Alliance
- Health Net CalViva
- Health Net Medi-Cal
- L.A. Care Health Plan

https://facilityinfo.logisticare.com/cafacility/

Logisticare Feb 2017

- NEMT Bulliten
- Must have received auth from Logisticare for your provider
- Must have a trip log
- Medicare/Commercial as Primary excluded
**Logisticare 2017 recognized problems**

- Logisticare required prior auth for HLOC
- Logisticare required prior auth for Hosp to SNF

**OUTCOME:**
- Logisticare no longer requires an auth for these services
- effective 7/1/17 (Claim processing or date of service?)

---

**Logisticare 2017 recognized problems**

- Requiring information above and beyond Medi-Cal (ie, patient’s signature)

**OUTCOME:**
- Logisticare stated they are preventing fraud and abuse. If member cannot sign indicate on the trip ticket

---

**Logisticare 2017 recognized problems**

- Overpayments
  - Logisticare would process and pay “cross over” claims from Medicare that were already paid
    - Logisticare stated the claims come in without the MEOB (Medicare EOB) so the claim is paid in full.
    - Logisticare recommended provider follow policy
    - NOTE: Not sure they understood the cross over comes from Mcare?
  - Logisticare would process and pay scheduled claims at the wrong rates
    - Logisticare stated this was corrected.
Logisticare 2017 recognized problems

- Logisticare would delay payments, not pay in a timely manner
  - Logisticare stated they are working to resolve this problem.
  - NOTE: the squeaky wheel gets the grease?
- Logisticare EOBs (scheduled) do not provide detail of payment for process
  - Logisticare stated this was a system limitation and did not have a fix for this issue.

Logisticare 2017 recognized problems

- Wrong Billing Codes for non transport, specifically Logisticare required A0998 for non transport
  - HN Mcal stated logisticare resolved this problem
- Logisticare would not approve a claim if auth was given to wrong provider
  - Example: American Ambulance is called to transport, does not have unit available so Sequoia Safety Council transports. Logisticare denies because wrong agency transported patient
  - Logisticare said to follow policy

QUESTIONS?
Medical Transportation Services

Medi-Cal Provider Training 2017


DHCS
Medical Transportation Services
The Outreach and Education team includes Regional Representatives, the Small Provider Billing Unit (SPBU) and Coordinators who are available to train and assist providers to efficiently submit their Medi-Cal claims for payment.

The Medi-Cal Learning Portal (MLP) brings Medi-Cal learning tools into the 21st Century. Simply complete a one-time registration to gain access to the MLP’s easy-to-use resources. View online tutorials, live and recorded webinars from the convenience of your own office and register for provider training seminars. For more information call the Telephone Service Center (TSC) at 1-800-541-5555 or go to the MLP at http://www.medi-cal.ca.gov/education.asp.

Free Services for Providers

Provider Seminars and Webinars
Provider training seminars and webinars offer basic and advanced billing courses for all provider types. Seminars are held throughout California and provide billing assistance services at the Claims Assistance Room (CAR). Providers are encouraged to bring their more complex billing issues and receive individual assistance from a Regional Representative.

Regional Representatives
The 24 Regional Representatives live and work in cities throughout California and are ready to visit providers at their office to assist with billing needs or provide training to office staff.

Small Provider Billing Unit
The four SPBU Specialists are dedicated to providing one-on-one billing assistance for one year to providers who submit fewer than 100 claim lines per month and would like some extra help. For more information about how to enroll in the SPBU Billing Assistance and Training Program, call 916-636-1275 or 1-800-541-5555.

All of the aforementioned services are available to providers at no cost!
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</table>
Medical Transportation Services

Introduction

Purpose

The purpose of this module is to provide information about medical transportation for Medi-Cal recipients and California Children’s Services (CCS) clients. Restricted eligibility, aid codes, claim submission, documentation and the Treatment Authorization Request (TAR) are explained. Also included are the HIPAA-compliant Healthcare Common Procedure Coding System (HCPCS) Level II national codes.

Module Objectives

- Identify Medi-Cal transportation policy for Medi-Cal recipients and California Children’s Services clients.
- Define “emergency medical service.”
- Detail appropriate emergency service documentation requirements.
- Explain emergency and non-emergency transportation.
- List the medical transportation HCPCS Level II codes and modifiers.
- Examine the policy and billing requirements for medical transportation.
- Describe the field requirements of the CMS-1500 claim form.
- Illustrate medical transportation claim examples.
- Provide TAR/eTAR documentation examples.

Resource Information

**Medi-Cal Subscription Service (MCSS)**

MCSS is a free subscription service that enables providers and others interested in Medi-Cal to receive subject-specific links to Medi-Cal news, Medi-Cal Update bulletins, urgent announcements and/or System Status Alerts via email. For more information and subscription instructions, visit the MCSS Subscriber Form at [www.medi-cal.ca.gov/mcss](http://www.medi-cal.ca.gov/mcss).
References
The following reference materials provide Medi-Cal program and eligibility information.

Provider Manual References

Part 1

Aid Codes Master Chart (aid codes)
OBRA and IRCA (obra)

Part 2

Ancillary Codes (ancil cod)
CMS-1500 Completion (cms comp)
Medical Transportation – Air (mc tran air)
Medical Transportation – Air: Billing Codes and Reimbursement Rates (mc tran air cd)
Medical Transportation – Air: Billing Examples (mc tran air ex)
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Medical Transportation – Ground: Billing Examples (mc tran gnd ex)
Modifier Approved (modif app)
TAR and Non-Benefit List (tar and non)
TAR Completion (tar comp)

Other References
Medi-Cal website:
(www.medi-cal.ca.gov)
To access medical transportation information, click the “Code Conversions” link under the Hot News heading, then click the “Medical Transportation” link.

Acronyms
A list of current acronyms is located in the Appendix section of this workbook.
Program Coverage

Emergency medical services are offered to Medi-Cal recipients and CCS clients* who meet the eligibility requirements. Ambulance and other medical transportation services are reimbursable only when:

- Ordinary public or private conveyance is medically contraindicated.
- The transportation is required for obtaining medical care.

To be eligible for medical transportation services, recipients/clients must be eligible for Medi-Cal on the date of service.

* Medi-Cal generally refers to individuals eligible for services as “recipients” and CCS refers to them as “clients.”

Medi-Cal Emergency Medical Condition

An “emergency medical condition” is a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, which, in the absence of immediate medical attention, could reasonably be expected to result in any of the following:

- Placing the patient’s health in serious jeopardy
- Serious impairment to bodily functions
- Serious dysfunction to any bodily organ or body part

CCS Emergency Medical Condition

CCS program clients are eligible for inpatient and most outpatient services necessary for treatment of an emergency medical condition as certified by the attending physician or provider as appropriate.

If a client is hospitalized for services related to a CCS-eligible medical condition, the emergency inpatient services require authorization. All hospitalizations are subject to CSS approval. Providers must submit a Service Authorization Request (SAR) to the appropriate CCS county or regional office by the first business day following the date of admission. The facility must be CCS-approved.

NOTE

Inpatient hospital services and follow-up care provided after the emergency is resolved are not reimbursable under Medi-Cal when restricted to emergency services. If the emergency was related to the CCS-eligible medical condition, providers must submit claims as CCS only.

All services provided to inpatient clients by the hospital must be billed as inpatient services, even if services were rendered in the hospital’s outpatient department or emergency room.

June 2015
Eligibility Verification

Providers must verify the eligibility of a recipient/client every month using the Medi-Cal Point of Service (POS) network to find out what types of services are covered and if there are any limitations or special instructions.

The following messages indicate the recipient’s level of eligibility:

<table>
<thead>
<tr>
<th>Message</th>
<th>Eligibility</th>
</tr>
</thead>
<tbody>
<tr>
<td>“Subscriber is Medi-Cal Eligible with No Share of Cost/Spend Down.”</td>
<td>Full-scope</td>
</tr>
<tr>
<td>“Medi-Cal Eligible for Emergency Services.”</td>
<td>Restricted *</td>
</tr>
</tbody>
</table>

* Restricted to emergency services

Providers should document restrictions and only render those services for which the recipient/client is eligible. CCS clients who are undocumented U.S. residents (and some amnesty aliens) may be eligible for only certain restricted services.

**NOTE**

Refer to the *Aid Codes Master Chart* (aid codes) section of the Part 1 provider manual for more information about aid codes and restricted services.
Policies

Medical Transportation Code Conversion

Effective for dates of service on or after July 1, 2016, the Department of Health Care Services (DHCS) has discontinued the use of HCPCS Level III local modifier Z1 and replaced several HCPCS Level III local codes with HCPCS Level II national HIPAA-compliant codes used by Medicare.

The medical transportation code conversion had an initial effective date of April 1, 2015, however a transition period was established to allow providers time to begin billing with the HCPCS Level II national HIPAA-compliant codes. The transition period expired on June 30, 2016.

NOTE
A “crosswalk” guide to the medical transportation billing codes is available in the appendix of this workbook.

Mileage Billing Policy Update

For dates of service on or after July 1, 2016, providers are instructed to begin using HCPCS code A0425 (ground mileage, per statute mile) for ambulance transportation mileage for both emergency and non-emergency services.

Effective for dates of service on or after July 1, 2016, providers are instructed to begin using HCPCS code A0380 (BLS mileage [per mile]) for ground mileage for litter van and wheelchair mileage for non-emergency services only.

HCPCS code A0390 (ALS mileage [per mile]) is discontinued for dates of service on or after July 1, 2016.

NOTE
Medi-Cal will continue to reimburse claims billed with HCPCS codes A0380, A0390 and A0425 for litter van and wheelchair mileage through June 30, 2016.

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Current Billing (through June 30, 2016)</th>
<th>New Billing (on or after July 1, 2016)</th>
</tr>
</thead>
<tbody>
<tr>
<td>A0425</td>
<td>Wheelchair and litter van mileage</td>
<td>Ambulance mileage for both emergency and non-emergency services</td>
</tr>
<tr>
<td>A0380</td>
<td>Ambulance Basic Life Support (BLS) mileage</td>
<td>Wheelchair and litter van mileage for non-emergency services only</td>
</tr>
<tr>
<td>A0390</td>
<td>Ambulance Advanced Life Support (ALS) mileage</td>
<td>Discontinued</td>
</tr>
</tbody>
</table>
TAR Policy Update

Effective for dates of service on or after July 1, 2016, providers should prepare and submit Treatment Authorization Requests (TARs) and a Service Authorization Requests (SARs) as follows:

Retroactive and Deferred TARs

All TARs with local codes and/or a combination of HCPCS Level III and Level II procedure codes, whether approved, retroactive or deferred, will be end-dated for dates of service on or after July 1, 2016. Providers are encouraged to submit new TARs or eTARs with the appropriate HCPCS Level II national code(s) prior to July 1, 2016.

Bypassing Medical Authorization/Replacement TARs

For end-dated TARs or eTARs that included a medical authorization prior to July 1, 2016, providers should bypass the medical authorization process. This is accomplished by entering the approved TAR number in the Medical Justification field (Box 8C) of the TAR or the Enter Miscellaneous TAR Information field of the eTAR.

