REVISION DATES: 9/30/21; 9/21/21; 11/8/2019; 10/1/2018; 7/1/2018; 05/04/2018; 01/09/2017; 09/28/2015;01/28/2015; 08/28/2014; 04/17/2014; 03/18/2014; 12/11/2013.

GENERAL INFORMATION

This chapter details transportation guidelines and reimbursement for all Fee-For-Service programs, including limitations.

EMERGENCY TRANSPORTATION SERVICES

AHCCCS covers emergency ground and air ambulance transportation services, within certain limitations, for most members.

This includes emergency ground and air ambulance services that are required to manage an emergency medical condition, both at an emergency scene and in transport to the nearest appropriate facility.

Prior authorization is not required for emergency transportation services.

Determination of whether a transport is an emergency is not based on the call to the provider, but upon the member's medical condition at the time of transport.

Emergency transportation may be initiated by an emergency response system call to “9-1-1,” fire, police, or other locally established system for emergency medical calls. Once emergency teams arrive on scene, the services required at that time (based on the field evaluation by the emergency team) may be determined to be:

- Emergent;
- Non-emergent, but medically necessary; or
- Not medically necessary.

Emergency transportation is determined to be needed due to the sudden onset of a medical condition or a behavioral health emergency manifesting itself by acute symptoms of sufficient severity (including severe pain), such that the absence of immediate medical attention could be reasonably expected to result in:

- Placing the member's health in serious jeopardy; and/or
- Serious impairment of bodily functions; and/ or
- Serious dysfunction of any bodily organ or part; and/or
- Serious physical harm to self or another person.

Emergency transportation includes transportation of a member to a higher level of care for immediate medically necessary treatment, even after stabilization at an emergency facility and may include, but is not limited to, the Maternal Transport Program (MTP), Newborn

Intensive Care Program (NICP), Basic Life Support (BLS), Advanced Life Support (ALS), and air ambulance services depending upon the member's medical needs.

The following coverage limitations and exclusions apply to emergency transportation services:

1. Coverage of ambulance transportation is limited to those emergencies in which specially equipped transportation is required to safely manage the member's medical condition.
2. Emergency transportation is covered only to the nearest appropriate facility medically equipped to provide definitive medical care.
3. Emergency transportation to an out-of-state facility is covered only if it is to the nearest appropriate facility. Mileage reimbursement is limited to loaded mileage. Loaded mileage is the distance traveled, measured in statute miles, while a member is on board the ambulance and being transported to receive emergency services.
4. A Fee-For-Service ground ambulance provider, who responds to an emergency call and provides medically necessary treatment at the scene, but does not transport the member, is eligible for reimbursement. This service is billed with HCPCS code A0998 (Response No Transport), and reimbursement can vary based on a provider's designation as follows:

   For ground ambulance providers operating under an Arizona Department of Health Services (ADHS) Certificate ofNecessity (CON):

   - For providers operating under a CON, ADHS does not set a rate specifically for A0998 Ambulance Response No Transport. The rate that applies for the CON provider is 68.59% of the ADHS-established ALS or BLS base rate that is effective with AHCCCS on the claim's date of service.
   - Where ADHS has established a base rate for the CON provider that <u>does not include</u> supplies, the provider may bill the supplies separately and be reimbursed separately for them; this is true for any ambulance trip whether or not a transport resulted.
   - Where ADHS has established a base rate for the CON provider that <u>includes</u> supplies, the provider may not bill supplies separately. Reimbursement for the supplies is included in the reimbursement for the ambulance trip; this is true whether the trip was a response with transport or A0998 Response No Transport.
   - Therefore, for some CON providers, A0998 includes reimbursement for supplies and they are not permitted to bill supplies separately; for other CON providers A0998 does not include supplies and they may bill and be reimbursed separately for the supplies. This is determined by ADHS, not AHCCCS.

For non-CON ambulance providers:

- Distinct from the above, AHCCCS has established a FFS rate for A0998 for non-CON ambulance providers, and that rate is deemed to include reimbursement for any supplies used during the service. The provider may not bill supplies separately.

5. A provider who responds to an emergency call, but does not treat or transport a member as a result of the call, is not eligible for reimbursement.
6. When two or more members are transported in the same ambulance, each shall be charged an equal percentage of the base rate and mileage charges.
7. Air ambulance services are covered under the following conditions:
    - If initiated at the request of:
        - An emergency response unit,
        - A law enforcement official,
        - A clinic or hospital medical staff member, or
        - A physician or practitioner.
    - The point of pick-up is inaccessible by ground ambulance,
    - Great distances or other obstacles are involved in getting the member to the nearest hospital with appropriate facilities, or
    - The medical condition of the member requires air ambulance services and ground ambulance services will not suffice.

Note: Emergency ambulance providers that are regulated by ADHS and operated under an ADHS-granted Certificate of Necessity (CON) are reimbursed according to A.R.S. R22-39(H).

If the diagnosis is unknown at the time of claim submission request, use the following diagnosis codes:

- For physical health use ICD-10 code R68.89, or
- For behavioral health use ICD-10 F99.

AIR AMBULANCE SERVICES

The current emergency air transportation procedure codes covered by AHCCCS are published annually, effective from October 1st to September 30th of the following calendar year. Refer to:

https://www.azahcccs.gov/PlansProviders/RatesAndBilling/FFS/transportationairambulance.html

Code A0888 may only be billed for AHCCCS members who also are covered by Medicare. Services must be medically necessary.

All covered services (oxygen, disposable supplies, etc.) are included in payment for the listed codes.

All air ambulance providers receive the same reimbursement for non-specialty care transports.

Effective 1/1/2014, the appropriate diagnosis code(s) must be billed. ICD-9 code 799.9 is no longer a valid or acceptable diagnosis code. Claims billed with this diagnosis code will be denied.

If the diagnosis is unknown at the time of claim submission request, use the following diagnosis codes:

- For physical health use ICD-10 code R68.89, or
- For behavioral health use ICD-10 F99.

SPECIALTY CARE TRANSPORTS

Specialty care transports are services for high-risk members through the Maternal Transport Program (MTP) and the Newborn Intensive Care Program (NICP) administered by the Arizona Department of Health Services (ADHS). ADHS provides special training and education to designated staff in the care of maternity and newborn emergencies during transport to a perinatal center.

