Medical Transportation – Air

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This section contains information about air medical transportation services and program coverage (*California Code of Regulations* [CCR], Title 22, Section 51323). For additional help, refer to the *Medical Transportation-Air: Billing Examples* section in this manual.

General Information

Provider Enrollment Requirements

Medical transportation providers who wish to render air medical transportation services to Medi-Cal recipients must first be certified by the Department of Health Care Services (DHCS) and have a specific air transportation provider type. This requires certification by the Federal Aviation Agency (FAA).

Note: Providers with only a ground medical transportation provider type cannot bill Medi-Cal for air medical transportation services.

Air medical transportation providers must submit the following documents to DHCS when applying for a provider number:

- A written statement signed by the President, Chief Executive Officer or Chief Operating Officer of the air ambulance provider company that gives the name and address of the facility where the aircraft is hangared.
- Proof that the air ambulance provider or its leasing company possesses a valid charter flight license (FAA 135 certificate) for the aircraft being used as an air ambulance. If the air medical transportation company owns the aircraft, the name of the owner on the FAA 135 certificate must be exactly the same as the name of the provider on the provider enrollment forms. If the air medical transportation company leases the aircraft, a copy of the lease agreement must accompany the enrollment package. The name of the company leasing the aircraft must be exactly the same as the name of the provider on the provider enrollment forms.
- A written statement signed by the President, Chief Executive Officer or Chief Operating Officer stating that the aircraft operated by the provider satisfies the definition of “Air Ambulance” contained in CCR, Title 22, Section 100280, that states:

  “Air Ambulance” as used in this Chapter means any aircraft specially constructed, modified or equipped, and used for the primary purposes of responding to emergency calls and transporting critically ill or injured patients whose medical flight crew has at a minimum two (2) attendants certified or licensed in advanced life support.

DHCS Contact and Enrollment Information

For additional enrollment requirements and the address and telephone number of the DHCS Provider Enrollment Division, see the *Provider Guidelines* section in the Part 1 manual.

Eligibility Requirements

To receive reimbursement, a recipient must be eligible for Medi-Cal on the date of service.

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 patient's medical needs (*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. In addition, medical transportation providers must maintain readily retrievable records to fully disclose the type and extent of services provided (CCR, Title 22, Section 51476).

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 and 51231.2).

Emergency Air Medical Transportation

Emergency Coverage

Emergency air medical transportation to the nearest hospital or acute care facility capable of meeting a recipient’s medical needs is covered under the following conditions:

- Such transportation is medically necessary; and,
- The medical condition of the recipient precludes the use of other forms of medical transportation; or,
- The recipient’s location, or the nearest hospital or acute care facility capable of meeting a recipient’s medical needs, is inaccessible to ground medical transportation; or,
- Other considerations make ground medical transportation not feasible.

Transportation to Nearest Medical Facility

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

Note: In other non-emergency situations, physicians and hospitals 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 is promptly transferred to a higher level of 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 air ambulance leaves the facility to return to its place of business or accepts another call.

Transportation by Closest Available Provider

Emergency air medical transportation must be rendered by the closest available provider. Services rendered by other than the closest available air medical transportation provider require submission and approval of a *Treatment Authorization Request* (TAR).

Out-of-State Emergency Restrictions

Medi-Cal claims billed for out-of-state emergency air medical transportation services are not reimbursable unless a TAR is obtained. This policy is based on the following:

- Emergency air medical transportation is a Medi-Cal benefit only when transporting a recipient to the nearest available facility capable of treating a recipient's medical needs. (CCR, Title 22, Section 51323 [b] [1])
- Only emergency hospital services are Medi-Cal benefits for recipients while they are in Mexico or Canada. (CCR, Title 22, Section 51006 [b])
- Out-of-state emergency air medical transportation services are Medi-Cal benefits without authorization only to or from specific border communities within the states of Arizona, Nevada or Oregon.

Transportation to or from Foreign Countries

Claims for medical transportation services to or from a foreign country including Mexico and Canada, are not covered and will not be reimbursed.