TARs Submitted After July 1, 2016

All TARs and eTARs submitted on or after July 1, 2016, that require authorization beyond July 1, 2016, will require submission of only HCPCS Level II national codes with applicable modifiers(s). Modifiers must be entered in the Medical Justification field (Box 8C) of the TAR or Enter Miscellaneous TAR Information field of the eTAR.
SAR Policy Update

SARs Extending After June 30, 2016

California Children’s Services (CCS) and Genetically Handicapped Persons Program (GHPP) providers should review medical transportation SARs that extend beyond June 30, 2016. Providers must submit a new SAR with the appropriate HCPCS Level II national code(s) to cover service periods after June 30, 2016.

SARs Previously Submitted with Through Dates Beyond June 30, 2016

Beginning July 1, 2016, SARs authorized with through dates beyond June 30, 2016, must be end-dated. Providers should ask for SARs containing HCPCS Level III local codes to be end-dated effective June 30, 2016.

SARs Submitted After July 1, 2016

Effective July 1, 2016, providers can begin requesting SARs with HCPCS Level II national codes for dates of service on or after July 1, 2016.

NOTE

SAR requests using HCPCS Level III local codes may only be submitted for dates of service ending on or before June 30, 2016.
Reminders

1. If a HCPCS Level II code is used on the claim multiple times, the HCPCS Level II code is entered only once on the TAR with the total number of units in the Units of Service field (Box 10B) of the TAR.

2. Providers are not required to use modifiers on TARs. However, providers must provide details related to the requested services in the Medical Justification field (Box 8C) on the paper TAR or in the Enter Miscellaneous TAR Information field of the eTAR.

3. If a TAR or SAR is submitted for the purpose of updating codes in the same authorization period, it will not be reviewed for medical necessity.

Acute Care Hospital/Long Term Care Facility

TAR Exceptions

For non-emergency transportation to move a recipient from an acute care hospital to a Long Term Care (LTC) facility, a TAR is not required. This is the only exception to the TAR requirement for non-emergency medical transportation and is indicated by the use of the HN + QN modifier on the claim form.

- The HN modifier must be the first modifier listed. This policy applies to transportation for recipients who receive acute care as hospital inpatients and who are being transferred to a Nursing Facility (NF) Level A or B.

Medi-Cal does not reimburse providers for waiting time or night calls when transporting a recipient from an acute care facility to an NF-A.

NOTES

___________________________________________________________________________
___________________________________________________________________________
___________________________________________________________________________
___________________________________________________________________________
___________________________________________________________________________
___________________________________________________________________________
___________________________________________________________________________

January 2017
TAR Completion and Submission Information

Medi-Cal strongly encourages the use of eTARs. Listed below are the benefits of submitting eTARs and tips on submitting paper TARs.

**eTARs**
- Faster response time
- Less expensive and less time consuming
- No mail delays, or postage
- Check status of eTARs online anytime

**Paper TARs**
Follow these tips to submit TARs correctly.
- TARs must be typed.
- Include necessary medical justification.
- Verify TAR information (provider number/National Provider Identifier [NPI], client ID, client sex, county code, aid code and date of birth).
- Include an original signature.

Verify the status of the TAR through the Provider Telecommunications Network (PTN) at 1-800-786-4346 or on the Medi-Cal website (www.medi-cal.ca.gov).

**NOTE**
Provider should refer to the monthly *Medi-Cal Update* and the *NewsFlash* on the Medi-Cal website for updates.
Documentation Example for eTAR

Night Call HCPCS Code A0428

Enter Miscellaneous TAR Information field includes:

- Hospital name
- Transportation destination
- Reason for transport
- Night call (include time and appropriate modifier)

La Palma InterCity Hosp. Called TXP To Fountain Valley Reg. Hospital For Fractured Leg. Night Call. Time: 1914. Modifier UJ.
Documentation Example for Paper TAR

**Share Ride HCPCS Code A0130**

*Medical Justification* field includes:

- Number of patients to be transported
- Initial location
- Destination location
- Type of transportation (for example, wheelchair van)
- Time of night call; include UJ modifier for night call
- Modifier UP to indicate non-emergency transport service for (3) patients

Transport (3 patients) Happytown Village to Dialysis. Clinic Time: (19:00). Wheelchair Van Night Call.

Required Mod. UP and UJ.
Medical Transportation – Ground

Program Coverage

Medi-Cal covers emergency and non-emergency medical transportation. Emergency medical transportation does not require authorization, but must be medically justified and documented. Non-emergency medical transportation is subject to authorization and is covered when the recipient’s medical and physical condition is such that transport by ordinary means of public or private conveyance is medically contraindicated and the transportation is required for the purpose of obtaining necessary health care covered by the Medi-Cal program.

To receive reimbursement, a client must have Medi-Cal and/or CCS eligibility on the date of service. All medical transportation related to the CCS client’s eligible medical condition requires submission of a SAR to the appropriate CCS county or regional office.

Transport Type

Authorization shall be granted or Medi-Cal reimbursement shall be approved only for the lowest cost type of medical transportation that is adequate for the recipient’s medical needs, and is available at the time transportation is required (California Code of Regulations [CCR] Title 22, Section 51323[b]).

Maintaining Transportation Records

Medical transportation providers are required to follow federal and state requirements when billing for services. Providers must keep, maintain and have readily retrievable records to fully disclose the type and extent of services provided (CCR, Title 22, Section 51476).

In addition, medical transportation providers must follow federal and state requirements for maintaining supporting documentation for drivers and vehicles associated with medical transportation services (CCR, Title 22, Sections 51476, 51231, 51231.1, 51231.2).
Emergency Ground Medical Transportation

Transportation to Nearest Hospital
Emergency medical transportation to the nearest hospital capable of meeting a recipient’s/client’s needs is covered only when transportation is medically necessary.

When the geographically nearest facility cannot meet the needs of a recipient/client, transportation to the closest facility able to provide the necessary medical care is appropriate under Medi-Cal. Coverage will be jeopardized if a recipient/client is not transported to the nearest acute hospital capable of meeting a recipient’s/client’s emergency medical needs (contract or non-contract).

NOTE
In non-emergency situations, physicians and hospitals that are not reimbursed according to the diagnosis-related group (DRG) reimbursement methodology must adhere to hospital contract regulations and admit recipients to the nearest contract hospital.

Transportation to a Second Facility
When the nearest facility serves as the closest source of emergency care and a recipient/client is promptly transferred to a more appropriate care facility, transportation from the first to the second facility is considered a continuation of the initial emergency trip. However, the transfer is not considered a continuation of the initial emergency trip if the provider’s vehicle leaves the facility to return to its place of business or to access another call.

Three types of vehicles provide non-emergency medical transportation: ambulances, litter vans and wheelchair vans. Ambulances are typically used in emergencies, but they may provide non-emergency transport for transfers.

If the recipient is an infant, the ambulance must have the necessary modular equipment.

NOTE
For complete information about ground medical transportation, please refer to the Medical Transportation – Ground (mc tran gnd) section in the appropriate Part 2 provider manual.
Clarification of Requirements for Medical Transportation Emergency Statement

When completing the emergency statement for air or ground medical transportation, providers must include the name of the hospital to which the recipient was transported in the Additional Claim Information field (Box 19) of the CMS-1500 claim form, the Remarks field (Box 80) of the UB-04 claim form or an attachment.

Claims submitted with an acronym in place of a hospital name (for example, VMC) will be denied. Abbreviations are acceptable (for example, Valley Med. Ctr.).

Providers are reminded that on the emergency statement the physician accepting responsibility for the recipient must be either a Doctor of Medicine (M.D.) or a Doctor of Osteopathic Medicine (D.O.).

NOTE
A physician’s signature is not required.

Tips
- The emergency statement must be typed or printed. Do not use a pre-printed checklist.
- The emergency indicator must be marked on all claim lines or emergency claims may be denied.
- Both the emergency certification and the emergency indicator(s) as appropriate must be present on the claim or the claim may be denied.
- Claims with both emergency and non-emergency services will be denied.
Emergency Transport Claim Example

Emergency Transport: from recipient's home to an acute care hospital.

Include an emergency statement (Box 19).

Include “X” indicator on all emergency claim lines (Box 24C).

January 2017
Non-Emergency Ground Medical Transportation

Non-Emergency Coverage
Non-emergency medical transportation (NEMT) is covered only when a recipient’s/client’s medical or physical condition does not allow travel by bus, passenger car, taxicab or another form of public or private conveyance. A TAR is required for non-emergency transportation, except when the transportation is from an acute care hospital to a Nursing Facility (NF) Level A or B.

NOTE
Reimbursement for NEMT services is only for benefits covered by Medi-Cal.
Non-Emergency Transport Claim Example

Non-Emergency Transport: from recipient's home to dialysis clinic and back.
Medical Transportation – Air

Provider Enrollment Requirements

Transportation providers who wish to render air medical transportation services to Medi-Cal recipients must first be certified by DHCS. Providers must also have a specific air transportation provider type, which requires certification by the Federal Aviation Administration (FAA).

**NOTE**
Providers cannot bill Medi-Cal for air medical transportations if they are only a ground medical transportation provider type.

Air Ambulance

An air ambulance is any aircraft specifically constructed, modified or equipped and used primarily for responding to emergency calls and to transport critically ill or injured patients. Air ambulances must have two medical flight crew members who are certified or licensed in advanced life support.

Transport Type

Authorization shall be granted or Medi-Cal reimbursement shall be approved only for the lowest cost type of medical transportation that is adequate for the recipient’s medical needs, and is available at the time transportation is required (CCR Title 22, Section 51323[b]).

Maintaining Transportation Records

Medical transportation providers are required to follow federal and state requirements when billing for services. Providers must keep, maintain and have readily retrievable records to fully disclose the type and extent of services provided (CCR, Title 22, Section 51476).

In addition, medical transportation providers must follow federal and state requirements for maintaining supporting documentation for drivers and vehicles associated with medical transportation services (CCR, Title 22, Sections 51476, 51231, 51231.1, 51231.2).

January 2016
Emergency Air Medical Transportation

Medi-Cal covers emergency air medical transportation to the nearest hospital capable of meeting a recipient’s needs. When the geographically nearest facility cannot meet a recipient's needs, the recipient should be transported to the nearest facility. Transporting a recipient to a facility that is not the nearest acute hospital can jeopardize coverage.

Services rendered by a provider other than the closest available air medical transportation provider require submission and approval of a TAR. HCPCS codes A0430 (ambulance service, conventional air services, transport, one way [fixed wing]) and A0431 (ambulance service, conventional air services, transport, one way [rotary wing]) do not require a TAR if the closest available provider renders the emergency medical transportation.

Out-of-state emergency air medical transportation services are only reimbursable with an approved TAR.

NOTE
For complete information about air medical transportation, please refer to the Medical Transportation – Air (mc tran air) section in the appropriate Part 2 provider manual.
Medical Transportation Modifiers

Providers are not always required to add modifiers to TARs. However, providers must enter details related to the services requested in the following fields:

- **Enter Miscellaneous TAR Information** box of the eTAR
- **Medical Justification** field (Box 8C) of the paper TAR

The new HCPCS codes and modifiers provide a more accurate picture of services rendered. Using the correct codes and modifiers is critical for receiving accurate claim reimbursements. Inappropriate or unnecessary modifier use will result in claim denial or delayed payments.