The high risk transport team is dispatched after consultation with the MTP or NICP perinatologist or neonatologist. Only MTP or NICP Contractors may provide air transport. A provider may bill for specialty care transport when the following conditions are met:

1. The provider must have a current MTP/NICP contract with ADHS, and AHCCCS must have a copy of that contract.
2. The provider must use a high-risk transport team and equipment for the transport.
3. The provider must send supporting documentation, including either:
   a. A completed Request for Participation Form with approval from an ADHS-contracted perinatologist or neonatologist, with privileges at an Arizona tertiary perinatal center; or
   b. A completed Request for Maternal Transport Form with approval from an ADHS-contracted perinatologist, with privileges at an Arizona tertiary perinatal center.

Specialty care transport providers must bill the "TH" modifier with one of the following: A0430, A0431, A0435, A0436 and A0888. If the “TH” modifier is used by a non-specialty care provider the claim will be denied.

In addition, code A0225 (Ambulance service, neonatal transport, base rate, emergency transport, one way) may be used for the maternal/neonate transport team to accompany the

ground ambulance. This code may only be used by specialty care providers, but it does not require the "TH" modifier.

GROUND AMBULANCE SERVICES

The current emergency ground transportation procedure codes covered by AHCCCS are published annually, effective from October 1st to September 30th of the following calendar year. Refer to:

https://www.azahcccs.gov/PlansProviders/RatesAndBilling/FFS/transportationground.html

Code A0888 may only be billed for AHCCCS members who also are covered by Medicare. Services must be medically necessary.

BILLING FOR AIR AND GROUND AMBULANCE SERVICE

Claims for ground and air ambulance service must be billed on the CMS 1500 claim form. Emergency transportation does not require prior authorization. However, providers must mark the emergency field (Field 24C) to indicate emergency services on each applicable line.

Emergency air and ground ambulance claims are subject to Medical Review. Claims must be submitted with documentation of medical necessity and a copy of the trip report evidencing:

1. Medical condition, signs and symptoms, procedures, and treatment;
2. Transportation origin, destination, and mileage (statute miles);
3. Supplies; and
4. Necessity of attendant, if applicable.

Claims submitted without such documentation are subject to denial.

MULTIPLE AMBULANCE TRANSPORTS

When multiple ground or air ambulance transports occur in the same day, only one base rate may be charged unless the additional transport is a separately identifiable service.

In addition, supplies (either BLS routine disposable supplies with code A0382 *or* ALS routine disposable supplies with code A0398) and oxygen supplies (for either BLS or ALS in a life sustaining situation with code A0422) may be charged for only one ground ambulance trip, unless the additional transport is a separately identifiable service.

EXAMPLE 1:
A member is transported by ground ambulance from an accident scene

to a hospital. The ambulance remains at the hospital while the member is stabilized. The same ambulance then transports the member to another hospital or airport for transfer to a higher level of care or for services not available at the current facility. In this example, one base rate, waiting time and total mileage should be billed. The provider also may bill the appropriate codes for supplies and oxygen, and the corresponding charges.
EXAMPLE 2:
A member is transported by air ambulance from an accident scene to a hospital. The air ambulance remains at the airstrip while the member is stabilized. The same air ambulance then transports the member to another hospital for services not available at the current facility. In this example, one base rate and total mileage should be billed.
EXAMPLE 3:
A member is transported by ground ambulance from an accident scene to a hospital. The ambulance leaves the hospital and returns to base or takes another call. At the hospital's request, the same ambulance returns to the hospital to transport the member to another hospital or airport for transfer to a higher level of care or for services not available at the current facility.

In example 3, the provider may bill two base rates, mileage, supplies, and oxygen using one of the following methods:

1. If the *same* HCPCS code is used to bill the base rate for separately identifiable trips:
    a. Two units of the base rate should be billed on Line 1 of the CMS 1500 claim form.
    b. The total mileage for both trips should be billed on Line 2.
    c. Supply charges for both trips should be billed on Line 3.
    d. Oxygen charges for both trips should be billed on Line 4.
    e. Waiting time should *not* be billed.

2. If a *different* HCPCS code is used to bill the base rate for each separately identifiable trip:
    a. One unit of the first base rate should be billed on Line 1 of the claim form.
    b. Mileage for the first trip should be billed on Line 2.
    c. One unit of the second base rate should be billed on Line 3.
    d. Mileage for the second trip should be billed on Line 4.
    e. Supply charges for both trips should be billed on Line 5.
    f. Oxygen charges for both trips should be billed on Line 6.
    g. Waiting time should *not* be billed.

Emergency Triage, Treat and Transport (ET3)

Emergency Triage, Treat and Transport (ET3) is a program designed to allow greater flexibility for ambulance providers registered with AHCCCS as Emergency Transportation providers (Provider Type 06) to address health care needs following a 9-1-1 call.

ET3 permits emergency transportation (ground ambulance) providers to:

1) Transport a member to an Alternative Destination Partner (such as a primary care doctor's office, an urgent care clinic or a community mental health partner), *or*
2) To initiate and facilitate a members' receipt of medically necessary covered service(s) by a Qualified Health Care Partner at the scene of a 9-1-1 response either in-person on the scene or via telehealth (Treatment in Place).

To bill for ET3 services a provider must:

1) Be registered with AHCCCS as Provider Type 06; and
2) Be responding to a "call" initiated by an emergency response system ("9-1-1" call, fire, police, or other locally established system for medical emergency calls); and
3) Upon arrival at the scene, the emergency team's field evaluation determines that the member's needs are non-emergent, but medical necessary; and
4) Follow all requirements as outlined in AMPM 310-BB.

To become an AHCCCS-registered provider type 06, ambulance providers must have received a Certificate of Necessity (CON) from ADHS.

Tribal providers who choose not to receive a CON from ADHS may become an AHCCCS-registered provider type 06 by signing the AHCCCS attestation of CON equivalency.

