Medical Transportation – Ground

This section contains information on ground medical transportation services and program coverage. For additional help, refer to the *Medical Transportation – Ground: Billing Examples* section in this manual.

General Information

Program Coverage

Medi-Cal covers ambulance and non-emergency medical transportation (NEMT) only when ordinary public or private conveyance is medically contra-indicated and transportation is required for obtaining needed medical care.

Non-medical transportation (NMT) is used for a recipient to obtain covered Medi-Cal services. NMT includes, at a minimum, round trip transportation for a recipient to obtain covered Medi-Cal services by passenger car, taxicab or any other form of public or private conveyance. NMT does not include the transportation of sick, injured, invalid, convalescent, infirm or otherwise incapacitated recipients by ambulances, litter vans or wheelchair vans licensed, operated and equipped in accordance with state and local statutes, ordinances or regulations, as these would be covered as NEMT.

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 must follow federal and state requirements for maintaining supporting documentation for drivers and vehicles associated with medical transportation services (CCR, Title 22, Sections 514"76", 51231, 51231.1 and 51231.2). Medical transportation providers may substitute vehicle GPS tracking or digital mapping software to track odometer readings at each origin and destination location.››

Emergency Ground Medical Transportation

Transportation to Nearest Medical Facility

Medi-Cal covers emergency ground medical transportation to the nearest hospital or acute care facility capable of meeting a recipient's 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 acute hospital or acute care facility capable of meeting a recipient's emergency medical needs (contract or non-contract).

Note: In 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

Recipients transported to a non-contract hospital must be taken to the nearest contract hospital or acute care facility as soon as they are stable. Recipients are considered stable for transport when they are able to sustain transport in an ambulance staffed by an Emergency Medical Technician I (EMT I) with no expected increase in morbidity or mortality as a result of the transportation. In addition, if a recipient is an infant, the ambulance must have necessary modular equipment.

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

Emergency Statement

Emergency medical transportation requires both:

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

- A statement in the *Additional Claim Information* field (Box 19) on the *CMS-1500* claim form, or the *Remarks* field (Box 80) on the *UB-04* claim form, or on an attachment, supporting that an emergency existed. The statement may be made by the provider of transportation and must include:

- The nature of the emergency

- The name of the hospital 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 – Ground: Billing Examples* section of this manual.

Neonatal Transport

Reimbursement for use of a neonatal intensive care incubator and compressed air for infant respirator are included in the rate for procedure code A0225 (ambulance service; neonatal transport, base rate, emergency transport, one way). Separate claims for these items will be denied.

Non-Emergency Ground Medical Transportation

Non-Emergency Coverage

Non-emergency medical transportation is covered only when a recipient's medical and physical condition does not allow that recipient to travel by bus, passenger car, taxicab, or another form of public or private conveyance. Transport is not covered if the care to be obtained is not a Medi-Cal benefit.

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.

Inter-Facility Transport – Pediatric Critical Care

Please refer to the *Evaluation and Management (E&M)* section of the Part 2 manual for information regarding facility-to-facility transport of critically ill or critically injured pediatric patients (24 months of age or less) with an attending physician.

Prescription Requirements

The prescription (or order sheet signed by the physician for institutional recipients) that is submitted with a 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 makes normal public or private transportation inadvisable

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.

Transport From Acute Care Hospital to Long Term Care Facility

A TAR, prescription or clinician signature is not required for non-emergency transportation from an acute care hospital to a long term care facility. This is the only exception to the TAR requirement for non-emergency medical transportation, as stated in CCR Title 22, Section 51323[b](c). All other non-emergency medical transportation with a different origin or destination other than as stated requires a TAR. This policy applies to transportation for recipients who received acute care as hospital inpatients who are being transferred to a Nursing Facility (NF) Level A or B.