**Modifier 99**

Modifier 99 is not necessary to indicate multiple modifiers. Claims submitted with modifier 99 will be denied.

**Destination and Location Modifiers**

Unless indicated on the Medical Transportation Code Conversion Table (see appendix) location and destination modifiers should not be included on the claim. Claims submitted with location and destination modifiers other than those indicated in the crosswalk table, will be denied.

**Combination Modifier Codes: HN and QN**

For dates of service on or after July 1, 2016, modifiers HN + QN should be used for non-emergency wheelchair or litter van transportation from an acute care hospital to a skilled nursing facility.

In the following example, HCPCS code A0380 (BLS mileage [per mile]) is entered for one-way mileage. A TAR is not required for non-emergency wheelchair or litter van transportation from an acute care hospital to a skilled NF.

NOTE

HCPCS code A0380 can be used for non-emergency services.
Night Calls

When billing for transport service between 7 p.m. and 7 a.m., providers must use one of the following HCPCS codes with modifier UJ (services provided at night).

<table>
<thead>
<tr>
<th>HCPCS Code</th>
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<tbody>
<tr>
<td>A0130</td>
</tr>
<tr>
<td>A0225</td>
</tr>
<tr>
<td>A0426</td>
</tr>
<tr>
<td>A0427</td>
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<tr>
<td>A0428</td>
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<tr>
<td>A0429</td>
</tr>
<tr>
<td>A0430</td>
</tr>
<tr>
<td>A0431</td>
</tr>
<tr>
<td>A0433</td>
</tr>
<tr>
<td>A0434</td>
</tr>
<tr>
<td>T2005</td>
</tr>
</tbody>
</table>

Claim Documentation

Indicate the time of service in the Additional Claim Information field (Box 19) of the CMS-1500 claim form or on an attachment.

TAR documentation

Provide details related to the service requested and enter any appropriate modifiers in the Medical Justification field (Box 8C) of the TAR or Enter Miscellaneous TAR Information field of the eTAR.

Sample: Night Call, Partial CMS-1500 claim form
Dry Run

A dry run occurs when a medical ground transportation provider or a medical air transportation provider responds to a call, but does not transport a recipient. Providers may be reimbursed for dry runs by entering both of the following modifiers on the claim:

- **DS** (ambulance service origin code D [diagnostic or therapeutic site other than P or H] and ambulance service destination code S [scene of accident or acute event])
- **QN** (ambulance service furnished directly by a provider of services) for medical transportation dry run services

Modifiers DS and QN are entered as first and second place holders in the Modifier field (Box 24 D) on the claim form. Modifiers DS must be in the first modifier position.

When billing a dry run with HCPCS code A0130, A0426, A0428 or T2005 for a non-emergency patient transfer from an acute care hospital to a nursing facility level A/B, modifiers HN and QN must be on the claim form. Modifier HN must be in the first modifier position. To signify this is a dry run, no other modifiers or service lines may appear on the claim.

Transport and Mileage Same Day

Dry run transport codes and mileage codes will no longer be reimbursable on the same day, for the same recipient and the same provider unless the documentation shows that the billed mileage was for an actual medical transport at a different time on the same date of service.

**NOTE**

A TAR is required for any non-emergency service other than non-emergency patient transfers from an acute care hospital to a nursing facility level A/B.

Sample: Dry Run Ground Transportation, Partial CMS-1500 claim form
Waiting Time – Ground Transportation

HCPCS code A0420 (ambulance waiting time [ALS or BLS], one-half [1/2] hour increments) may be used to bill emergency or non-emergency services. Medi-Cal will reimburse up to 90 minutes, 3 units of waiting time in excess of the first 15 minutes. If the recipient is a neonate, Medi-Cal will reimburse up to 8 hours, or 16 units in excess of the first 15 minutes for documented waiting time needed to stabilize prior to transport. Waiting time may only be billed for time spent waiting to load the patient for transport, not for time waiting to drop off the patient at the destination or for any other purpose.

Miscellaneous Codes

HCPCS code A0999 (unlisted ambulance service) may be used to bill for emergency or non-emergency services.

New Medical Transportation Code Benefits

Effective for dates of service on or after July 1, 2016, HCPCS code A0433 (advanced life support, level 2 [ALS2]) and HCPCS code A0434 (specialty care transport [SCT]) are Medi-Cal benefits.

Medical Transportation Code Conversion Crosswalk

The Medical Transportation Code table shows providers how to use the new HIPAA-compliant codes and modifiers, “crosswalking” the discontinued billing codes to the new HCPCS Level II billing codes.

For details on these codes, see the appendix of this workbook or visit the Medi-Cal website at (http://files.medi-cal.ca.gov/pubsdoco/hipaa/hipaacorrelations_home.asp).
Medical Transportation Code Conversion FAQs

1. What does the conversion from HCPCS Level III codes to HCPCS Level II codes mean?
   The conversion means that any provider submitting HCPCS Level III codes for medical transportation services will be required to submit claims using the specified HCPCS Level II codes for dates of service on or after July 1, 2016.

2. What is HIPAA and how does it relate to HCPCS Level II codes?
   HIPAA is the acronym for the Health Insurance Portability and Accountability Act that was passed by Congress in 1996. HIPAA does the following:
   - Provides the ability to transfer and continue health insurance coverage for millions of American workers and their families when they change or lose their jobs;
   - Reduces health care fraud and abuse;
   - Mandates industry-wide standards for health care information on electronic billing and other process; and;
   - Requires the protection and confidential handling of protected health information.

3. Why did the conversion happen?
   California has historically used thousands of HCPCS Level III or local (also known as interim) codes for billing and reimbursement of services and supplies. National codes, such as Current Procedural Terminology (CPT) codes and Healthcare Common Procedural Coding System (HCPCS) codes, are typically more general in nature compared to local codes. Using CPT and HCPCS Level II codes will:
   - Simplify processes and decrease the costs associated with payment for health care services;
   - Improve the efficiency and effectiveness of the health care system and decrease administrative burdens on providers (i.e., medical practices, hospitals and health care plans);
   - Provide standardization and consistency in medical service coding; and
   - Characterize a general administrative situation, rather than a medical condition or service, by using non-clinical or non-medical code sets.

4. When did the conversion take place?
   The effective date of service for this conversion from HCPCS Level III codes to HCPCS Level II codes is July 1, 2016.

5. Who is affected by the conversion?
   Any provider submitting medical transportation claims for emergency or non-emergency services with dates of service on or after July 1, 2016, or Treatment Authorization Requests (TARs) or Service Authorization Requests (SARs) with requested dates of service on or after July 1, 2016, will be required to use HCPCS Level II codes identified in the Medical Transportation Code Conversion Table.
6. **How does the conversion impact my TARs on or after the effective date?**
   Effective for dates of service on or after July 1, 2016, TARs and SARs using HCPCS Level III local medical transportation codes and HCPCS Level III local modifier Z1 are no longer be permitted. All TARs and SARs submitted with dates of service on or after July 1, 2016, require the HCPCS Level II national medical transportation service codes.

7. **How does the conversion impact claims billed with dates of service on or after the effective date?**
   Effective for dates of service on or after July 1, 2016, all claims billed with HCPCS Level III local medical transportation codes and HCPCS Level III local modifier Z1 are no longer eligible for reimbursement. All TARs with local codes and/or a combination of HCPCS Level III and HCPCS Level II procedure codes, regardless of status (approved, retroactive or deferred), are end-dated for dates of service on or after July 1, 2016. Providers are encouraged to submit new TARs or electronic TARs (eTARs) with the appropriate HCPCS Level II national code(s) prior to July 1, 2016.

   Providers should refer to the Medical Transportation Code Conversion: Policy Overview article for additional information.

8. **What do I do if my end-dated TAR had a medical authorization assigned to it?**
   When replacing end-dated TARs or eTARs that include a medical authorization prior to July 1, 2016, bypass the medical authorization process by including the previously approved TAR number in the **Medical Justification** field (Box 8C) of the TAR or the **Enter Miscellaneous TAR Information** field of the eTAR.

9. **If I submit a new TAR/SAR on or after July 1, 2016, which HCPCS Level codes do I use – Level II or Level III?**
   Providers submitting new TARs and/or new SARs for service periods on or after July 1, 2016, should no longer use the discontinued HCPCS Level III codes for medical transportation services. New TARs and SARs must use the HCPCS Level II national codes for service periods on or after July 1, 2016.

10. **How do I use combination modifier codes?**
    Modifier HN, which is the combination of ambulance service origin code H (hospital) and ambulance service destination code N (skilled nursing facility), must be used in conjunction with modifier QN (ambulance service furnished directly by a provider of services) for medical transportation for a non-emergency transfer from an acute care facility to Nursing Facility Levels A/B.

    Modifier DS, which is a combination of ambulance service origin code D (diagnostic or therapeutic site other than P or H) and ambulance service destination code S (scene of accident or acute event), must be billed in conjunction with modifier QN (ambulance service furnished directly by a provider of services) for medical transportation for dry run services.

    Modifiers HN and DS must be billed before modifier QN on or after July 1, 2016. Modifier HN or DS must be placed in the first modifier position on the claim form to ensure reimbursement.

    **Example:** A0426 HN + QN OR A0426 + DS + QN

    **NOTE**
    A TAR is not required for non-emergency transportation when the transportation is from an acute care hospital to a skilled nursing facility and is indicated by the use of the HN + QN modifier.
11. Where do I put the modifier on the TAR?

Applicable modifiers are to be entered in the Medical Justification field (Box 8C) on the TAR or the Enter Miscellaneous TAR Information field on the eTAR.

**NOTE**

Box 8C on the TAR must include not only the modifier used, but also the description of service provided. (Example: A0130 + UJ, wheelchair service, night transport service)

Providers are not always required to add modifiers to TARs. However, providers must enter details related to the services requested in the Enter Miscellaneous TAR Information field of the eTAR and in the Medical Justification field (Box 8C) of the TAR.

For additional information, providers may view eTAR tutorials, which are accessible on the Provider Training page of the Medi-Cal Learning Portal.

12. Do I need to use the 99 modifier to indicate multiple modifiers?

No, it is not necessary to use the 99 modifier to indicate multiple modifiers. Claims using the 99 modifier will be denied.

13. Should I submit location and destination modifiers on the claim?

Unless indicated in the Medical Transportation Code Conversion Table, location and destination modifiers should not be included on the claim. Claims submitted with location and destination modifiers, other than those indicated in the crosswalk table, will be denied.