Transport to an Alternative Destination Partner

An Emergency Transportation provider may transport a member to an Alternative Destination Partner (i.e. Urgent Care Clinic, Behavioral Health Clinic, Primary Care Physician, Specialist, etc.) when the field team's evaluation determines that the member's needs are non-emergent, but medically necessary, and that an Alternative Destination Partner will meet the member's level of care more appropriately than an emergency department.

Prior to initiating ET3 transport to an alternative destination intervention, the provider must have pre-established arrangements with alternative destination partners within their region, who have confirmed they see AHCCCS Fee-for-Service members, ***in advance of the***

***transport*,** and knowledge of the Alternative Destination Partner's:

1) Hours of operation, and[14]
2) Clinical staff available and services provided.[15]

NOTE: If an emergency transportation provider transports a member to an Alternative Destination Partner and determines at the time that the Alternative Destination Partner is either a) closed, or b) unable to provide the needed level of care, or c) unable to arrange for transportation of the member for their return home, then the emergency transportation provider shall transport the member to the nearest emergency department. In these cases, the provider may not bill for two transports.

The Alternative Destination Partner shall be within or near the responding emergency transportation provider's service area

- For example, an ambulance picks up a member at the border of their service area. The member requires an urgent care center, not an ER level of care. The ambulance provider has an alternative destination partner within their service area that is 10 miles away, and another alternative destination partner outside their service area that is 1 mile away from their current location. In this scenario, it would be appropriate to transport the member outside the ambulance company's service area, since the alternative destination partner is closer.

Billing for Transport to an Alternate Destination

When billing for transport to an alternative destination, providers shall bill on a CMS 1500 Claim Form, using the most clinically appropriate HCPCS code (A0426 or A0428) and a CG Modifier to indicate ET3 services. Providers should also bill mileage as appropriate.

- A0426 – Ambulance Service, Advanced Life Support, Non-Emergency Transport Level 1
- A0428 - Ambulance Service, Basic Life Support, Non-Emergency Transport

Treatment in Place

An Emergency Transportation provider may provide treatment to the member on the scene, in accordance with the emergency team's scope of practice and their emergency transport services' medical direction and established protocols.

Billing for Treatment in Place

When billing for treatment in place, providers shall bill on a CMS 1500 Claim Form, using HCPCS code A0998 and the CG modifier.

- A0998 – Ambulance Response and Treatment, No Transport

NOTE: A0998 with the CG modifier indicates ET3. This is different than when A0998 is billed with a UA, UB, UC, or UD modifier for Treat and Refer services. Treat and Refer providers may not bill for A0998 utilizing the CG modifier.

Treat and Refer Billing Guidance

Effective for dates of service on and after October 1, 2016, AHCCCS may reimburse ADHS approved and AHCCCS-registered Treat and Refer providers (Provider Type TR) for qualifying services.

Billing shall be done in a similar manner to billing for ambulance services.

To bill for Treat and Refer services, utilize HCPCS code A0998 (Ambulance response and treatment, no transport) with the appropriate modifier as listed below.

- UA -- Treat at home, refer to PCP/Specialist
- UB – Treat at home, refer to Crisis Response
- UC – Treat at home, refer to Behavioral Health Provider
- UD – Treat at home, refer to Urgent Care

The address of the service location (i.e. their home, assisted living facility, etc.) shall be listed in Field 32 (Service Facility Location Information). If an address is not available, the provider shall list the available location information of where the member was treated (i.e. street address, geographic coordinates, “20 miles South of Route #”, etc.).

Treat and Refer providers shall provide the patient care report (PCR) with their claim submission as supporting documentation.

For additional information refer to the AHCCCS and ADHS websites at:

- https://www.azahcccs.gov/PlansProviders/NewProviders/treatandrefer.html
- https://www.azdhs.gov/preparedness/emergency-medical-services-trauma-system/index.php#tr-ems-agency-recognition

NON-EMERGENCY AMBULANCE TRANSPORTATION SERVICES

AHCCCS covers medically necessary, non-emergency ground ambulance and air transportation to and from a required, covered medical service for most members.

Non-emergency transportation is not covered for Federal Emergency Services Program members.

Round-trip air or ground ambulance transportation services may be covered when a hospitalized member is transported to another facility for necessary specialized diagnostic and/or therapeutic services if all of the following requirements are met:

1. The member's condition is such that the use of any other method of transportation is not appropriate;
2. Services are not available in the hospital, in which the member is an inpatient;
3. The hospital furnishing the services is the nearest one with such facilities; and
4. The member returns to the point of origin.

Non-ambulance transportation providers may not provide emergency transportation because providers cannot assure adequate life support systems.

NON-EMERGENCY MEDICAL TRANSPORTATION SERVICES

When free transportation services are unavailable and an eligible person is unable to arrange or pay for transportation, AHCCCS covers medically necessary non-emergency medical transportation (NEMT) to and from an AHCCCS covered medical or behavioral health service for most members. Non-emergency medical transportation is not covered for Federal Emergency Services Program members.

Transportation is limited to the cost of transporting the member to and from either of the following active AHCCCS registered provider locations capable of meeting the member's needs:

- The nearest appropriate IHS/Tribal 638 medical or behavioral health facility, *or*
- The nearest appropriate medical or behavioral health provider.

In addition to the above, as of 7/1/18, non-emergency transportation services are covered under the following circumstances:

- To transport a member to obtain Medicare Part D covered prescriptions; and
- To transport a member to participate in one of the local community based support programs, as identified in the member's service plan. Transportation coverage to these programs is limited to transporting the member to the nearest program capable of meeting the member's need as identified on the member's service plan. Covered local community-based support programs are limited to the programs identified in AMPM 310 BB, Transportation, Attachment A, Community Based Support Programs.

As of 4/1/2014, all NEMT providers MUST have a sign or logo with the transport company's name on the vehicle when transporting AHCCCS members.

Special Considerations for Non-Emergency Medical Transportation

Attendant Care Non-Emergency Medical Transportation

NEMT services may be provided, with limitations, by providers registered as provider type 40

(Attendant Care). If the provider has been an AHCCCS registered provider for 12 months, then the provider may bill for NEMT services if that category of service has been approved by provider registration. However, the NEMT services cannot exceed 30% of their overall services billed.

Family Members

Transportation of a member by a family member will not be reimbursable unless the transportation provider is an AHCCCS registered provider *prior* to the transportation *and* prior to seeking PA *if* PA is required.