This service must be billed with one of the appropriate non-emergency transportation codes (HCPCS codes A0130, A0380, A0422, A0425, A0426, A0428, A0434, T2001, T2005). Refer to the *Medical Transportation – Ground: Billing Codes and Reimbursement Rates* section in this manual for code descriptions and rates. Services billed with other non-emergency transportation codes require authorization.

Note: Medi-Cal does not cover waiting time or night calls for transport from an acute care facility to NF-A care.

Reimbursement

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

- Backboards
- Flat/scoop stretchers
- Long boards
- Disposable oxygen masks and tubing
- Disposable I.V. tubing

- Childbirth assistance

- Restraint of recipient

- Suction/suction equipment

- Resuscitation

- Ventilator/Respirator/Intermittent Positive Pressure Breathing (IPPB)

- A crew of two persons

- Pick-up off paved road

- Pick-up of overweight or difficult-to-reach recipients

- Linens and blankets

Types of Ground Medical Transportation

Non-emergency medical transportation is provided by three types of vehicles: ambulance, litter van and wheelchair van.

Ambulance: Qualified Recipients

Ambulances are generally used for emergencies, but may provide non-emergency transport for certain types of recipients. Non-emergency transport by ambulance can include:

- Transfers between facilities for recipients who require continuous intravenous medication, medical monitoring or observation

- Transfers from an acute care facility to another acute care facility

- Transport for recipients who have recently been placed on oxygen (not chronic emphysema recipients who carry their own oxygen for continuous use)

- Transport for recipients with chronic conditions who require oxygen if monitoring is required

Ambulance: Non-Qualified Recipients

Non-emergency transport by ambulance does not include:

- Individuals with chronic conditions who require oxygen, but do not require monitoring. Such individuals should be transported in a litter van or wheelchair van when all of the following criteria are met:

  – Cannot use public or private means of transportation

  – Clinically stable

- Can transport upright in a litter van or wheelchair van

- Able to self-monitor oxygen delivery system

- No other excluding conditions

Litter Van

Transport by litter van is appropriate when a recipient's medical and physical condition:

- Require that the recipient be transported in a prone or supine position because the recipient is not able to sit for the period of time needed for transport.

- Require specialized equipment and/or more space than is normally available in passenger cars, taxicabs or other forms of public transportation.

- Do not require the specialized services, equipment and personnel of an ambulance because the recipient is in a stable condition and does not need constant observation.

Examples of recipients who qualify for litter van transport include:

- Recipients in a spica cast

- Bed bound recipients

- Post-operative, stable recipients who cannot tolerate sitting upright for the time required for transport from pick-up point to destination

- Individuals with chronic conditions who require oxygen, but do not require monitoring

Wheelchair Van

Transport by wheelchair van is appropriate when a recipient's medical and physical condition:

- Render the recipient unable to sit in a private vehicle, taxicab, or other form of public transportation for the time needed for transport

- Require that the recipient be transported in a wheelchair

- Render the recipient unable to transfer unassisted from a residence to a public or private conveyance because of a disabling physical or mental limitation

- Do not require the specialized services, equipment and personnel of an ambulance because the recipient is in a stable condition and does not need constant observation

Examples of recipients who qualify for wheelchair van transport include:

- Recipients who suffer from severe mental confusion

- Recipients with paraplegia

- Dialysis recipients

- Individuals with chronic conditions who require oxygen, but do not require monitoring

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, ground [ALS or BLS], [per hour]) may claim up to a maximum of 10 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 vehicle from a common loading point, 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.