14. What billing policy changes should I expect to see with HCPCS Level II codes on or after July 1, 2016?

For dates of service on or after July 1, 2016, medical transportation billing policy is updated to accommodate the following HCPCS Level II codes:

<table>
<thead>
<tr>
<th>HCPCS Level II Codes</th>
<th>HCPCS Level II Code Descriptions</th>
<th>Modifiers, Instructions and Clarification</th>
</tr>
</thead>
<tbody>
<tr>
<td>A0380</td>
<td>BLS mileage (per mile) (use for wheelchair and litter van transports only)</td>
<td>Modifier HN + QN is to be used for non-emergency wheelchair or litter-van transportation from an acute care hospital to a skilled nursing facility. A TAR is not required for non-emergency wheelchair or litter-van transportation from an acute care hospital to a skilled nursing facility. <strong>Example:</strong> A0380 + HN + QN (mileage from an acute care hospital to a skilled nursing facility). <strong>NOTE</strong> Used to bill for non-emergency medical transportation mileage only.</td>
</tr>
<tr>
<td>A0390</td>
<td>ALS mileage (per mile)</td>
<td>Discontinued for dates of services on or after July 1, 2016.</td>
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</tbody>
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<table>
<thead>
<tr>
<th>HCPCS Level II Codes</th>
<th>HCPCS Level II Code Descriptions</th>
<th>Modifiers, Instructions and Clarification</th>
</tr>
</thead>
<tbody>
<tr>
<td>A0425</td>
<td>Ground mileage, per statute mile (use for ambulance transports only)</td>
<td>Modifier HN + QN is to be used for non-emergency ambulance transportation from an acute care hospital to a skilled nursing facility. A TAR is not required for non-emergency ambulance transportation from an acute care hospital to a skilled nursing facility. Example: A0425 + HN + QN (mileage from an acute care hospital to a skilled nursing facility) <strong>NOTE</strong> Can be used to bill for emergency or non-emergency ambulance mileage only.</td>
</tr>
<tr>
<td>A0433</td>
<td>Advanced life support, level 2 (ALS2)</td>
<td>Modifier UN is to be used for two patients served. Modifier UJ is to be used for night calls, 7 p.m. to 7 a.m. Modifier DS + QN is to be used for no transport (dry run). <strong>Examples:</strong> A0433 + UN (two patients served) A0433 + UJ (services provided at night) A0433 + UN (two patients served) +UJ (services provided at night) A0433 + DS + QN (ambulance response, no transport) <strong>NOTE</strong> Should be used to bill for emergency ambulance transportation only.</td>
</tr>
<tr>
<td>HCPCS Level II Codes</td>
<td>HCPCS Level II Code Descriptions</td>
<td>Modifiers, Instructions and Clarification</td>
</tr>
<tr>
<td>----------------------</td>
<td>---------------------------------</td>
<td>------------------------------------------</td>
</tr>
</tbody>
</table>
| A0434                | Specialty care transport (SCT)  | Modifier UN is to be used for two patients served.  
Modifier UJ is to be used for night calls, 7 p.m. to 7 a.m.  
Modifier DS + QN is to be used for no transport (dry run).  
Examples:  
A0434 + UN (two patients served)  
A0434 + UJ (services provided at night)  
A0434 + UN (two patients served) + UJ (services provided at night)  
A0434 + DS + QN (ambulance response, no transport)  
NOTE Should be used to bill for emergency ambulance transportation only. |

15. **How do I indicate emergency or non-emergency when using the same procedure code?**

Providers must indicate if emergency services are provided by using the appropriate HCPCS Level II code(s) and marking the EMG field (Box 24C) on the CMS-1500 claim form or by including condition code 81 (emergency indicator) on the UB-04 claim form. Providers may refer to the *Medical Transportation – Ground and Medical Transportation – Air* sections of the Part 2 manual for further instruction.

Providers must indicate if non-emergency services are provided by using the appropriate HCPCS Level II code(s) with an associated TAR (e.g. A0420 or A0425). One exception applies when the transportation is from an acute care hospital to a skilled nursing facility; in this scenario, use modifiers HN + QN.

16. **How do I indicate number of patients transported?**

To indicate the number of patients receiving non-emergency services, use the appropriate modifier in the *Medical Justification* field (Box 8C) on the TAR and on the claim form.

To indicate the number of patients receiving emergency services, use the appropriate modifiers on the claim form.
17. Where do I find more information related to the medical transportation conversion from Level III HCPCS codes to Level II HCPCS codes?

Providers may request additional onsite or telephone support via the Telephone Services Center (TSC) at 1-800-541-5555, available 8 a.m. to 5 p.m., Monday through Friday.

For additional information, providers may:

- Routinely check the Medi-Cal Update provider bulletins
- Routinely check the Medi-Cal Learning Portal Training Calendar for announcement of the upcoming Medical Transportation Webinar
- View the Medical Transportation Code Conversion Table
- The following provider manual sections:
  - Modifiers: Approved List
  - Medical Transportation – Air
  - Medical Transportation – Air: Billing Codes and Reimbursement Rates
  - Medical Transportation – Air: Billing Examples
  - Medical Transportation – Ground
  - Medical Transportation – Ground: Billing Codes and Reimbursement Rates
  - Medical Transportation – Ground: Billing Examples
Learning Activity

1. Providers must verify recipient eligibility every month to confirm which types of services and/or restrictions the recipient may have.
   True □   False □

   True □   False □

3. A Treatment Authorization Request (TAR) is required for all emergency-related transportation services.
   True □   False □

4. When completing a CMS-1500 claim form or UB-04 claim form, what documentation must you include when submitting claims for emergency transportation?
   a. __________________________________________________________________________
   b. __________________________________________________________________________

5. The new medical transportation HCPCS codes include codes that can be used for both emergency and non-emergency services.
   True □   False □

6. What modifier is used when billing services for a night call? What documentation must be included with this claim?
   ____________ — ____________________________________________________________________

7. Where do I place a modifier on a TAR/eTAR?
   a. __________________________________________________________________________
   b. __________________________________________________________________________

8. What is the exception for not requiring a TAR for non-emergency transportation service?
   a. __________________________________________________________________________

Answer Key: 1) True; 2) True; 3) False; 4a) “X” in CMS-1500 claim form Emergency Indicator field (Box 24 C) and Emergency Statement in the Additional Claim Information field (Box 19), 4b) UB-04 claim form Condition Codes Field “81” and include Emergency Statement in Box 80; 5) True; 6) UJ—include the time of service in the Remarks field (Box 80); 7a) TAR Box 8c Medical Justification field; 7b) Enter Miscellaneous TAR Information field on eTAR; 8) Transportation from an acute care hospital to a skilled nursing facility.
Appendix

Acronyms

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
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</thead>
<tbody>
<tr>
<td>CAL-POS</td>
<td>California Point of Service Network</td>
</tr>
<tr>
<td>CCS</td>
<td>California Children’s Services</td>
</tr>
<tr>
<td>CMC</td>
<td>Computer Media Claims</td>
</tr>
<tr>
<td>COHS</td>
<td>County Organized Health Systems</td>
</tr>
<tr>
<td>DHCS</td>
<td>Department of Health Care Services</td>
</tr>
<tr>
<td>FI</td>
<td>Fiscal Intermediary; contractor for DHCS responsible for claims processing, provider services, and other fiscal operations of the Medi-Cal program</td>
</tr>
<tr>
<td>HCPCS</td>
<td>Healthcare Common Procedure Coding System</td>
</tr>
<tr>
<td>HIPAA</td>
<td>Health Insurance Portability and Accountability Act</td>
</tr>
<tr>
<td>ID</td>
<td>Identification</td>
</tr>
<tr>
<td>IRCA</td>
<td>Immigration Reform and Control Act</td>
</tr>
<tr>
<td>LTC</td>
<td>Long Term Care</td>
</tr>
<tr>
<td>NEMT</td>
<td>Non-Emergency Medical Transportation</td>
</tr>
<tr>
<td>NPI</td>
<td>National Provider Identifier</td>
</tr>
<tr>
<td>OBRA</td>
<td>Federal Omnibus Budget Reconciliation Act</td>
</tr>
<tr>
<td>PHP</td>
<td>Prepaid Health Plan</td>
</tr>
<tr>
<td>POS</td>
<td>Point of Service</td>
</tr>
<tr>
<td>PTN</td>
<td>Provider Telecommunications Network</td>
</tr>
<tr>
<td>SAR</td>
<td>Service Authorization Request</td>
</tr>
<tr>
<td>SNF</td>
<td>Skilled Nursing Facility</td>
</tr>
<tr>
<td>TAR</td>
<td>Treatment Authorization Request</td>
</tr>
<tr>
<td>TSC</td>
<td>Telephone Service Center</td>
</tr>
</tbody>
</table>
# Medical Transportation Code Conversion

<table>
<thead>
<tr>
<th>Discontinued Billing Codes</th>
<th>New Billing Codes</th>
<th>Instructions and Clarifications</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Interim Code</strong></td>
<td><strong>National Code or Modifier</strong></td>
<td><strong>Description</strong></td>
</tr>
<tr>
<td>X0002</td>
<td>Response to call, two patients, each patient</td>
<td>A0427§ and UN or A0429§ and UN</td>
</tr>
<tr>
<td></td>
<td></td>
<td>and A0427§ and UN and UJ or A0429§ and UN and UJ</td>
</tr>
<tr>
<td>X0006</td>
<td>Emergency run</td>
<td>No New Code(s) Available</td>
</tr>
</tbody>
</table>

† A Treatment Authorization Request (TAR) is required for the reimbursement of any non-emergency services provided. Indicate the number of patients receiving non-emergency services in the Medical Justification field (Box 8C).

§ Providers must indicate if emergency services are provided by marking the EMG field (Box 24C) on the CMS-1500 claim form or by including condition code 81 (emergency indicator) on the UB-04 claim form. Providers may refer to the Medical Transportation – Ground and Medical Transportation – Air sections in the appropriate Part 2 manual for further instruction.
A Treatment Authorization Request (TAR) is required for the reimbursement of any non-emergency services provided. Indicate the number of patients receiving non-emergency services in the Medical Justification field (Box 8C).

Providers must indicate if emergency services are provided by marking the EMG field (Box 24C) on the CMS-1500 claim form or by including condition code 81 (emergency indicator) on the UB-04 claim form. Providers may refer to the Medical Transportation – Ground and Medical Transportation – Air sections in the appropriate Part 2 manual for further instruction.

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</thead>
<tbody>
<tr>
<td>Interim Code</td>
<td>Description</td>
<td>National Code or Modifier</td>
</tr>
<tr>
<td>X0008</td>
<td>Neonatal intensive care incubator</td>
<td>A0225§</td>
</tr>
<tr>
<td>X0010</td>
<td>Ground ambulance waiting time over 15 minutes; each 15 minutes</td>
<td>A0420†§</td>
</tr>
</tbody>
</table>
Appendix

Medical Transportation Services

A Treatment Authorization Request (TAR) is required for the reimbursement of any non-emergency services provided. Indicate the number of patients receiving non-emergency services in the Medical Justification field (Box 8C).

† Providers must indicate if emergency services are provided by marking the EMG field (Box 24C) on the CMS-1500 claim form or by including condition code 81 (emergency indicator) on the UB-04 claim form. Providers may refer to the Medical Transportation – Ground and Medical Transportation – Air sections in the appropriate Part 2 manual for further instruction.

§ There is no national code for compressed air for a neonatal incubator. Since compressed air is used in conjunction with a neonatal incubator, this service is to be included with overall neonatal transport. Modifier UJ is to be used for night calls, 7 p.m. to 7 a.m. A0225 and A0225+UJ should be used to bill for emergency medical transportation only.