If the family member, who is an AHCCCS registered provider, could reasonably be expected to provide transportation services to the member, such as a mother providing transportation to their child, then transportation would not be reimbursable. Transportation is only reimbursable if transportation services would otherwise be unavailable and an eligible person is unable to arrange or pay for transportation.

NEMT on Reservations

Effective 10/1/2014, all non-emergency medical transportation providers that transport AHCCCS members (pick up and/or drop off) on reservation will be required to obtain a Tribal business license from the Tribe. A copy of the Tribal business license must be submitted to AHCCCS Provider Registration for documentation. When auditing claims AHCCCS will ensure that this documentation is on file. Failure to obtain and submit your Tribal business license will result in claims recoupment

Prior authorization will be denied for transport services on reservation if the NEMT provider does not have the corresponding Tribal business license on file with AHCCCS Provider Registration. Please refer to exhibit 14-3 for tribal contact information.

Pick-Up and Drop-Off Locations

The pick-up and drop-off locations do not always have to be at/to the member's home address. However, additional information may be requested by the AHCCCS Administration if it looks like the difference in mileage between the pick-up/drop-off locations and the member's home address could result in AHCCCS reimbursing a higher mileage to the provider.

If using a location other than the member's home address would result in a higher mileage for the NEMT, then the provider will need to provide a justification to AHCCCS. The provider will have to provide justification as to why it was necessary to pick-up/drop-off the member at a location other than the member's home. AHCCCS may also request details regarding the necessity if enough details are not provided in the initial request.

Prescription Pick-Up

A NEMT provider may not submit any claim for unloaded mileage. This includes prescription pick-up. A NEMT provider may not bill for picking up a member's prescription on the member's behalf.

Self-Driving

No member may drive themselves and subsequently bill AHCCCS for it, even if they are driving themselves to an AHCCCS approved service. To qualify for NEMT, free transportation services must be unavailable and an eligible person must be unable to arrange or pay for transportation. If an eligible person drives themselves, they were able to arrange for their own transportation. This is **not** reimbursable.

Special Considerations Involving Minors

In order for a member to sign for their own transportation, they must be either 18 years of age or older *or* an emancipated minor in accordance with A.R.S. §12- 2451 and §44-131. Emancipated minors must prove that they are emancipated, and then they may sign for their own transportation.

Minors that are not emancipated must have their legal guardian sign for their transportation. If a member is a minor and has a minor child, only the legal guardian of the minor child may sign for their transportation.

NEMT Authorization Requirements

Prior authorization is required for NEMT trips in excess of 100 miles (one-way, round trip, or multiple trips in the same day) for both medical and behavioral health services for FFS members.

Exception: PA is not required for IHS/Tribal 638 transportation providers.

For NEMT trips less than 100 miles (one-way, round trip, or multiple trips in the same day) for both medical and behavioral health services, prior authorization is not required for FFS members.

When prior authorization (PA) is required for transportation, PA will not be issued unless the transportation provider is an AHCCCS registered provider *prior* to seeking the PA.

Transports over 100 miles require authorization from the AHCCCS Prior Authorization (PA) Department for Acute FFS Members or from the Tribal ALTCS Case Manager for Tribal ALTCS Members. Only codes for base and mileage will be authorized.

- In order to obtain prior authorization for NEMT services the provider must provide AHCCCS with enough information to demonstrate that the member is being transported to an AHCCCS covered service. Prior authorization

requests with insufficient or vague information regarding the reason for the NEMT will result in a request for additional information. This can include a request for supporting documentation from the referring provider. The supporting documentation must provide the information necessary to allow AHCCCS to determine the medical necessity.

- The referring medical or behavioral health provider can fax this information directly to the Prior Authorization Department using the Medical Documentation form located at: https://www.azahcccs.gov/PlansProviders/RatesAndBilling/FFS/priorauthorizationforms.html

Note: It is not a violation of the Health Insurance Portability and Accountability Act (HIPAA) for a NEMT provider to request sufficient information to determine whether the transport is to an AHCCCS covered service.

When audits are conducted additional information may be requested to verify that the NEMT was to an AHCCCS covered service. Verifying that transportation is to an AHCCCS covered service is the provider's responsibility, regardless of whether or not the service was prior authorized.

Special Considerations:

For American Indian members enrolled with AIHP, and /or who are enrolled with a TRBHA, or who receive medical or behavioral health services at an IHS/Tribal 638 facility, transportation services are covered through DFSM.

For American Indian members enrolled with a RBHA, who receive behavioral health services at an IHS/Tribal 638 facility, transportation services are covered through the RBHA.

For American Indian members enrolled with an ACC plan, who receive services at an IHS/Tribal 638 facility, transportation services are covered through the ACC plan.

For American Indian members, who are TRBHA enrolled and who are also enrolled with an ACC plan for physical health services, transportation to physical health services are covered through the ACC plan.

For an ACC/TRBHA enrolled member receiving behavioral health services, transportation services are covered through DFSM.

Refer to AMPM Policy 310-BB for a complete description and discussion of covered transportation services.

For information on submission of prior authorization requests please refer to AMPM 820,

Prior Authorization.

A prior authorization request for NEMT must contain a valid diagnosis code for physical or behavioral health services, if known.

If the diagnosis is unknown at the time of the authorization request, use the following diagnosis codes:

- For physical health use ICD-10 code R68.89, or
- For behavioral health use ICD-10 F99.

Note: The diagnosis codes R68.89 and F99 are also valid diagnosis codes for claims submitted for NEMT.

Effective for service dates prior to 1/1/2017:

For AHCCCS American Indian members who reside either on-reservation or off-reservation and are enrolled with AIHP (Contract ID number 999998) transportation services are covered on a FFS basis under the following conditions:

1. The request for transportation service is prior authorized through the AHCCCS DFSM UM/CM department, when mileage is greater than 100 miles per trip, whether one-way or round trip. PA is not required for IHS/638 providers.
2. The member is not able to provide, secure or pay for their own transportation and free transportation is not available; and
3. The transportation is provided to and from either of the following locations:
   a. The nearest appropriate IHS/Tribal 638 medical facility located either on-reservation or off-reservation, or
   b. The nearest appropriate AHCCCS registered provider located off-reservation.