Emergency Statement

Emergency air 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 to 24 on the *UB-04* claim form).
- A statement in the *Additional Claim Information* field (Box 19) of the claim, or *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 or acute care facility to which a recipient was transported (not required for claims submitted for emergency transport billed as a dry run)
  - No acronym in place of a hospital or acute care facility name (for example, VMC). Abbreviations are acceptable (for example, Valley Med. Ctr.)
  - The name of the physician (Doctor of Medicine [M.D.] or Doctor of Osteopathic Medicine [D.O.]) accepting responsibility for the recipient. The name of the staff M.D., D.O. or emergency department medical director is acceptable. (This is not required for claims submitted for emergency transport billed as a dry run.)

    Note: A physician's signature is not required

The statement of emergency must be typed or printed. Do not use a pre-printed checklist. Clearly label any attachments that are part of the emergency statement and enter a note in the *Additional Claim Information* field (Box 19) of the claim referring to the attachments. For additional help, refer to the *Medical Transportation - Air*: *Billing Examples* section in this manual.

Non-Emergency Air Medical Transportation

Air Medical Transportation

Non-emergency air medical transportation is covered only when the medical condition of the recipient or practical considerations render ground transportation not feasible and at least one of the following conditions are met:

- The medical condition of the recipient precludes the use of other forms of medical transportation.
- The patient's location, or the nearest hospital capable of meeting a recipient's medical needs, is not readily accessible to ground medical transportation.
- Air transportation is less costly than ground transportation

Examples of non-emergency air medical transportation include, but are not limited to:

- Any "pre-arranged" transports (more than 24 hours notice)
- Transportation of a recipient from one hospital to another
- Transportation of a newborn or child from one hospital to another to be closer to his or her parents
- Transportation of a patient after discharge from one medical facility for admission to another medical facility

Non-Emergency Coverage

Non-emergency medical transportation (NEMT) necessary to obtain medical services is covered subject to the written authorization of a licensed practitioner consistent with their scope of practice. Additionally, if the non-physician medical practitioner is under the supervision of a physician, then the ability to authorize NEMT also must have been delegated by the supervising physician through a standard written agreement.

Providers that can authorize NEMT are physicians, podiatrists, dentists, physician assistants, nurse practitioners, certified nurse midwives, physical therapists, speech therapists, occupational therapists and mental health or substance use disorder providers.

Authorization

A *Treatment Authorization Request* (TAR) is required for non-emergency transportation. A legible prescription (or order sheet signed by the physician for institutional recipients) must accompany the TAR.

Note: The TAR may require inclusion of modifiers. Up to four modifiers are allowable. Modifier 99 is not allowed in conjunction with procedure codes associated with non-emergency medical transportation.

For dates of service on or after August 27, 2018: On paper TARs the appropriate modifier is entered after the procedure code in the *NDC/UPN or Procedure Code* field (Box 11). For eTARs the modifier is entered in the *Modifiers Box* of the *Transportation Service Codes & Total Units* field. Details related to the services may be required in the *Enter Miscellaneous TAR* Information field.

For dates of service on July 1, 2016 through August 26, 2018: Applicable modifiers are entered in the *Medical Justification* field (Box 8C) of the paper TAR or the *Enter Miscellaneous TAR Information* field on the eTAR.

In order for the claim to be reimbursed, modifiers on the TAR and the claim must match.

All TARs for non-emergency medical transportation must be submitted to the TAR Processing Center.

Prescription Requirements

The prescription (or order sheet signed by a physician for institutional recipients) that is submitted with the TAR must include the following:

- Purpose of the trip
- Frequency of necessary medical visits/trips or the inclusive dates of the requested medical transportation
- Medical or physical condition that precludes normal public or private transportation or non-emergency ground transportation

  Note: When transportation is requested on an ongoing basis, the chronic nature of a recipient's medical or physical condition must be indicated and a treatment plan from the physician or therapist must be included. A diagnosis alone, such as multiple sclerosis or stroke, will not satisfy this requirement.

The Medi-Cal consultant needs the above information to determine the medical necessity of a specialized medical transport vehicle and the purpose of the trip. Incomplete information will delay approval.

Helicopter Transportation

When submitting a TAR for helicopter transportation, a statement, signed by the air transport operator or the chief pilot, that the use of fixed wing aircraft or combination of fixed wing aircraft and ground transport is not operationally feasible must be included.