<table>
<thead>
<tr>
<th>Discontinued Billing Codes</th>
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</tr>
</thead>
<tbody>
<tr>
<td><strong>Interim Code</strong></td>
<td><strong>Description</strong></td>
</tr>
<tr>
<td>X0012</td>
<td>Compressed air for infant respirator</td>
</tr>
<tr>
<td>Or</td>
<td>A0225§ and UJ</td>
</tr>
<tr>
<td>X0014</td>
<td>Extra attendant – RN/EMT first hour</td>
</tr>
<tr>
<td>X0016</td>
<td>Extra attendant – RN/EMT 2nd and 3rd hour each</td>
</tr>
<tr>
<td>X0018</td>
<td>Extra attendant – RN/EMT (each additional hour)</td>
</tr>
<tr>
<td>X0020</td>
<td>Cost of I.V. fluids (invoice must be attached)</td>
</tr>
</tbody>
</table>
### Discontinued Billing Codes

<table>
<thead>
<tr>
<th>Interim Code</th>
<th>Description</th>
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<th>New Billing Codes</th>
<th>Instructions and Clarifications</th>
</tr>
</thead>
<tbody>
<tr>
<td>X0030</td>
<td>Ambulance service, Basic Life Support (BLS) base rate, emergency transport, one way (includes allowance for emergency run).</td>
<td>A0427§</td>
<td>Ambulance service, advanced life support, emergency transport, level 1 (ALS1-emergency)</td>
<td>Modifier UJ is to be used for night calls, 7 p.m. to 7 a.m. A0427, A0429, A0427+UJ, and A0429+UJ should be used to bill for emergency medical transportation only.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>or A0429§</td>
<td>Ambulance service, basic life support, non-emergency transport (BLS)</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>or A0427§ and UJ</td>
<td>Services provided at night</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>or A0429§ and UJ</td>
<td></td>
<td></td>
</tr>
<tr>
<td>X0032</td>
<td>Non-emergency transportation, ambulance, base rate, one way</td>
<td>A0426†</td>
<td>Ambulance service, basic life support, non-emergency transport (BLS)</td>
<td>Modifier UJ is to be used for night calls, 7 p.m. to 7 a.m. A0426, A0428, A0426+UJ, and A0428+UJ should be used to bill for non-emergency medical transportation only.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>or A0428†</td>
<td>Ambulance service, basic life support, non-emergency transport (BLS)</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>or A0426† and UJ</td>
<td>Services provided at night</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>or A0428† and UJ</td>
<td></td>
<td></td>
</tr>
<tr>
<td>X0034</td>
<td>Ambulance service, (BLS), per mile, transport, one way</td>
<td>A0380†§</td>
<td>BLS mileage (per mile)</td>
<td>A0380 and A0390 may be used to bill for either emergency or non-emergency services.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>or A0390†§</td>
<td>ALS mileage (per mile)</td>
<td></td>
</tr>
<tr>
<td>X0036</td>
<td>Ambulance service, oxygen, administration and supplies, life sustaining situation</td>
<td>A0422†§</td>
<td>Ambulance (ALS or BLS) oxygen and oxygen supplies, life sustaining situation</td>
<td>A0422 may be used to bill for either emergency or non-emergency services.</td>
</tr>
</tbody>
</table>

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§ Providers must indicate if emergency services are provided by marking the EMG field (Box 24C) on the CMS-1500 claim form or by including condition code 81 (emergency indicator) on the UB-04 claim form. Providers may refer to the Medical Transportation – Ground and Medical Transportation – Air sections in the appropriate Part 2 manual for further instruction.
## Discontinued Billing Codes

<table>
<thead>
<tr>
<th>Interim Code</th>
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</tr>
</thead>
<tbody>
<tr>
<td>X0200</td>
<td>Response to call – non-litter patient, 1 patient</td>
<td>A0130†</td>
<td>Non-emergency transportation: wheelchair van</td>
<td>A0130 should be used to bill for non-emergency medical transportation only.</td>
</tr>
<tr>
<td>X0202</td>
<td>Response to call – non-litter patient, 2 patients, each patient</td>
<td>A0130† and UN</td>
<td>Non-emergency transportation: wheelchair van</td>
<td>A0130+UN should be used to bill for non-emergency medical transportation only.</td>
</tr>
<tr>
<td>X0204</td>
<td>Response to call – non-litter patient, 3 patients, each patient</td>
<td>A0130† and UP</td>
<td>Non-emergency transportation: wheelchair van</td>
<td>A0130+UP should be used to bill for non-emergency medical transportation only.</td>
</tr>
<tr>
<td>X0206</td>
<td>Response to call – non-litter patient, 4 or more patients, each patient</td>
<td>A0130† and UQ or UR or US</td>
<td>Non-emergency transportation: wheelchair van</td>
<td>A0130+UQ, +UR, or +US should be used to bill for non-emergency medical transportation only.</td>
</tr>
<tr>
<td>X0208</td>
<td>Response to call – non-litter patient, wheelchair use</td>
<td>No New Code(s) Available</td>
<td></td>
<td>This code will be deactivated, as it is used to bill for a service that is included as part of the overall transportation service.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
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</tr>
</thead>
<tbody>
<tr>
<td>X0210</td>
<td>Response to call – litter patient</td>
<td>T2005†</td>
<td>Non-emergency transportation: stretcher van</td>
<td>T2005 should be used to bill for non-emergency medical transportation only.</td>
</tr>
<tr>
<td>X0212</td>
<td>Response to call – litter patient, attendant</td>
<td>T2001†</td>
<td>Non-emergency transportation: patient attendant/escort</td>
<td>T2001 should be used to bill for non-emergency medical transportation only.</td>
</tr>
</tbody>
</table>

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<tr>
<th>Discontinued Billing Codes</th>
<th>New Billing Codes</th>
<th>Instructions and Clarifications</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Interim Code</strong></td>
<td><strong>Description</strong></td>
<td><strong>National Code or Modifier</strong></td>
</tr>
<tr>
<td>X0214</td>
<td>Waiting time over 15 minutes – each 15 minutes (maximum of 90 minutes)</td>
<td>T2007†§</td>
</tr>
<tr>
<td>X0216</td>
<td>Mileage one way – per mile (mileage with patient on board)</td>
<td>A0425†</td>
</tr>
<tr>
<td>X0218</td>
<td>Night call – 7 p.m. to 7 a.m.</td>
<td>A0130† and UJ or T2005† and UJ</td>
</tr>
<tr>
<td>X0220</td>
<td>Oxygen – per tank</td>
<td>A0422†§</td>
</tr>
<tr>
<td>X0222</td>
<td>Unlisted</td>
<td>A0999†§</td>
</tr>
</tbody>
</table>

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<th>Description</th>
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</tr>
</thead>
<tbody>
<tr>
<td>X0400</td>
<td>Response to call, ambulance</td>
<td>A0426</td>
<td>Ambulance service, advanced life support, non-emergency transport, level 1 (ALS1)</td>
<td>All X04XX codes were used for non-emergency patient transfer from acute care facility to nursing facility levels A/B.</td>
</tr>
<tr>
<td></td>
<td>or</td>
<td>A0428</td>
<td>Ambulance service, basic life support, non-emergency transport (BLS)</td>
<td>Modifier HN is H + N.</td>
</tr>
<tr>
<td></td>
<td>and</td>
<td>QN</td>
<td>Ambulance service furnished directly by a provider of services</td>
<td>A TAR is not required for non-emergency transportation from an acute care hospital to a skilled nursing facility.</td>
</tr>
<tr>
<td></td>
<td>and</td>
<td>HN</td>
<td>Hospital to skilled nursing facility</td>
<td></td>
</tr>
<tr>
<td>X0402</td>
<td>Ambulance mileage, one way – per mile (mileage with patient on board)</td>
<td>A0380</td>
<td>BLS mileage (per mile)</td>
<td>Modifier HN is H + N.</td>
</tr>
<tr>
<td></td>
<td>or</td>
<td>A0390</td>
<td>ALS mileage (per mile)</td>
<td>A TAR is not required for non-emergency transportation from an acute care hospital to a skilled nursing facility.</td>
</tr>
<tr>
<td></td>
<td>and</td>
<td>QN</td>
<td>Ambulance service furnished directly by a provider of services</td>
<td></td>
</tr>
<tr>
<td></td>
<td>and</td>
<td>HN</td>
<td>Hospital to skilled nursing facility</td>
<td></td>
</tr>
<tr>
<td>X0404</td>
<td>Response to call, litter patient, litter van transportation</td>
<td>T2005</td>
<td>Non-emergency transportation: stretcher van</td>
<td>Modifier HN is H + N.</td>
</tr>
<tr>
<td></td>
<td>and</td>
<td>QN</td>
<td>Ambulance service furnished directly by a provider of services</td>
<td>A TAR is not required for non-emergency transportation from an acute care hospital to a skilled nursing facility.</td>
</tr>
<tr>
<td></td>
<td>and</td>
<td>HN</td>
<td>Hospital to skilled nursing facility</td>
<td></td>
</tr>
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A Treatment Authorization Request (TAR) is required for the reimbursement of any non-emergency services provided. Indicate the number of patients receiving non-emergency services in the Medical Justification field (Box 8C).

Providers must indicate if emergency services are provided by marking the EMG field (Box 24C) on the CMS-1500 claim form or by including condition code 81 (emergency indicator) on the UB-04 claim form. Providers may refer to the Medical Transportation – Ground and Medical Transportation – Air sections in the appropriate Part 2 manual for further instruction.

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</tr>
</thead>
<tbody>
<tr>
<td><strong>Interim Code</strong></td>
<td><strong>Description</strong></td>
</tr>
<tr>
<td>X0406</td>
<td>Response to call, non-litter patient, wheelchair van transportation</td>
</tr>
<tr>
<td>X0408</td>
<td>Wheelchair/litter van mileage, one way – per mile (mileage with patient on board)</td>
</tr>
<tr>
<td>X0410</td>
<td>Wheelchair use, wheelchair/litter van</td>
</tr>
<tr>
<td>X0412</td>
<td>Oxygen, per tank</td>
</tr>
</tbody>
</table>
### Discontinued Billing Codes

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<tr>
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</thead>
<tbody>
<tr>
<td>X0414</td>
<td>Attendant, wheelchair/litter van transportation</td>
<td>T2001 and QN and HN</td>
<td>Non-emergency transportation, patient attendant/escort Ambulance service furnished directly by a provider of services Hospital to skilled nursing facility</td>
<td>Modifier HN is $H + N$. A TAR is not required for non-emergency transportation from an acute care hospital to a skilled care facility.</td>
</tr>
<tr>
<td>X0416</td>
<td>Unlisted</td>
<td>A0999†§</td>
<td>Unlisted ambulance service</td>
<td>A0999 may be used to bill for either emergency or non-emergency services.</td>
</tr>
<tr>
<td>X0504</td>
<td>Night call, 7 p.m. to 7 a.m.</td>
<td>A0430†§ and UJ or A0431†§</td>
<td>Ambulance service, conventional air services, transport, one way (fixed wing) Services provided at night Ambulance service, conventional air services, transport, one way (rotary wing) Services provided at night</td>
<td>Modifier UJ is to be used for night calls, 7 p.m. to 7 a.m. A0430+UJ or A0431+UJ may be used to bill for either emergency or non-emergency services.</td>
</tr>
<tr>
<td>X0506</td>
<td>Waiting time over 15 minutes, each 15 minutes</td>
<td>T2007†§ and TU</td>
<td>Transportation waiting time, air ambulance, and non-emergency vehicle, one-half (1/2) hour increments Special payment rate, overtime</td>
<td>Medi-Cal will reimburse up to 90 minutes, three units, of waiting time in excess of the first 15 minutes. In cases where a recipient is a neonate, Medi-Cal will reimburse up to 3 hours, 6 units, in excess of the first 15 minutes for documented waiting time needed to stabilize prior to transport. T2007+TU may be used to bill for either emergency or non-emergency services.</td>
</tr>
</tbody>
</table>