Effective 10/1/2014 prior authorization will be denied for transport services on reservation if the NEMT provider does not have the corresponding Tribal business license on file with AHCCCS Provider Registration.

For American Indian members enrolled in either an AHCCCS Complete Care Health Plan or ALTCS managed care organization, please check with the managed care organization for prior authorization requirements.

Members who are enrolled with AIHP and live either on-reservation or off-reservation, and are receiving behavioral health services as specified in Chapter 12, Behavioral Health Services, may receive non-emergency medically necessary on-reservation transportation services as follows:

1. Non-emergency medical transportation may be provided as outlined above on a FFS basis for the following members:
   a. An AIHP enrolled member, residing either on-reservation or off-reservation, who is

receiving behavioral health services, but is not enrolled with an ADHS designated Regional Behavioral Health Authority (RBHA); or

b. An AIHP enrolled member, who lives on-reservation, but is a member of a tribe that is not designated as a Tribal Behavioral Health Authority (TRBHA) through an agreement with the ADHS, and who receives services at an IHS/Tribal 638 facility or through an off-reservation provider; or

2. If the AIHP member is enrolled with and receiving behavioral health services through a RBHA or TRBHA, non-emergency medically necessary on-reservation transportation is coordinated, authorized and provided by the RHBA or TRBHA.

PA for non-emergency medical transport provided to an AHCCCS FFS member or American Indian Health Plan (AIHP) enrolled member through the use of a private vehicle must be requested by the member's medical service provider. PA for transportation will not be issued unless the transportation provider is an AHCCCS registered provider prior to seeking PA

Effective 4/1/2012, members enrolled in a Tribal Regional Behavioral Health Authority (TRBHA) and the American Indian Health Plan (AIHP) must obtain Prior Authorization for non-emergency transportation service that is:

- In excess of 100 miles, whether one way or round trip; and
- Billed with ICD-9 diagnosis code 799.9 (prior to date of service 10/1/2015) or billed with ICD-10 diagnosis code R68.89 (effective date of service 10/1/2015).

Members enrolled in a TRBHA and a health plan, other than AIHP, non-emergency medical transportation claims that are billed with a behavioral health diagnosis code should continue to follow the Department of Behavioral Health Services guidelines.

Transports over 100 miles will continue to require authorization from the AHCCCS Prior Authorization Department for Acute Care members or from the ALTCS case manager for ALTCS members. Only codes for base and mileage will be authorized.

BILLING FOR NON-EMERGENCY MEDICAL TRANSPORTATION

The AHCCCS Daily Trip Report **must** be submitted with the claim.

Providers may bill without obtaining Prior Authorization if the total mileage for one member, on one date of service, is under 100 miles.

All trips for the same member, for the same date of service should be submitted on one claim form.

NEMT providers submitting claims can bill in the following ways:

- By using the Professional Claim, if using the provider web portal;

- By using the 837P for electronic claims submissions; or
- By using the CMS 1500 Claim Form.

All services occurring on the same date of service for a member's transport ***must*** be billed on a single claim. If multiple transports occurred on the same date of service, then the provider must bill the total number of trips (base rate) on the first line and the total loaded mileage on the second line of the claim.

- All trips taking place on the same day, for the same member, must be billed on one claim. The base rate must be billed on the first line, the loaded mileage on the second line, and the wait time (in the event that wait time is billed for) on the third line. Any additional lines will deny.

A claim submitted with only the base code and a second claim submitted with only the mileage ***will be denied***, as split-billing transport services is not permitted. Multiple claimssubmitted for the same date of service will be denied as duplicates.

Non-emergency transportation providers must bill the number of trips and the number of loaded miles as units of service on the CMS 1500 claim form. Loaded mileage is defined as the distance traveled, measured in statute miles, with a member on board the vehicle and being transported to receive medically necessary AHCCCS covered medical or behavioral health services.

Example case scenarios:

1. If a member travels from his/her home to an AHCCCS provider's office in town and the total trip is 95 miles then the trip does **NOT** require Prior Authorization**.**

2. If a member is transported from a car accident scene in a BLS or ALS ambulance to an emergency room then the trip is considered to be emergency transportation and does **NOT** require Prior Authorization. The return trip, however, could be non-emergency and could possibly require Prior Authorization IF the return trip is **more** than 100 miles**.**

3. Dialysis, non-emergency transports that had previously been billed monthly and exceeded 100 miles in total must be billed individually (per trip). Date span or "bulk" billing is no longer acceptable. Each service date must be identifiable on the claim and must be billed with actual loaded miles, as supported by odometer readings.

4. If a member is transported via non-emergency AIR ambulance for medically necessary discharge to a lower level facility and that transport is **less than 100 miles** then the trip **DOES** require Prior Authorization.

Effective 9/1/2014, all services for the member's transport ***must*** be billed on one claim using multiple lines for that date of service. A claim submitted with base code only and a second claim submitted with mileage only ***will be denied***, as split-billing the transport service is inappropriate.

Non-emergency transportation providers must bill the number of trips and the number of loaded miles as units of service on the CMS 1500 claim form. Loaded mileage is defined as the distance traveled, measured in statute miles, with a member on board the vehicle and being transported to receive medically necessary AHCCCS covered services.

If **multiple transports on the same day** are authorized for a member, providers must bill the second trip (and any subsequent trips) as follows:

- Two units of the authorized base rate should be billed on Line 1 of the claim form. (If there are two trips on the same day for the member.)
- The total mileage for both trips should be billed on Line 2

If a member's transport involves multiple destinations then the daily trip report must document each segment of the transport, including the full address of each location as well as the times and odometer readings.

Special Consideration for Multiple Transports on the Same Day

All FFS transports occurring on the same day for the same member must be billed on the same claim, including multiple stops.

Non-FFS transports (e.g. transports for a RBHA enrolled member to a behavioral health provider) shall be billed to the RBHA.

> Note: This means that when multiple stops occur that it is possible, depending on the type of service, that you may need to submit one claim to FFS and one to the RBHA.

Wait time shall only be billed for the amount of time the driver *actually waited* at the member's medical service destination ***if*** the distance traveled was such that it was not feasible for the driver to return to the provider's base of operations or the origination site.