For each trip with multiple recipients, the medical transportation provider must bill Medi-Cal with the appropriate HCPCS code for each recipient and on only one claim for the following:

‹‹**HCPCS Code Table: Multiple Recipients**››

HCPCS Code	Description
A0380	BLS mileage (per mile) (use for wheelchair and litter van transports only)
A0420	Ambulance waiting time (ALS or BLS), one-half (1/2) hour increments
A0425	Ground mileage, per statute mile (use for ambulance transports only)

Ambulance

HCPCS codes A0426, A0427, A0428, A0429, A0433 and A0434 may be billed with modifier UN (two patients served) on each claim:

‹‹**HCPCS Code Table: Multiple Recipients Ambulance**››

HCPCS Code	Description
A0426	Ambulance service, advanced life support, non-emergency transport, level 1 (ALS1)
A0427	Ambulance service, advanced life support, emergency transport, level 1 (ALS1-emergency)
A0428	Ambulance service, basic life support, non-emergency transport (BLS)
A0429	Ambulance service, basic life support, emergency transport (BLS-Emergency)
A0433	Advanced life support, level 2 (ALS2)
A0434	Specialty care transport (SCT)

<u>Litter Van and Wheelchair Van</u>

HCPCS code A0130 (non-emergency transportation: wheel chair van) may be billed with any of the following modifiers on each claim:

- UN (two patients served)
- UP (three patients served)
- UQ (four patients served)
- UR (five patients served)
- US (six or more patients served)

When billing for a trip with multiple recipients, the above items must be billed only on the claim submitted for the first recipient transported. For recipients other than the first recipient, the provider may bill only "response to call" codes as appropriate and services other than those listed under "Trips With Multiple Recipients" (for example, HCPCS code A0422 for oxygen in an ambulance).

Note: The above policy does not apply to recipients picked up at different points of origin or delivered to different destinations.

When multiple patients are picked up from the same location and transported to the same location, a TAR is required for each patient. The names of all transported patients and the TAR Control Numbers of all the submitted TARs must be documented in the *Medical Justification* area of each TAR. If the area is not sufficient for the required information, enter "see attached" and include the information on an attached 8 ½ x 11-inch sheet of paper.

<u>TARs for Multiple Recipients</u>

A single TAR may be approved for multiple patient trips. The number of patients receiving non-emergency services must be indicated in the TAR *Medical Justification* field (Box 8C). If the TAR is approved for three or more patients, but fewer patients are transported than authorized on the TAR, a new TAR is not required if the trip still meets the multiple patient trip definition (more than one patient transported from a common point). However, if a multiple patient trip is authorized and only one patient is transported, a new TAR is required.

Multiple Trips for Same Recipient

If multiple trips for the same recipient are provided on the same date of service, enter the time of day and the points of destination in the *Additional Claim Information* field (Box 19) of the *CMS-1500* claim. ‹‹Modifier "76" (Repeat procedure or service by same physician or other qualified health care professional) may be appended to each billing code on the claims accordingly. Without this information, subsequent trips for the same recipient on the same date of service may be denied as duplicate services.››

Round-Trips

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

Enter the appropriate "response to call" procedure code:

- On one billing line, showing a "2" in the *Days or Units* field (Box 24G) and one charge for this portion of the service, or

- On two billing lines, showing a "1" in the *Days or Units* field (Box 24G) with a charge for each individual leg of the service, or

- On two separate claims, showing a "1" in the *Days or Units* field (Box 24G) with a charge for the individual leg of the service

Transportation From and Back to a Hospital: Place of Service Code "21"

To bill for transporting a recipient who remains an inpatient from an inpatient hospital, providers must enter Place of Service code "21" (inpatient hospital) in the *Place of Service* field (Box 24B). Also, they must enter the provider address and the National Provider Identifier of the inpatient hospital of pick-up in the *Service Facility Location Information* field (Boxes 32 and 32A).

If the trips from a hospital to a doctor's office and back to that hospital are billed as two separate trips, both must be billed with Place of Service code "21."