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June 2015
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<th>Description</th>
<th>Instructions and Clarifications</th>
</tr>
</thead>
<tbody>
<tr>
<td>X0508</td>
<td>Federal excise tax for fixed-wing aircraft over 6,000 pounds</td>
<td>No New Code(s) Available</td>
<td>This code will be deactivated due to low utilization.</td>
<td></td>
</tr>
<tr>
<td>X0510</td>
<td>Oxygen – per tank</td>
<td>A0422†§</td>
<td>Ambulance (ALS or BLS) oxygen and oxygen supplies, life sustaining situation</td>
<td></td>
</tr>
<tr>
<td>X0512</td>
<td>Neonatal intensive care incubator</td>
<td>A0999†§</td>
<td>Unlisted ambulance service</td>
<td></td>
</tr>
<tr>
<td>X0514</td>
<td>Compressed air for infant respirator</td>
<td>A0999†§</td>
<td>Unlisted ambulance service</td>
<td></td>
</tr>
<tr>
<td>X0516</td>
<td>Admin. I.V. Sol., 1000cc, incl. tubing and other supplies</td>
<td>No New Code(s) Available</td>
<td>This code will be deactivated, as it is used to bill for a service that is considered included as part of a bundled service and should not be billed separately.</td>
<td></td>
</tr>
<tr>
<td>X0518</td>
<td>Admin. I.V. Sol., 500cc, incl. tubing and other supplies</td>
<td>No New Code(s) Available</td>
<td>This code will be deactivated, as it is used to bill for a service that is considered included as part of a bundled service and should not be billed separately.</td>
<td></td>
</tr>
<tr>
<td>X0522</td>
<td>Unlisted air transportation (invoice must be attached)</td>
<td>A0999†§</td>
<td>Unlisted ambulance service</td>
<td></td>
</tr>
</tbody>
</table>

† A Treatment Authorization Request (TAR) is required for the reimbursement of any non-emergency services provided. Indicate the number of patients receiving non-emergency services in the Medical Justification field (Box 8C).

§ Providers must indicate if emergency services are provided by marking the EMG field (Box 24C) on the CMS-1500 claim form or by including condition code 81 (emergency indicator) on the UB-04 claim form. Providers may refer to the Medical Transportation – Ground and Medical Transportation – Air sections in the appropriate Part 2 manual for further instruction.
Clarification of Requirements for Medical Transportation Emergency Statement

November 1, 2016

When completing the emergency statement for air or ground medical transportation, providers must include the name of the hospital to which a recipient was transported. This information must be included in the Additional Claim Information field (Box 19) of the CMS-1500 claim form or the Remarks field (Box 80) of the UB-04 claim form, or on an attachment. Claims submitted with an acronym in place of a hospital name (for example, VMC) will be denied. Abbreviations are acceptable (for example Valley Med. Ctr.).

Providers are reminded that on the emergency statement the physician accepting responsibility for the recipient must be either a Doctor of Medicine (M.D.) or a Doctor of Osteopathic Medicine (D.O.). A physician signature is not required.

Additional information and provider manual updates regarding this issue will publish in a future Medi-Cal Update.

Medi-Cal Update

Medical Transportation | April 2017 | Bulletin 499

4. SSN Removal Initiative to Replace HIC Number on Medicare Cards

The Medicare Access and CHIP Reauthorization Act of 2015 requires Centers for Medicare & Medicaid Services (CMS) to remove Social Security Numbers (SSNs) from all Medicare cards by April 2019. A new Medicare Beneficiary Identifier (MBI) will replace the SSN-based Health Insurance Claim (HIC) number on new Medicare cards and will be used for transactions such as billing, eligibility status and claim status.

A transition period will allow providers to use either the HIC number or the MBI. The transition will begin no earlier than April 1, 2018, and run through December 31, 2019.

CMS currently uses SSN-based HIC numbers to identify Medicare recipients and have used HIC numbers with state Medicaid agencies, health care providers and health plans. Under the new system, CMS will assign a new MBI and send a new Medicare card for each recipient enrolled in Medicare. The MBI should be protected as Personally Identifiable Information (PII).

Additional resources can be found on the Providers and Health & drug plans Web pages of the CMS website.

Additional information regarding this transition will be announced in a future Medi-Cal Update.

5. Updated Emergency Statement for Emergency Ground and Air Transportation

Effective for dates of service on or after April 1, 2017, the Emergency Statement required to bill for emergency ground medical transportation and emergency air medical transportation no longer includes the following:

- The name of the person or agency that requested the service
- Clinical information on a recipient’s condition
- The reason the services were considered to be immediately necessary (medical necessity)

Additionally, the emergency department physician or medical director can now accept responsibility for the recipient.
6. Clarification of Authorization Requirements for Non-Emergency Transport

Effective retroactively for dates of service on or after April 1, 2015, a prescription or clinician signature is not required for non-emergency transportation services from an acute care hospital to a Long Term Care (LTC) facility.

7. Update to Medical Transportation Policy for Round Trips and Night Calls

Effective for dates of service on or after April 1, 2017, policy is updated for round-trips and night calls during ground medical transportation.

When billing round-trips, transportations must be documented with the time of day and points of destination in the Additional Claim Information field (Box 19) of the CMS-1500 claim form.

Enter the appropriate “response to call” procedure code:

- On one billing line, showing a “2” in the Days or Units field (Box 24G) and one charge for this portion of the service, or;
- On two billing lines, showing a “1” in the Days or Units field (Box 24G) with a charge for each individual leg of the service, or;
- On two separate claims, showing a “1” in the Days or Units field (Box 24G) with a charge for the individual leg of the service.

For night calls, bill a round-trip on one billing line only if both legs of the trip occurred at night. Document the start and stop times for each leg of the service in the Additional Claim Information field (Box 19) of the CMS-1500 claim form. A quantity of “2” in the Days or Units field (Box 24G) and one charge for this portion of the service is required. Append modifier UJ to the appropriate HCPCS code.

If one of the transports did not occur at night, document the start and stop times for the transports and use two claim lines (or two claims). Append modifier UJ to only one of the claim lines or claims. Documentation must support the use of modifier UJ.

This information is reflected in the following provider manual(s):

<table>
<thead>
<tr>
<th>Provider Manual(s)</th>
<th>Page(s) Updated</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical Transportation</td>
<td>Item 5: mc tran gnd (6)</td>
</tr>
<tr>
<td></td>
<td>Item 6: mc tran air (4); mc tran gnd (3); mc tran air ex (2); mc tran gnd ex (4, 5);</td>
</tr>
<tr>
<td></td>
<td>Item 7: mc tran gnd (14, 16)</td>
</tr>
</tbody>
</table>
Medical Emergency Statement

(From page 3 of the mc tran gnd support by California Code of Regulations [CCR], Title 22, Section 51323). All emergency medical transportation requires both:

- The emergency service indicator on the claim (EMG field [Box 24C] on the CMS-1500 claim form, or condition code 81 [emergency indicator] in boxes 18–24 on the UB-04 claim form)

- A statement in the Additional Claim Information field (Box 19) on the CMS-1500 claim form, or the Remarks field (Box 80) on the UB-04 claim form, or on an attachment, supporting that an emergency existed. The statement may be made by the provider of transportation and must include:
  - The nature of the emergency
  - The name of the hospital to which a recipient was transported
  - The name of the physician accepting responsibility for the recipient

Example Medi-Cal Checklist

My “checklist” for an internal audit (from the medi-cal billing guide, page 3 of mc tran gnd) which is required in ADDITION to the emergency box being CHECKED for EVERY line item on the 1500/ECS file:

1) The nature of the emergency (ie the diagnosis and/or description of pt condition)
2) The name of the hospital to which recipient was transported (abbreviations are bad and if hospital name DOES NOT include the word hospital better add it).
3) The NAME of the physician accepting responsibility for the recipient

Not listed but necessary is

4) The full LOCATION of the call (full address) because they want to check the mileage.
5) the START AND END TIME of the call and the word NIGHT if at night (to justify night calls).
6) The word EMERGENCY has to be in the comments (along with the Emergency check box).
7) The word AMBULANCE to show it was ambulance (over littervan/wheelchair) I think because someone told me to do that once...
Emergency Cert Format Checklist

Here is the “checklist” for the billing comments (from the medical billing guide, page 3 of MC TRAN GND) in the order in which our software formats the comments. These are REQUIRED in ADDITION to the emergency box being CHECKED on every line item of the 1500/ECS file.

1) The start time of the call and the word NIGHT if at night (to justify night calls).
   A. Use the time unit alert for the start time
   B. Use the time unit at destination for the end time
2) The word EMERG has to be in the comments (along with the Emergency box checked).
3) The word AMBUL has to be in the comments (to indicate this is an ambulance transport).
4) The full LOCATION of the call (full address) because they want to check the mileage.
5) The full DESTINATION of the CALL including HOSP at end of destination (if EMERG)
   A. DO NOT USE Acronym for destination name (ie RMC)
   B. Can use abbreviations (ie Reg Med Cntr)
   C. Recommend putting HOSP at end of DEST Name
6) The NAME of the physician accepting responsibility for the recipient (with MD at end)
   A. Do not use Staff-MD
   B. Use the Medical Director for Non Transport
   C. Use the Emergency room physician if attending unknown
7) If Billing additional line items
   A. Oxygen then OXY in comments
   B. If Billing ECG then ECG in comments
   C. 12 lead then 12 lead in comments

Emergency Cert Example

START TIME: 12:41 AM, END TIME 1:35 AM NIGHT TRAN. EMERG. AMBUL. FM: RESIDENCE, 1837 6TH ST, MENDOTA, CA 93640. TO: REG MED CNT HOSP, 2823 FRESNO ST, FRESNO, CA 93721. PHYS: SHU,EILEEN-MD. PT ACUTE CONDITION REQUIRED: ECG.

And breaking it down:
START TIME: 12:41 AM, (#1A)
END TIME 1:35 AM NIGHT TRAN. (#1B)
NIGHT TRAN (#1).
EMERG. AMBUL. (#2 and 3)
FM: RESIDENCE, 1837 6TH ST, MENDOTA, CA 93640. (#4)
TO: REG MED CNT HOSP, 2823 FRESNO ST, FRESNO, CA 93721. (#5)
PHYS: SHU,EILEEN-MD. (#6)
PT ACUTE CONDITION REQUIRED: ECG. (#7)
Emergency Cert Attached Page Example
The following page is an example of the emergency Cert Document we use when billing on paper.