Reimbursement

Separate reimbursement will not be made for services or items included in the base rate, such as:

- Additional nursing hours or services
- Airway management
- Backboards, long boards, cervical boards
- Blood drawn
- Cardioscope, defibrillator, cardioverter
- Cardioversion/defibrillation, Cardiovascular Pulmonary Resuscitation (CPR)
- Childbirth assistance or OB kit
- Crew of three persons
- Dead at scene
- Disposable I.V. tubing, I.V. monitoring
- Dry run (No recipient found/recipient refusal)
- Electrocardiograms (EKGs), telemetry
- Extrication from vehicle
- First aid, vital signs
- Flat/scoop stretchers

- Linens and blankets
- Mileage surcharge
- Overweight or difficult-to-reach recipients
- Oxygen masks, tubing, cannulae, airways
- Pick-up not from paved road
- Pulse oximetry, electronic monitors
- Ventilator/Respirator/Intermittent Positive Pressure Breathing (IPPB)
- Restraint of recipient
- Sand bags
- Special gurney
- Suction/suction equipment
- Surcharges or special handling fees
- Weekend

Billing Information

Emergency and Non-Emergency Services

Emergency and non-emergency billing codes should not appear on the same claim form. Claim forms submitted with both emergency and non-emergency billing codes will be denied.

Modifiers on Claims for Non-Emergency Services

Up to four modifiers on a service line are allowable in association with procedure codes submitted for non-emergency medical transportation. In order for the claim to be reimbursed, modifiers on the TAR and the claim must match.

Note: Modifier 99 is not allowable and multiple modifiers must not be listed in the *Remarks* field (Box 80) of the UB-04 claim or the *Additional Claim Information* field (Box 19) of the CMS-1500 claim.

Extra Attendant

Providers billing code A0424 (extra ambulance attendant, air [fixed or rotary winged], [per hour]) may claim up to a maximum of ten hours per day. A0424 may be used to bill for either emergency or non-emergency services.

Trips With Multiple Recipients

When more than one recipient is transported to the same destination in the same aircraft, the provider must indicate on a separate attachment, with each claim submitted, the names and Medi-Cal ID numbers (if applicable) of the other recipients. This information is not allowed in the *Additional Claim* Information field (Box 19) on the *CMS-1500* claim form or in the *Remarks* field (Box 80) on the *UB-04* claim form.

Supplies Billed for Unlisted Ambulance Service

Providers billing for code A0999 (unlisted ambulance service) must itemize all supplies billed and attach a manufacturer or supplier invoice showing the wholesale price. An internal company invoice or catalog page is not acceptable.

Note: Providers may bill for the use of a neonatal intensive care incubator separately from the use of compressed air for infant respirator during air transportation by using code A0999. An invoice is not required when billing for either of these services with code A0999.

Patient on Board Miles

Air ambulance one-way recipient miles must be billed in statute miles, not in nautical miles. Mileage must be calculated with Global Positioning System (GPS) coordinates from point of takeoff to point of landing. Providers must document the GPS coordinates of takeoff and landing points in the *Additional Claim Information* field (Box 19) on the *CMS-1500* claim form or on an attachment to the claim, using the degrees, minutes and decimal minutes (DD:MM.MMM) format only. Claims using any other format will be denied. Providers should bill for the actual miles flown, even if this exceeds the straight-line distance between point of takeoff and point of landing.

Air Mileage Greater than 999 Miles

A maximum of 999 statute miles may be billed on one claim line. For distances greater than this, use multiple claim lines. For additional help, refer to the *Medical Transportation – Air: Billing Examples* section in this manual.

Night Calls

Night calls (transportation responses between the hours of 7 p.m. and 7 a.m.) start at the time of unit alert and end upon arrival at the destination with the recipient onboard. Night calls may be reimbursable in any of the following scenarios:

- The transport starts during the day and ends at night
- The entire transport occurs at night
- The transport starts at night and ends during the day

When requesting authorization for transportation services between the hours of 7 p.m. and 7 a.m., providers must use the appropriate HCPCS code and notation for night call service, along with the start and stop time of the service in the *Medical Justification* field (Box 8C) of the TAR. When billing for air ambulance transport services between the hours of 7 p.m. and 7 a.m., use code A0430 (ambulance service, conventional air services, transport, one way [fixed wing]) or code A0431 (ambulance service, conventional air services, transport, one way [rotary wing]) with modifier UJ (services provided at night). Indicate the time of the service in the *Additional Claim Information* field (Box 19) of the *CMS-1500* claim form. If the transportation spans the 7 p.m. or 7 a.m. hour, the UJ modifier is still reimbursable.