Mileage

To bill for ground mileage for litter-van and wheelchair transportation for non-emergency services only, use HCPCS code A0380 (BLS mileage [per mile] [use for wheelchair and litter van transports only]). To bill for ambulance transportation mileage for both emergency and non-emergency services, use HCPCS code A0425 (ground mileage, per statute mile [use for ambulance transports only]). When billing mileage, use either A0380 or A0425 as appropriate, and show the total miles from point of recipient pick-up to destination (and return mileage for round-trip billing) in the *Days or Units* field (Box 24G). The complete origination and destination addresses, including city and ZIP code, must be indicated in the *Additional Claim Information* field (Box 19) of the claim.

If an origination or destination address is not available, the following types of origination and/or destination sites are reimbursable when accompanied with documentation that the emergency occurred in an area where no specific address is available, with a description of the location, either in the *Additional Claim Information* field (Box 19) or on an attachment:

- Interstate, highway or freeway

- Indian lands and reservations

- Bodies of water and their shorelines

- Campgrounds

- State and national parks and recreation areas

- Mountains

- Deserts

- Farms and ranch land

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 transport services between the hours of 7 p.m. and 7 a.m., use the appropriate HCPCS code from the following code table with modifier UJ (services provided at night). Indicate the start and stop 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 reimbursable.

‹‹HCPCS Code Table: Night Calls››

HCPCS Code	Description
A0130	Non-emergency transportation: wheel-chair van
A0225	Ambulance service; neonatal transport, base rate, emergency transport, one way
A0426	Ambulance service, advanced life support, non-emergency transport, level 1 (ALS1)
A0427	Ambulance service, advanced life support, emergency transport, level 1 (ALS1-emergency)
A0428	Ambulance service, basic life support, non-emergency transport (BLS)
A0429	Ambulance service, basic life support, emergency transport (BLS-emergency)
A0433	Advanced life support, level 2 (ALS2)
A0434	Specialty care transport (SCT)
T2005	Non-emergency transportation: stretcher van

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

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

Dry Run

Medical ground transportation providers may be reimbursed for responding to a call (emergency [911] or non-emergency) but not transporting the recipient (dry run).

When applicable, bill for a dry run by appending modifiers DS followed by modifier QN (ambulance service furnished directly by a provider of services) to the HCPCS code for the transport. The DS modifier 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) and ambulance service destination code S (scene of accident or acute event).

‹‹HCPCS Code Table: Dry Run››

HCPCS Code	Description
A0130	Non-emergency transportation: wheelchair van
A0225	Ambulance service, neonatal transport, base rate, emergency transport, one way
A0426	Ambulance service, advanced life support, non-emergency transport, level 1 (ALS1)
A0427	Ambulance service, advanced life support, emergency transport, level 1 (ALS1-emergency)
A0428	Ambulance service, basic life support, non-emergency transport (BLS)
A0429	Ambulance service, basic life support, emergency transport (BLS-emergency)
A0433	Advanced life support, level 2 (ALS2)
A0434	Specialty care transport (SCT)
T2005	Non-emergency transportation: stretcher van

When a ground transportation 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 the 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 Transport From an Acute Care Hospital to a Long Term Care Facility

Providers may be reimbursed for responding to a transport service request from an acute care hospital to a Nursing Facility (NF) Level A or B without transporting the recipient (dry run). To bill for a dry run transport from an acute care hospital to a NF Level A or B, providers must use A0130, A0426, A0428 or T2005 with modifier HN followed by modifier QN. No other modifiers or service lines may be billed on the claim. This service does not require a TAR.

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 for 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.

‹‹**HCPCS Code Table: Mileage Reimbursement**››

HCPCS Code	Description
A0380	BLS mileage (per mile) (use for wheelchair and litter van transports only)
A0425	Ground mileage, per statute mile (use for ambulance transports only)

Emergency Call

Use HCPCS code A0427 (ambulance service, advanced life support, emergency transport, level 1 [ALS1-emergency]) or A0429 (ambulance service, basic life support, emergency transport [BLS-emergency]) 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, and is not reimbursement for a non-transporting county EMT team. Mileage is not reimbursed.