EMERGENCY CERTIFICATION / ADDITIONAL COMMENTS

PATIENT NAME: [FIRST LAST]
INSURANCE ID: [MEDI-CAL ID]
PATIENT ACCOUNT: [OUR TICKET ID]

START TIME: 12:41 AM, END TIME 1:35 AM NIGHT TRAN. EMERG. AMBUL. FM: RESIDENCE, 1837 6TH ST, MENDOTA, CA 93640. TO: REG MED CNT HOSP, 2823 FRESNO ST, FRESNO, CA 93721. PHYS: SHU,EILEEN-MD. PT ACUTE CONDITION REQUIRED: ECG.
Technical details about electronic billing comments

The link to the medi-cal electronic claims guide:

Page 19 talks about the NTE01 and NTE02 fields. It does have a formatting statement that we should review for electronic claims: **Medi-Cal expects to receive “EMCER” in the first five characters followed by the Emergency Certification documentation (page 20 nte02 comments)**

The electronic file contains CER (automatically when file is created) and that seems to work (note: might want clarification on what the bolded statement means. My thought is that segment/loop/area only allows 3 characters so they shortened to CER).

This is some information my programmer sent to me about the emergency flag and how it is set in our file (to verify each line of the ECS file has emergency):

*The segment to look for is the one starting with "SV1", which repeats for each line item being billed. The emergency flag is in the 9th position of the segment, which means 9 asterisks after the "SV1" identifier. It is the last element in the segment so if you just look for the first ~ after the SV1 it will be just before that. If the emergency flag is set that element will have a "Y". (nerdy note: the ~~~ indicates the beginning and end of each segment. So you will see ~and then the segment name and then some data and then the ~ to move to the next segment).*

This is some information about how the notes “link” together.
The ~NTE*CER* is the billing comments for the CLAIM and it allows 80 characters
The ~nte*ADD* is the billing comments for the first line item and it allows 80 characters
The ~nte*ADD* is the billing comments for the second line item and it allows 80 characters
(and onward for each line item)

Here is the math:
Non transport 160 characters
Base/miles 240 characters
Base/miles ECG or O2 320 characters
Base/miles ECG and O2 400 characters

Manual Override of the Electronic Billing Comments
If your software allows you to create claim and line item comments, you can manually enter the billing comments. The first 80 characters are put on the “claim comments”, the next 80 on line item 1, the next 80 on line item 2, etc. You can create a template in Excel to easily split the comments (I can send you a template), but make sure your software “supports” line item comments before billing this way.
Electronic Billing comments example

Below is an example of one claim text file that is created. Ticket 1788610 where CCN 6250618726801 (base) was paid and 6250618726802 (miles) denied 0369

ISA*00*00*ZZ*R51ZZ*610442
*161007*1250***00501*00103500*0*P*161007*1250*103500*X*005010
X222A1*ST*837*103500*005010X222A1*ST*837*103500*20161007*1250*CH*NM1*41*2*AMERICAN AMBULANCE*****46*R51*PER*IC*DONNA HANKINS*TE*5594435991*NM1*40*2*MEDICAL*****46*610442~HL*1***20*1~PRV*BI*PXC*341600000X~NM1*85*2*AMERICAN AMBULANCE*****XX*1598767501*NM*3*2911 E.
TULARE*N4*FRESNO*CA*937211502~REF*EI*942281434~HL*2*1*22*0~SBR*P*18~NM1*IL*1*LAST*FI
RST*A***MI*medicalID~N3*123 Patient
Address*N4*City*CA*937031247~DMG*D8*19640629*M~NM1*PR*2*MEDICAL*****PI*610442~CLM*F1788610*1083.24***41|B|1*Y*A*Y*Y~NTE*CER*TIME: 7:00 PM NIGHT TRAN.
EMER FM: COMM SUBACUTE CARE CTR, 3003 N MARIPosa ST
4~CR1******A*DH*4~CRC*07*Y*06~CRC*07*N*12*05~HI*ABK|I679~NM1*DN*1*BIVINS*HERBERT
MD******XX*1972619518~NM1*PW*2~N3*3003 N MARIPosa ST
48~N4*FRESNO*CA*93703~NM1*45*2*REGIONAL MED CNT~N3*2823 FRESNO ST
~N4*FRESNO*CA*93721~LV*1~SV1*HC|A0427|UJ*994*UN*1***1**Y
~DTP*472*D8*20160829~REF*6R*3691394~NTE*ADD*8,FRESNO,CA 93703. TO: REGIONAL MED CNT, 2823 FRESNO ST, FRESNO, CA 93721.
REF~LX*2~SV1*HC|A0425*89.24*UN*4***1**Y
~DTP*472*D8*20160829~REF*6R*3691395~NTE*ADD
*BY: 911. ATTEND PHYS: BIVINS, HERBERT - MD.
PT COND: HEADACHE, PAIN SCALE
10.*SE*42*103500~GE*1*103500~IEA*1*000103500~

Highlighted yellow is the emergency flag set for A0427.
Highlighted green is the emergency flag set for A0425.
Highlighted blue is the CER settings
Highlighted PINK is the NTE ADD settings.

The idea is that medi-cal process the file, then “sews” the comments back together. Here is the 3 note lines separated by a| to see the break (in theory the software removes the word ADD and links the comments together for EACH LINE ITEM)

TIME: 7:00 PM NIGHT TRAN.
EMER FM: COMM SUBACUTE CARE CTR, 3003 N MARIPosa ST 4 8,
FRESNO, CA 93703. TO: REGIONAL MED CNT, 2823 FRESNO ST, FRESNO, CA 93721. REF |BY: 911.
ATTEND PHYS: BIVINS, HERBERT - MD.
PT COND: HEADACHE, PAIN SCALE 10.

Here are the comments put back together

TIME: 7:00 PM NIGHT TRAN.
EMER FM: COMM SUBACUTE CARE CTR, 3003 N MARIPosa ST 48, FRESNO,
CA 93703. TO: REGIONAL MED CNT, 2823 FRESNO ST, FRESNO, CA 93721. REF BY: 911.
ATTEND PHYS: BIVINS, HERBERT - MD.
PT COND: HEADACHE, PAIN SCALE 10.
Date: February 22, 2017

To: Valued Transportation Providers

From: Jody Gonzalez, General Manager
       Carla Corona, Director Network Management

Subj: LogistiCare Claims Advisory

The purpose of this advisory is to re-state the requirements for submitting a clean claim to LogistiCare Solutions, whether or not you are a member of the LogistiCare Transportation Network.

For all health plans serviced by LogistiCare, in order to be considered for payment, the trip:

1. must have been assigned to you directly by LogistiCare transportation personnel, and

2. must be submitted with a Trip Log containing the following information, at a minimum:
   a. Driver’s name
   b. Vehicle number
   c. Date of service
   d. Job Number/Trip ID
   e. Member Name
   f. Level of service
   g. Pick-up Time (military time)
   h. Drop Off Time (military time)
   i. Trip mileage
   j. Member’s signature (live or via tablet)
   k. Amount billed
   l. Driver’s Signature

Effective with the Monday, February 27, 2017, date of service, any claim submitted without a LogistiCare Job Number/Trip ID will be denied. Additionally, any trip that is not assigned to you directly by LogistiCare personnel will be denied, including those assigned by physicians, participating physician groups, hospitals, skilled nursing facilities, and dialysis centers. If you accept a trip assignment from an entity other than LogistiCare for a member covered by a LogistiCare client, you do so at your own financial risk.

Clean claim requirements can be found on the following page.

If you have any questions regarding our Claims process or requirements, please feel free to contact your LogistiCare Regional Manager or Carla Corona at (877)917-8166.
Clean Claim Requirements

1. Information required to process Tier I trips include:
   i. NET Trips (Ambulatory, wheelchair, etc.)
      1. Trip log
   ii. Gurney/Stretcher Trips
      1. Trip Log, or
      2. 1500 Claim form
   iii. Higher levels of Service – (Basic Life Support, Advanced Life Support, Specialty Care Transport)
      1. 1500 Claim form and PCR (Patient Care Record)
      2. Supporting documentation if denied by Primary Insurance

2. Exceptions (Billing Priority):
   i. Medicare Prime (BLS & Above) – Transportation Provider is required to bill Medicare as primary insurance. If trip is denied by Medicare, Transportation Provider can bill LogistiCare as the secondary and has to include the EOB as support.
   ii. Commercial Insurance (BLS & Above) – Transportation Provider is required to bill Commercial Insurance as primary insurance. If trip is denied by Commercial Insurance, Transportation Provider can bill LogistiCare as the secondary and has to include the denial letter/EOB as support.

Appeals

Underpaid/Denied claims – If you do not agree with the payment or denial, submit written disputes (Utilize Provider Dispute Request Form provided by LogistiCare or your own version providing information on the claim and actual dispute) to:

Logisticare Solutions
ATTN: Appeals
2552 W Erie Drive, Ste 101
Tempe, AZ 85282
DATE: July 17, 2017

ALL PLAN LETTER 17-010 (REVISED)

TO: ALL MEDI-CAL MANAGED CARE HEALTH PLANS

SUBJECT: NON-EMERGENCY MEDICAL AND NON-MEDICAL TRANSPORTATION SERVICES

PURPOSE:
This All Plan Letter (APL) provides Medi-Cal managed care health plans (MCPs) with guidance regarding Non-Emergency Medical Transportation (NEMT) and Non-Medical Transportation (NMT) services. With the passage of Assembly Bill (AB) 2394 (Chapter 615, Statutes of 2016), which amended Section 14132 of the Welfare and Institutions Code (WIC), the Department of Health Care Services (DHCS) is clarifying MCPs’ obligations to provide and coordinate NEMT and NMT services. In addition, this APL provides guidance on the application of NEMT and NMT services due to the Medicaid Mental Health Parity Final Rule (CMS-2333-F). Revised text is found in italics.

BACKGROUND:
DHCS administers the Medi-Cal Program, which provides comprehensive health care services to millions of low-income families and individuals through contracts with MCPs. Pursuant to Social Security Act (SSA) Section 1905(a)(29) and Title 42 of the Code of Federal Regulations (CFR) Sections 440.170, 441.62, and 431.53, MCPs are required to establish procedures for the provision of Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services for qualifying members to receive medically necessary transportation services. NEMT services are authorized under SSA Section 1902 (a)(70), 42 CFR Section 440.170, and Title 22 of the California Code of Regulations (CCR) Sections 51323, 51231.1, and 51231.2.

AB 2394 amended WIC Section 14132(ad)(1) to provide that, effective July 1, 2017, NMT is covered, subject to utilization controls and permissible time and distance standards, for MCP members to obtain covered Medi-Cal medical, dental, mental health, and substance use disorder services. Beginning on July 1, 2017, MCPs must provide NMT for MCP members to obtain medically necessary MCP-covered services and must make their best effort to refer for and coordinate NMT for all Medi-Cal services.
not covered under the MCP contract. Effective October 1, 2017, in part to comply with CMS-2333-F and to have a uniform delivery system, MCPs must also provide NMT for Medi-Cal services that are not covered under the MCP contract. Services that are not covered under the MCP contract include, but are not limited to, specialty mental health, substance use disorder, dental, and any other services delivered through the Medi-Cal fee-for-service (FFS) delivery system.

REQUIREMENTS:

Non-Emergency Medical Transportation
NEMT services are a covered Medi-Cal benefit when a member needs to obtain medically necessary covered services and when prescribed in writing by a physician, dentist, podiatrist, or mental health or substance use disorder provider. NEMT services are subject to a prior authorization, except when a member is transferred from an acute care hospital, immediately following an inpatient stay at the acute level of care, to a skilled nursing facility or an intermediate care facility licensed pursuant to Health and Safety Code (HSC) Section 1250².

