

REVISION DATES: January 2015 clarification on page 11-11;
August 2014; April 2014; March 2014; December 2013; August 2013;
June 2013; May 2012

EMERGENCY TRANSPORTATION SERVICES

AHCCCS covers emergency ground and air ambulance transportation services, within certain limitations, for most recipients. Covered transportation services include:

1. Emergency ground and air ambulance services required to manage an emergency medical condition at an emergency scene and in transport to the nearest appropriate facility.
 - a. Determination of whether a transport is an emergency is not based on the call to the provider but upon the recipient's medical condition at the time of transport unless the call is initiated by an emergency response (9-1-1) system.
 - b. Emergency transportation is determined to be needed due to a sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could be expected to result in:
 - i. Placing the recipient's health in serious jeopardy,
 - ii. Serious impairment of bodily functions, or
 - iii. Serious dysfunction of any bodily organ or part.
 - c. Emergency transportation includes transportation of a recipient to a higher level of care for immediate medically necessary treatment, even after stabilization at an emergency facility.
2. Maternal Transport Program (MTP), Newborn Intensive Care Program (NICP), Basic Life Support (BLS), Advanced Life Support (ALS), and air ambulance services depending upon the recipient'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 recipient'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.
4. Mileage reimbursement is limited to loaded mileage. Loaded mileage is the distance traveled, measured in statute miles, while a recipient is on board the ambulance and is being transported to receive emergency services.

5. A provider who responds to an emergency call and provides medically necessary treatment at the scene but does not transport the recipient is eligible for reimbursement limited to the approved base rate and medical supplies to be billed with HCPCS code A0998.
6. A provider who responds to an emergency call but does not treat or transport a recipient as a result of the call is not eligible for reimbursement.
7. When two or more recipients are transported in the same ambulance, each shall be charged an equal percentage of the base rate and mileage charges.
8. Air ambulance services are covered under the following conditions:
 - a. The point of pick-up is inaccessible by ground ambulance,
 - b. Great distances or other obstacles are involved in getting the recipient to the nearest hospital with appropriate facilities, or
 - c. The medical condition of the recipient requires air ambulance service, and ground ambulance services will not suffice.

AIR AMBULANCE SERVICES

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

www.azahcccs.gov/commercial/ProviderBilling/rates/Transportationrates.aspx

Code A0888 may only be billed for AHCCCS recipients 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 – 799.9 is no longer valid or acceptable. Claims will be denied.

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 education and training 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. A provider will receive the specialty care transport reimbursement rates 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 1 thru September 30 the following calendar year. Refer to:

www.azahcccs.gov/commercial/ProviderBilling/rates/Transportationrates.aspx

Code A0888 may only be billed for AHCCCS recipients 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, treatment
2. Transportation origin, destination, and mileage (statute miles)
3. Supplies
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 (A0382 – BLS routine disposable supplies or A0398 – ALS routine disposable supplies) and oxygen (A0422 – Ambulance (BLS or ALS) oxygen and oxygen supplies, life sustaining situation) may be charged for only one ground ambulance trip unless the additional transport is a separately identifiable service.

EXAMPLE 1:
<p>A recipient is transported by ground ambulance from an accident scene to a hospital. The ambulance remains at the hospital while the recipient is stabilized. The same ambulance then transports the recipient to another hospital or airport for transfer to a higher level of care or for services not available at the current facility.</p> <p>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.</p>

EXAMPLE 2:

A recipient is transported by air ambulance from an accident scene to a hospital. The air ambulance remains at the airstrip while the recipient is stabilized. The same air ambulance then transports the recipient 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 recipient 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 recipient to another hospital or airport for transfer to a higher level of care or for services not available at 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.

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 recipients.

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

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

1. The recipient'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 recipient is an inpatient,
3. The hospital furnishing the services is the nearest one with such facilities, and
4. The recipient 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 to and from an AHCCCS covered medical service for most recipients. Non-emergency medical transportation is not covered for Emergency Services Program recipients.

Transportation is limited to the cost of transporting the recipient to the nearest AHCCCS registered provider capable of meeting the recipient's medical needs. Transportation must only be provided to transport the recipient to and from the required, AHCCCS covered medical service.

Effective 4/1/2014 all non-emergency transportation providers that transport AHCCCS recipients (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 claim recoupment. (See Exhibit 3 for Tribal contacts)

Also effective 4/1/2014 all NEMT providers MUST have a sign and/or logo with the company name on the vehicle when transporting AHCCCS recipients.

Authorization Requirements to Receive Medically Necessary Non-Emergency Transport Service to Obtain AHCCCS Covered Medical Services

For AHCCCS American Indian recipients who reside either on-reservation or off-reservation and are enrolled with AIHP (Contractor 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 DFMS 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 recipient 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.

For American Indian recipients enrolled in either an acute or ALTCS managed care organization, please check with the managed care organization for prior authorization requirements.

Recipients 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 recipients:
 - a. An AIHP enrolled recipient, 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).
 - b. An AIHP enrolled recipient 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 recipient 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 RBHA or TRBHA.