Dry Run

Medical air transportation providers may be reimbursed for responding to a call (emergency [911] or non-emergency) but not transporting the recipient (dry run). To bill for a dry run, providers should append modifier DS followed by modifier QN (ambulance service furnished directly by a provider of services) to either HCPCS code A0430 (ambulance service, conventional air services, transport, one way [fixed wing]) or code A0431 (ambulance service, conventional air services, transport, one way [rotary wing]).

Modifier DS is created by the combination of ambulance service origin code D (diagnostic or therapeutic site other than P or H when these are used as origin codes) with ambulance service destination code S (scene of accident or acute event).

When an air ambulance response occurs between the hours of 7 p.m. and 7 a.m. (night call), and the recipient is not transported (dry run), providers may bill by appending modifier UJ. Indicate the time of service in the *Additional Claim Information* field (Box 19) of the *CMS-1500* claim form. No other modifiers or service lines may be billed on the claim. For night call dry run transports, the night call starts at the time of unit alert and ends upon leaving the scene without the recipient onboard.

Dry Run Emergency Statements Differ

Providers billing for dry run services are reminded their emergency statement requirements differ. No one was transported, therefore emergency statements associated with dry runs exclude the name of a receiving hospital or physician. Refer to “Emergency Statement” in this section for additional information.

Mileage Reimbursement

Dry run transport and mileage are not reimbursable on the same day, same recipient and same provider unless documentation states that billed mileage was for an actual medical transport at a different time on the date of service. These mileage codes are as seen below:

Mileage Code	Description
A0435	Fixed wing air mileage, per statute mile
A0436	Rotary wing air mileage, per statute mile

Emergency Call

Use HCPCS codes A0430 (ambulance service, conventional air services, transport, one way [fixed wing]) or A0431 (ambulance service, conventional air services, transport, one way [rotary wing]) when billing for response to an emergency (911) call. This is reimbursement for a call with the purpose of transport, even though the person was not available to be transported. Mileage is not reimbursed.

Non-Emergency Trip

Use HCPCS codes A0430 or A0431 when billing for response to a “non-emergency” trip. Reimbursement requires an approved *Treatment Authorization Request* (TAR). Mileage is reimbursed only during transport of the recipient.

Refer to the *Medical Transportation - Air: Billing Codes and Reimbursement Rates* section in this manual for rates.

Waiting Time

Waiting time is billed in 30-minute increments. The first 15 minutes are included in the air ambulance base rate (HCPCS code A0430 or A0431). Waiting time in excess of 15 minutes must be billed with HCPCS code T2007 (transportation waiting time, air ambulance, one half hour [1/2] increments) and modifier TU (special payment rate, overtime; [air ambulance transportation only], [emergency or non-emergency]).

When completing the claim, enter the total number of units of waiting time, in excess of the first 15 minutes, to the nearest 30-minute increment in the *Days or Units* field (Box 24G) of the claim form. (For example, 18 minutes equals one unit of waiting time; 54 minutes equals two units.) A statement justifying the wait and giving the clock time when the wait began and ended must be included in the *Additional Claim Information* field (Box 19) of the claim or on an attachment.

Medi-Cal will reimburse up to 90 minutes, three units, of waiting time in excess of the first 15 minutes, except in cases where a recipient is a neonate. Medi-Cal will reimburse up to 180 minutes (three hours), six units, in excess of the first 15 minutes for documented waiting time needed to stabilize a neonate before transport.

Note: Air ambulance waiting time does not require authorization for emergency air medical transportation.

Waiting time charges are to be billed only for time spent while waiting to load the patient. Charges for any other situation will not be reimbursed.

‹‹Legend››

‹‹Symbols used in the document above are explained in the following table.››

Symbol	Description
‹‹	This is a change mark symbol. It is used to indicate where on the page the most recent change begins.
››	This is a change mark symbol. It is used to indicate where on the page the most recent change ends.