MCPs must ensure that the medical professional’s decisions regarding NEMT are unhindered by fiscal and administrative management, in accordance with their contract with DHCS³. MCPs are also required to authorize, at a minimum, the lowest cost type of NEMT transportation (see modalities below) that is adequate for the member’s medical needs. For Medi-Cal services that are not covered by the MCP’s contract, the MCP must make its best effort to refer for and coordinate NEMT. MCPs must ensure that there are no limits to receiving NEMT as long as the member’s medical services are medically necessary and the NEMT has prior authorization.

MCPs are required to provide medically appropriate NEMT services when the member’s medical and physical condition is such that transport by ordinary means of public or private conveyance is medically contraindicated and transportation is required for obtaining medically necessary services⁴. MCPs are required to provide NEMT for members who cannot reasonably ambulate or are unable to stand or walk without assistance, including those using a walker or crutches⁵. MCPs shall also ensure door-to-door assistance for all members receiving NEMT services.

Unless otherwise provided by law, MCPs must provide transportation for a parent or a guardian when the member is a minor. With the written consent of a parent or guardian, MCPs may arrange NEMT for a minor who is unaccompanied by a parent or a guardian.

² 22 CCR Section 51323 (b)(2)(C)
³ Exhibit A, Attachment 1 (Organization and Administration of the Plan)
⁴ 22 CCR Section 51323 (a)
⁵ Manual of Criteria for Medi-Cal Authorization, Chapter 12.1 Criteria for Medical Transportation and Related Services
MCPs must provide transportation services for unaccompanied minors when applicable State or federal law does not require parental consent for the minor’s service. The MCP is responsible to ensure all necessary written consent forms are received prior to arranging transportation for an unaccompanied minor.

MCPs must provide the following four available modalities of NEMT transportation in accordance with the Medi-Cal Provider Manual and the CCR when the member’s medical and physical condition is such that transport by ordinary means of public or private conveyance is medically contraindicated and transportation is required for the purpose of obtaining needed medical care:

1. MCPs must provide **NEMT ambulance services** for:
   - Transfers between facilities for members who require continuous intravenous medication, medical monitoring or observation.
   - Transfers from an acute care facility to another acute care facility.
   - Transport for members who have recently been placed on oxygen (does not apply to members with chronic emphysema who carry their own oxygen for continuous use).
   - Transport for members with chronic conditions who require oxygen if monitoring is required.

2. MCPs must provide **litter van services** when the member’s medical and physical condition does not meet the need for NEMT ambulance services, but meets both of the following:
   - Requires that the member be transported in a prone or supine position, because the member is incapable of sitting for the period of time needed to transport.
   - Requires specialized safety equipment over and above that normally available in passenger cars, taxicabs or other forms of public conveyance.

3. MCPs must provide **wheelchair van services** when the member’s medical and physical condition does not meet the need for litter van services, but meets any of the following:
   - Renders the member incapable of sitting in a private vehicle, taxi or other form of public transportation for the period of time needed to transport.

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6 Medi-Cal Provider Manual: Medical Transportation – Ground
7 22 CCR Section 51323(a) and (c)
8 Medi-Cal Provider Manual: Medical Transportation – Ground, page 9, Ambulance: Qualified Recipients
9 22 CCR Section 51323 (2)(A)(1)
10 22 CCR Section 51323 (2)(B)
11 22 CCR Section 51323 (3)(A)
• Requires that the member be transported in a wheelchair or assisted to and from a residence, vehicle and place of treatment because of a disabling physical or mental limitation12.
• Requires specialized safety equipment over and above that normally available in passenger cars, taxicabs or other forms of public conveyance13.

Members with the following conditions may qualify for wheelchair van transport when their providers submit a signed Physician Certification Statement (PCS) form (as described below)14:
• Members who suffer from severe mental confusion.
• Members with paraplegia.
• Dialysis recipients.
• Members with chronic conditions who require oxygen but do not require monitoring.

4. MCPs must provide NEMT by air only under the following conditions15:
• When transportation by air is necessary because of the member’s medical condition or because practical considerations render ground transportation not feasible. The necessity for transportation by air shall be substantiated in a written order of a physician, dentist, podiatrist, or mental health or substance use disorder provider.

NEMT Physician Certification Statement Forms
MCPs and transportation brokers must use a DHCS approved PCS form to determine the appropriate level of service for Medi-Cal members. Once the member’s treating physician prescribes the form of transportation, the MCP cannot modify the authorization. In order to ensure consistency amongst all MCPs, all NEMT PCS forms must include, at a minimum, the components listed below:
• Function Limitations Justification: For NEMT, the physician is required to document the member’s limitations and provide specific physical and medical limitations that preclude the member’s ability to reasonably ambulate without assistance or be transported by public or private vehicles.
• Dates of Service Needed: Provide start and end dates for NEMT services; authorizations may be for a maximum of 12 months.
• Mode of Transportation Needed: List the mode of transportation that is to be used when receiving these services (ambulance/gurney van, litter van, wheelchair van or air transport).

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12 22 CCR Section 51323 (3)(B)
13 22 CCR Section 51323 (3)(C)
14 Medi-Cal Provider Manual: Medical Transportation – Ground, page 11, Wheelchair Van
15 22 CCR Section 51323 (c)(2)
• Certification Statement: Prescribing physician’s statement certifying that medical necessity was used to determine the type of transportation being requested.

Each MCP must have a mechanism to capture and submit data from the PCS form to DHCS. Members can request a PCS form from their physician by telephone, electronically, in person, or by another method established by the MCP.

Non-Medical Transportation
NMT has been a covered benefit when provided as an EPSDT service\textsuperscript{16}. Beginning on July 1, 2017, MCPs must provide NMT for MCP members to obtain medically necessary MCP-covered services. For all Medi-Cal services not covered under the MCP contract, MCPs must make their best effort to refer for and coordinate NMT.

Effective October 1, 2017, MCPs must provide NMT for all Medi-Cal services, including those not covered by the MCP contract. Services that are not covered under the MCP contract include, but are not limited to, specialty mental health, substance use disorder, dental, and any other benefits delivered through the Medi-Cal FFS delivery system.

NMT does not include transportation of the sick, injured, invalid, convalescent, infirm, or otherwise incapacitated members who need to be transported by ambulances, litter vans, or wheelchair vans licensed, operated, and equipped in accordance with state and local statutes, ordinances, or regulations. Physicians may authorize NMT for members if they are currently using a wheelchair but the limitation is such that the member is able to ambulate without assistance from the driver. The NMT requested must be the least costly method of transportation that meets the member’s needs.

MCPs are contractually required to provide members with a Member Services Guide that includes information on the procedures for obtaining NMT transportation services\textsuperscript{17}. The Member Services Guide must include a description of NMT services and the conditions under which NMT is available.

At a minimum, MCPs must provide the following NMT services\textsuperscript{18}:

• Round trip transportation for a member by passenger car, taxicab, or any other form of public or private conveyance (private vehicle)\textsuperscript{19}, as well as mileage reimbursement for medical purposes\textsuperscript{20} when conveyance is in a private vehicle arranged by the member and not through a transportation broker, bus passes, taxi vouchers or train tickets.

\textsuperscript{16} WIC 14132 (ad)(7)
\textsuperscript{17} Exhibit A, Attachment 13 (Member Services), Written Member Information
\textsuperscript{18} WIC Section 14132(ad)
\textsuperscript{19} Vehicle Code (VEH) Section 465
\textsuperscript{20} IRS Standard Mileage Rate for Business and Medical Purposes
• Round trip NMT is available for the following:
  o Medically necessary covered services.
  o Members picking up drug prescriptions that cannot be mailed directly to the member.
  o Members picking up medical supplies, prosthetics, orthotics and other equipment.
• MCPs must provide NMT in a form and manner that is accessible, in terms of physical and geographic accessibility, for the member and consistent with applicable state and federal disability rights laws.

Conditions for Non-Medical Transportation Services:
• MCP may use prior authorization processes for approving NMT services and re-authorize services every 12 months when necessary.
• NMT coverage includes transportation costs for the member and one attendant, such as a parent, guardian, or spouse, to accompany the member in a vehicle or on public transportation, subject to prior authorization at time of initial NMT authorization request.
• With the written consent of a parent or guardian, MCPs may arrange for NMT for a minor who is unaccompanied by a parent or a guardian. MCPs must provide transportation services for unaccompanied minors when state or federal law does not require parental consent for the minor’s service. The MCP is responsible to ensure all necessary written consent forms are received prior to arranging transportation for an unaccompanied minor.
• NMT does not cover trips to a non-medical location or for appointments that are not medically necessary.
• For private conveyance, the member must attest to the MCP in person, electronically, or over the phone that other transportation resources have been reasonably exhausted. The attestation may include confirmation that the member:
  o Has no valid driver’s license.
  o Has no working vehicle available in the household.
  o Is unable to travel or wait for medical or dental services alone.
  o Has a physical, cognitive, mental, or developmental limitation.

Non-Medical Transportation Private Vehicle Authorization Requirements
The MCPs must authorize the use of private conveyance (private vehicle)\(^\text{21}\) when no other methods of transportation are reasonably available to the member or provided by the MCP. Prior to receiving approval for use of a private vehicle, the member must exhaust all other reasonable options and provide an attestation to the MCP stating other methods of transportation are not available. The attestation can be made over the

\(^{21}\) VEH Section 465
phone, electronically, or in person. In order to receive gas mileage reimbursement for use of a private vehicle, the driver must be compliant with all California driving requirements, which include:

- Valid driver's license.
- Valid vehicle registration.
- Valid vehicle insurance.

MCPs are only required to reimburse the driver for gas mileage consistent with the Internal Revenue Service standard mileage rate for medical transportation.

**Non-Medical Transportation Authorization**

MCPs may authorize NMT for each member prior to the member using NMT services. If the MCP requires prior authorization for NMT services, the MCP is responsible for developing a process to ensure that members can request authorization and be approved for NMT in a timely matter. The MCP’s prior authorization process must be consistently applied to medical/surgical, mental health and substance use disorder services as required by CMS-2333-F.

**Non-Medical Transportation and Non-Emergency Medical Transportation Access Standards**

MCPs are contractually required to meet timely access standards. MCPs that have a Knox-Keene license are also required to meet the timely access standards contained in Title 28 CCR Section 1300.67.2.2. The member’s need for NMT and NEMT services do not relieve the MCPs from complying with their timely access standard obligations.

MCPs are responsible for ensuring that their delegated entities and subcontractors comply with all applicable state and federal laws and regulations, contractual requirements, and other requirements set forth in DHCS guidance, including APLs and Dual Plan Letters. MCPs must timely communicate these requirements to all delegated entities and subcontractors in order to ensure compliance.

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22 VEH Section 12500, 4000, and 16020
23 IRS Standard Mileage Rate for Business and Medical Purposes
24 28 CCR Section 1300.51(d)(H); Exhibit A, Attachment 9 (Access and Availability)
If you have any questions regarding this APL, contact your Managed Care Operations Division Contract Manager.

Sincerely,

Original Signed by Nathan Nau

Nathan Nau, Chief
Managed Care Quality and Monitoring Division