Wait time is billed with code T2007 where each unit is 30 minutes. If transporting multiple members at one time, the wait time shall be reimbursed for no more than one member.

In addition, billing for wait time is not appropriate:

- If the odometer reading changes from the drop-off at the medical service to the pick-up at the medical service;
- For a one way trip;
- When two different vehicles and/or drivers are used for the round trip;
- If wait time is less than 30 minutes; or
- If the distance to the medical service location is 10 miles or less.

Special Considerations for the Transportation of Multiple Members

If multiple AHCCCS members are transported in the same vehicle a separate AHCCCS daily trip report must be submitted for each member.

Each AHCCCS Daily Trip Report must list the location where the member was picked up and dropped off. The reported miles from the odometer shall reflect the number of miles of the most direct route between **that member's pick up and drop off location.**

Billing with the "TN" Modifier

AHCCCS has established separate urban and rural rates and procedure codes for certain non- ambulance transportation services. Urban transports are those that originate within the Phoenixand Tucson metropolitan areas. All other transports, outside of the Phoenix and Tucson metropolitan areas, are defined as rural and must be billed with the "TN" modifier. A rural designation is meant to accommodate atypical conditions, such as the use of unmaintained and/or dirt roads, long distances required to reach the member, and a lack of providers in the area.

Transportation Codes

The Health Insurance Portability and Accountability Act (HIPAA) mandates that all local codes be replaced with the appropriate HCPCS, CPT-4, and revenue codes and modifiers for dates ofservice on and after December 1, 2003. This applies to non-emergency transportation providers who submit claims electronically and on paper.

The AHCCCS website provides a table that summarizes available non-emergency transportation procedure (HCPCS, CPT) codes and provides the AHCCCS Capped Fee-For-Service Fee Schedule for transportation, for each code. NEMT reimbursement is dependentupon the code billed for reimbursement, not the FFS member type. There is no difference in reimbursement between FFS and ALTCS members. For further information refer to:

https://azahcccs.gov/PlansProviders/RatesAndBilling/FFS/

Mileage Discrepancies

If there is a mileage discrepancy between the total loaded mileage on the 1st trip (from the pick-up location to the drop-off destination) and the total loaded mileage on the 2nd trip (from the service location to the original pick-up destination), justification for the discrepancy must be provided. If no justification is provided than the mileage difference may be reduced by AHCCCS.

The justification can be provided on the AHCCCS Daily Trip Report. There is a section for additional information to be entered in at.

DOCUMENTATION REQUIREMENTS

All non-emergency medical transport providers will be required to use the AHCCCS Daily Trip Report, which is Exhibit 14-1. Detailed instructions for completing the Daily Trip Report can be found in Exhibit 14-2.

Any non-emergency transportation claim submitted without the AHCCCS Daily Trip Reportfound in Exhibit 14-1 will be denied.

- Please note that different versions of the Daily Trip Report may ***not*** be used or submitted. The attachment in Exhibit 14-1 is the ***only version*** that may be submitted.
- Providers are ***not*** permitted to create their own versions of the Daily Trip Report for submission. **Only the AHCCCS approved Daily Trip Report can be used.**

The AHCCCS Daily Trip Report may be filled out in either blue or black ink.

The AHCCCS Daily Trip Report may be filled out on a tablet or another electronic device, so long as all federal and state requirements for the protection of member information are taken, including but not limited to HIPAA compliance and adherence to the AHCCCS Security Rule Compliance Summary Checklist (found in ACOM Policy 108, Attachment A).

If the AHCCCS Daily Trip Report is filled out electronically it may be submitted by printing it out and mailing it in, or electronically submitting it through the 275 provider portal as a PDF file.

- AHCCCS **will not** accept HTML files of the AHCCCS Daily Trip Report.
- AHCCCS **will not** accept Excel files of the AHCCCS Daily Trip Report. If a provider uses the Excel file, they **must** convert to a PDF before submission. The Excel file was included at provider request.
- AHCCCS **will** accept PDF files of the AHCCCS Daily Trip Report.
    - Note: If the AHCCCS Daily Trip Report is submitted as a PDF file through the 275 Provider Portal, it is necessary that the PDF file allow AHCCCS to extract the document, otherwise AHCCCS will not be able to view the submitted PDF file.

AHCCCS will conduct retrospective audits of non-emergency ground transportation providers to verify that the mileage, wait time, diagnosis, and medical necessity are correct and that all charges are supported and justifiable. The transportation provider will submit all requested documentation, including the justification of the transport, upon request by AHCCCS anytime after the date of service. Each service must be supported with the following documentation on the Daily Trip Report:

- **Provider Information:** NEMT provider name, ID, address, and phone number. Using a stamp is acceptable.

- **Driver's name:** Printed first and last name of the driver who provided the service.
- **Date:** Indicate the date of service (mm/dd/ccyy).
- **Vehicle Identification:** This must include the state the vehicle is licensed in, the fleet or license plate number, and the make and color of the vehicle.
    - NOTE: If the driver uses more than one vehicle for the same date of service, they must use a new Daily Trip Report for each separate vehicle and they must indicate (at the bottom right) the page number. All pages become the *complete* Daily Trip Report for the transport services for that member, on that service date.