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.

PA for non-emergency medical transport provided to an AHCCCS FFS recipient or American Indian Health Plan (AIHP)-enrolled recipient through the use of a private vehicle must be requested by the recipient'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 Recipients enrolled in a Tribal 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
is billed with diagnosis code 799.9

Recipients enrolled in a TRBHA and a health plan other than AIHP or non-emergency medical transportation claims billed with a behavioral 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 (acute care recipients) or a case manager (ALTCS recipients). Only codes for base and mileage will be authorized.

Prior Authorization requests for Fee for Service Acute Care recipients may be submitted online at www.azahcccs.gov or may be faxed to the AHCCCS Prior Authorization Department at 602-254-2431.

If requesting by fax, the PA mandatory fax form is online at www.azahcccs.gov/commercial/FFSclaiming/priorauthorization/priorauthorization.aspx

The PA fax form must be complete and the recipient's eligibility must be verified before faxing to AHCCCS.

AHCCCS providers may check the status of a PA online via the AHCCCS website, at <http://www.azahcccs.gov>

BILLING FOR NON-EMERGENCY MEDICAL TRANSPORTATION

Non-emergency ground transportation of 100 miles or less, regardless whether one way or round trip, will not require Prior Authorization (PA).

Providers may bill without obtaining Prior Authorization as long as the total mileage billed on any one CMS 1500 (837P for electronic claims) does not exceed 100 miles, whether one way or round trip.

Example case scenarios:

1. If a recipient travels from his/her home to an AHCCCS provider's office in town and the total trip is 95 miles; the trip does **NOT** require Prior Authorization.
2. If a recipient is transported from a car accident scene in a BLS or ALS ambulance to an emergency room, the trip is 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 the odometer readings.
4. If a recipient is transported via non-emergency AIR ambulance for medically necessary discharge to a lower level facility and that transport is **less than 100 miles**; the trip **DOES** require Prior Authorization.

Effective 9/1/2014 all services for the recipient'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 recipient on board the vehicle and being transported to receive medically necessary AHCCCS covered services.

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 Phoenix and Tucson metropolitan areas. All other transports are defined as rural and must be billed with the "TN" modifier.

The Health Insurance Portability and Accountability Act (HIPAA) mandates that all local codes must be replaced with the appropriate HCPCS, CPT-4, and revenue codes and

modifiers for dates of service 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 Transportation Rate for each code. Refer to:

www.azahcccs.gov/commercial/ProviderBilling/rates/Transportationrates.aspx

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

1. Two units of the authorized base rate should be billed on Line 1 of the claim form.
2. The total mileage for both trips should be billed on Line 2.

If a recipient'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 clock times and odometer readings.

Wait time shall only be billed for the amount of time the driver *actually waited* at the recipient's medical service destination *and* 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 recipients at one time, the wait time shall be reimbursed for no more than one recipient. 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;
- If wait time is less than 30 minutes;
- When two different vehicles and/or drivers are used for the round trip;
- For a one way trip.

Wait time will not be covered if the distance to the medical service location is 10 miles or less.

DOCUMENTATION REQUIREMENTS

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 a trip report and justification of the transport upon request by AHCCCS anytime after the date of service. Each service must be supported with the following documentation:

- Complete transport service provider's name and address
- Printed name and signature of the driver who provided the service
- Vehicle identification (license # and state.)
- Vehicle type (car, van, wheel chair van, stretcher, etc.)
- Recipient's full name
- Recipient's AHCCCS ID#
- Complete date of service, including month, day and year
- Complete address of pick up destination
- Complete address of drop off destination
- Clock time of pick up *and* clock time of drop off
- Odometer reading at pick up
- Odometer reading at drop off
- Type of trip – one way or round trip
- Escort name and relationship to recipient being transported
- Signature (or fingerprint) of recipient* verifying services were rendered

****Clarification of recipient's "signature" requirement***

If a recipient 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 recipient and indicate their relationship to the recipient. If the recipient 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 recipient, the trip report should show the recipient's name and a notation such as "by J Smith, daughter" to identify the person signing for the recipient.

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

Effective on date of service 7/1/2013 forward, all non-emergency medical transport providers will be required to use the AHCCCS standard Daily Trip Report, Exhibit 11-1, with instructions for completing the standard Daily Trip Report at Exhibit 11-2.

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

It is the provider's responsibility to maintain documentation that supports each transport service claimed. The trip report must be completed 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.

REIMBURSEMENT

Reimbursement of transportation services is calculated based on:

1. The provider-specific rate or billed charges, whichever is less.
2. If a provider-specific rate does not exist, reimbursement is billed charges or the capped fee for the procedure, whichever is less.
3. If neither a provider-specific rate nor an AHCCCS capped fee exists, reimbursement is based on the amount prior authorized.
4. If there is no provider-specific rate, no capped fee, and no prior authorized amount, reimbursement is calculated at a percentage of billed charges.

ILLEGAL INCENTIVES/REMUNERATIONS

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

Among other impermissible activities, 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.

- (2) 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.