- **Vehicle Type:** Indicate the type of vehicle (car, van, wheel chair van, stretcher van, etc.)
- **Member Information:** Member's full name, AHCCCS ID, date of birth (mm/dd/ccyy), and mailing address.
- **Pick-up address:** Complete address (including street address, city, state and zip code) of pick-up destination.
    - If no formal street address is available coordinates can be used. An address must be included in some format, so the lack of a formal street address is not a cause for no address to be listed. In the event that no coordinates can be found, the address or coordinates of a nearby landmark, with the mileage from that landmark to the pick-up location can be used.
- **Pick-up time:** Clock time including the a.m./p.m. indicator (example: 7:12 AM). Please circle the appropriate time of day (a.m./p.m.) provided.
- **Pick-up Odometer:** Document the actual odometer reading at the pick-up location.
- **Drop-off address:** Complete address (including street address, city, state and zip code) of drop-off address.
    - If no formal street address is available coordinates can be used. An address must be included in some format, so the lack of a formal street address is not a cause for no address to be listed. In the event that no coordinates can be found, the address or coordinates of a nearby landmark, with the mileage from that landmark to the drop-off location can be used.
- **Drop-off time:** Clock time including the a.m./p.m. indicator (example: 4:46 PM). Please circle the appropriate time of day (a.m./p.m.) provided.
- **Drop-off Odometer:** Document the actual odometer reading at the drop-off location.
- **Trip miles:** Subtract the pick-up odometer reading from the drop-off odometer reading. This will be the number of trip miles. (Drop-off odometer reading – pick-up odometer reading = trip miles)
- **Type of Trip:** Round Trip, One Way, or Multiple Stops
- **Reason for Visit:** Only include as much information as the member is willing to share.
    - **Note:** When transportation services are initially arranged, the transportation provider must obtain sufficient information to determine whether the transportation is occurring to an AHCCCS covered service.
- **Diagnosis (if known):** Only include as much information as the member is willing to share.

- **Name of Escort:** If member is traveling with an escort, include their first and last name.
- **Relationship:** Indicate the escort's relationship to the member.
- **Member Signature:** Member must sign, if able. If member is unable to sign, please check the appropriate box and identify the person* signing for the member ***or*** include the member's fingerprint.
    - If a tablet or other electronic device is being used, a method for the member or authorized representative of the member to sign their signature must be

      available (typically by an electronic pen or using their fingertip to sign their name). A fingerprint may also be used if they are unable to sign.
    - Typing the member's name in cannot serve as a substitute for an actual signature or fingerprint.
- **Driver's Signature:** The driver must sign each page.
    - If a tablet or other electronic device is being used, a method for the driver to sign their signature must be available (typically by an electronic pen or using their fingertip to sign their name).
    - Typing the driver's name in cannot serve as a substitute for an actual signature or fingerprint.
- **Date:** The driver must date each page.
- **Page____of___:** Indicate each page number and the total number of pages used to document all transports for the member, for the same date of service.
- **Did multiple members get transported in the same vehicle on this trip?** Choose yes if multiple AHCCCS members are being transported in the same vehicle.
    - **Were the pick-up and drop-off locations different for the members?** Choose yes if even one member in the vehicle had a different pick-up or drop-off location, as this can affect the odometer readings.
- **Additional Information:** Any additional information that the provider thinks is needed for the processing of the claim can be entered here.

Clarification of member's "signature" requirement

If a member is physically unable to sign (or fingerprint) the non-emergency medical transport trip report then a parent or guardian, caretaker, escort, or family member can sign for the member and indicate their relationship to the member. If the member is transporting alone, then the trip report may be signed by the provider at the medical service appointment.

When someone else signs the trip report for the member, the trip report should show the member's name and a notation such as "by J Smith, daughter" to identify the person signing for the member.

Under no circumstances is the transport driver to sign for a member.

- Even if the transport driver is a physical or behavioral health care provider for the member, they still cannot sign for the member. If the member cannot sign for themselves then a parent, guardian, caretaker, escort, or other family member would have to sign for them. **The driver cannot sign, even if the**

driver overlaps one of the categories that normally could.

For further instructions on how to fill out the Daily Trip Report, please see the Non-Emergency Medical Transportation Daily Trip Report Instructions, Exhibit 14-2.

It is the provider's responsibility to maintain documentation that supports each transport service claimed. The AHCCCS Daily Trip Report must be completed by the driver in pen with all information clear and legible.

Erasures and white-out are not acceptable. If an error is made, draw a single line through the error and enter the correct information.

Trip records with missing information will be subject to audit error and recoupment.

Effective for dates of service 7/1/2013 and forward, all non-emergency medical transport providers will be required to use the AHCCCS standard Daily Trip Report, Exhibit 14-1, with instructions for completing the standard Daily Trip Report found at Exhibit 14-2.

Effective for dates of service 8/1/2013 and forward, any non-emergency transport claim submitted without the AHCCCS standard Daily Trip Report will be denied.

PUBLIC TRANSPORTATION

Effective dates of service 10/1/2021and forward, eligible Providers with a Category of Service (COS) 31 may offer Public Transportation options to FFS members traveling to and from AHCCCS approved services, in accordance with AMPM 310-BB.

Provider types that are eligible to claim reimbursement for public transportation passes include 02, 05, 13, 14, 25, 27, 29, 41, 77, 81, 85, 86, 87, A3, A4, A6, B7, BC, C2, and C5.

Submission of public transportation claims require the following conditions:

1. Transportation passes may be up to 1 month in duration; and
2. Replacement or duplicate transportation passes are not eligible for Medicaid reimbursement; and
3. There shall be a continuous need for transportation to Medicaid reimbursable services consistent with the length of the purchased transportation pass; and
4. Providers shall determine the appropriate type/duration of public transportation pass to issue to members in accordance with the member's treatment plan and existing future appointment dates.

    a. Example: A member has an evaluation visit at a behavioral health provider, which results in the recommendation for intensive outpatient treatment three times a week for the next four weeks. The provider issues the member a monthly public transportation pass to travel to their appointments.

5. Providers shall bill using Code A0110 for the net cost of the transportation pass, not to exceed the cost of a 30-day pass.

Complete submission of public transportation claims shall be accompanied by documentation to include:

- Copy of public transportation pass,
- Itemized receipt specifying cost of public transportation pass,
- Pricing that corresponds with the price of the pass in the geographic areas of issuance.
- Completed Public Transportation Pass form to include the following:
    - Provider's name and ID#,
    - Public Transportation pass type (daily, weekly, or monthly),
    - Price of the Public Transportation pass,
    - Date of issuance,
    - Name, title, signature, and signature date of person issuing Public Transportation pass to the member,
    - Member name, AHCCCS ID#, signature and signature date.

Incomplete or inaccurate documentation may result in a claims denial.

ILLEGAL INCENTIVES/REMUNERATIONS

Providers offering gift cards, free lunches or other cash in kind inducements to have the member select their transportation services are prohibited by Federal Criminal Penalties Statute 42 USC 1320a-7b(b)(2).

Among other activities not permitted, this law prohibits individuals from (knowingly and willfully) offering or paying any remuneration, whether it is cash or in kind, to anyone for the purpose of inducing that individual to order or arrange for any service or item for which payment may be made by a federal health care program, including Medicaid. The offer or payment may be direct or indirect. Such conduct is considered a felony with the possibility of imprisonment up to 5 years as well as a fine not to exceed $25,000.

The provision from 42 USC 1320a-7b (b)(2) reads:

(b) Illegal remunerations
(1) Whoever knowingly and willfully solicits or receives any remuneration (including any kickback, bribe, or rebate) directly or indirectly, overtly or covertly, in cash or in kind--
(A) in return for referring an individual to a person for the furnishing or arranging for the furnishing of any item or service for which payment may be made in whole or in part under a Federal health care program, or
(B) in return for purchasing, leasing, ordering, or arranging for or recommending purchasing, leasing, or ordering any good, facility, service, or item for which payment

may be made in whole or in part under a Federal health care program, shall be guilty of a felony and upon conviction thereof, shall be fined not more than $25,000 or imprisoned for not more than five years, or both.

Whoever knowingly and willfully offers or pays any remuneration (including any kickback, bribe, or rebate) directly or indirectly, overtly or covertly, in cash or in kind to any person to induce such person-

(A) To refer an individual to a person for the furnishing or arranging for the furnishing of any item or service for which payment may be made in whole or in part under a Federal health care program, or

(B) To purchase, lease, order or arrange for, or recommend purchasing, leasing, or ordering any good, facility, service, or item for which payment may be made in whole or in part under a Federal health care program, shall be guilty of a felony and upon conviction thereof, shall be fined not more than $25,000 or imprisoned for not more than five years, or both.

For further information regarding provider regulations when it comes to incentives, please refer to Chapter 3, Provider Records and Registration, of the Fee-For-Service Provider Billing Manual.

References

Refer to AMPM Chapter 310-BB for additional information regarding transportation services.

Refer to AMPM Chapter 1200 for additional information regarding Arizona Long Term Care System (ALTCS) authorization requirements.

Refer to AMPM Chapter 800 for additional information regarding prior authorization for non-ALTCS FFS members.

Refer to Exhibit 14-1 for the AHCCCS Daily Trip Report for NEMT.

Refer to Exhibit 14-2 for instructions on how to fill out the AHCCCS Daily Trip Report for NEMT.

Refer to Exhibit 14-3 for Tribal Contact Information.

Revision History

Date	Description of changes	Page(s)
9/30/21	New section added for Public Transportation Pass effective 101/21	23-24
9/21/2021	New section added for Emergency Triage, Treat, and Transfer (ET3) effective 10/1/21 New section added for Treat and Refer Billing guidance	7 9

11/8/2019	Clarifying language added to A0998 section.	2
10/1/2018	Information regarding procedure code A0998, ambulance providers operating under an ADHS Certificate of Necessity (CON), and providers not operating under an ADHS CON was added under bullet point number 4. Bullet point number 8 was updated, due to a change in rule. It now reads as: *Air ambulance services are covered under the following conditions:*	2 3
	• *If initiated at the request of:* ▪ *An emergency response unit,* ▪ *A law enforcement official,* ▪ *A clinic or hospital medical staff member, or* ▪ *A physician or practitioner.* The following information was added under the emergency transportation section: *If the diagnosis is unknown at the time of claim submission request, use the following diagnosis codes:* • *For physical health use ICD-10 code R68.89, or* • *For behavioral health use ICD-10 F99* The following information was added under the air ambulance transportation section: *If the diagnosis is unknown at the time of claim submission request, use the following diagnosis codes:* • *For physical health use ICD-10 code R68.89, or* • *For behavioral health use ICD-10 F99.* Information regarding PA requests and claims for NEMT services and appropriate diagnosis codes, when the diagnosis code is not known at the time of PA or claim submission was added. NEMT Prior Authorizations and Special Considerations sections were updated for integration	3 4 11 11--13

7/1/2018	Clarification added regarding the initiation of emergency transportation. An update regarding what NEMT services are covered as of 7/1/18 was added, including transports to: • Take a member to obtain Medicare Part D covered prescriptions; and • Take a member to participate in one of the local community based support programs, as identified in the member's service plan. Transportation coverage to these programs is limited to transporting the member to the nearest program capable of meeting the member's need as identified on the member's service plan. Covered local community-based support	1 6
	programs are limited to the programs identified in AMPM 310 BB, Transportation, Attachment A, Community Based Support Programs. The PA requirements section was updated, including the special considerations section. A section on Special Consideration for Multiple Transports on the Same Day was added. A section on Special Considerations for the Transportation of Multiple Members was added.	8-11 13-14 14
05/04/2018	Clarification added to A0998, regarding supplies. Note added regarding emergency ambulance providers regulated by the Department of Health Services (ADHS) and operating under an ADHS-granted Certificate of Necessity. NEMT information clarified Attendant Care NEMT Section Added Family Members Section Added Pick-Up and Drop-Off Locations Section Added Prescription Pick-Up Section Added Self Driving Section Added Minors (Special Considerations) Billing section updated Wait Time Billing Section Added TN Modifier Section Added Mileage Discrepancies Section Added Documentation Requirements Updated Trip Report Information Updated References Updated The word 'recipient' was changed to 'member' throughout. Formatting Updated version of the Trip Report added as Exhibit 14-1	2 2 6 6 7 7 7-8 8 8 11-12 13 13 13-14 14 14-16 18-19 All All Exhibit 14-1

	Updated version of the Trip Report Instructions added as Exhibit 14-2	Exhibit 14-2
01/09/2017	Revision Date added Updated links Insert policy language effective on or after 01/01/2017 Add identifier for policy language effective prior to 01/01/2017 Update Revision History table	1 2, 3, 7, 10 6-7 14
09/28/2015	Effective date of service 10/01/2015: ICD-9 code 799.9 replaced with ICD-10 code R68.89	2, 7
01/28/2015	Clarification language added for member's signature requirements on NEMT trip report	10, 11
08/28/2014	Effective 09/01/2014 split billing services on multiple claims will be denied Effective 10/01/2014 PA denied if no tribal business license on file for NEMT provider	8 6