Note: Providers must check the *EMG* field (Box 24C) if emergency services are provided. See Emergency Statement.

Non-Emergency Trip

Use the appropriate HCPCS code below when billing for response to a "non-emergency" trip, if there is an approved *Treatment Authorization Request* (TAR). This is not reimbursement for a non-transporting county EMT team. Mileage is reimbursed only during transport of the recipient.

‹‹**HCPCS Code Table: Mileage Reimbursement**››

HCPCS Code	Description
A0130	Non-emergency transportation: wheelchair van
A0426	Ambulance service, advanced life support, non-emergency transport, level 1 (ALS1)
A0428	Ambulance service, basic life support, non-emergency transport (BLS)
T2005	Non-emergency transportation: stretcher van

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

Waiting Time

Providers may bill for medical ground transportation waiting time in excess of the first 15 minutes using either HCPCS code A0420 (ambulance waiting time (ALS or BLS), one-half (1/2) hour increments) for ground ambulance services, or HCPCS code T2007 (transportation waiting time, air ambulance, and non-emergency vehicle, one-half (1/2) hour increments) for wheelchair van and litter van transportation services. Each 30-minute increment is billed as a quantity of one (1). A maximum of 90 minutes (three units) of waiting time in excess of 15 minutes may be reimbursed. Waiting time in excess of 1½ hours will not be reimbursed. In addition to justifying the wait, providers must also document the clock time when the wait began and ended in the *Additional Claim Information* field (Box 19) of the claim or on an attachment.

An exception to the 90-minute waiting time is made for ground ambulance service (A0225) in cases where the recipient is a neonate. Providers may be reimbursed up to eight hours (16 units) in excess of the first 15 minutes when documentation indicates that the waiting time was required to stabilize a neonate before transport. In addition to justifying the wait, providers must also document the clock time when the wait began and ended in the *Additional Claim Information* field (Box 19) of the claim or on an attachment.

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.

<u>Non-Medical Transportation</u>

Enrolling as an NMT Provider

Transportation providers who are currently enrolled in Medi-Cal as non-emergency medical transportation (NEMT) providers or transportation providers who wish to newly enroll as a provider of non-medical transportation (NMT) services may request to become an NMT provider and provide NMT services.

<u>NEMT Providers Enrolling as NMTs</u>

NEMT providers who wish to provide NMT services must submit a completed *Medi-Cal Supplemental Changes* (DHCS 6209) form and must also report that information in the "Other Information" section of the DHCS 6209 form.

NEMT providers who wish to provide NMT services using only NEMT vehicles will need to submit a completed DHCS 6209 form to add the NMT category of service and must also report that information in the "Other Information" section of the DHCS 6209 form and submit a letter stating they will use existing NEMT vehicles and drivers previously approved by DHCS.

Newly Enrolling as NMT Provider

Transportation providers who wish to newly enroll in Medi-Cal to render NMT services need to submit a completed Medi-Cal Transportation Provider Application package, which includes a *Medi-Cal Medical Transportation Provider Application* (DHCS 6206) form, a *Medi-Cal Provider Agreement* (DHCS 6208) form, a *Medi-Cal Disclosure Statement* (DHCS 6207) form, and an application fee. These forms can be retrieved from the DHCS website (*www.dhcs.ca.gov*).

DHCS 6206 and 6209 Completion Guidelines

All applicable information must be completed on the *Medi-Cal Medical Transportation Provider Application* (DHCS 6206) form and *Medi-Cal Supplemental Changes* (DHCS 6209) form, including but not limited to the following:

- National Provider Identifier (NPI)

- Provider type (Non-medical)

- Action requested (Add NMT vehicle[s] or driver[s])

- For all NMT vehicles:

    – Vehicle identification number

    – Make and model of vehicle

    – Year of vehicle

    – License plate number

- Legible copies of the following documents for all vehicles:

    – DMV vehicle registration that complies with state law

    – Proof of vehicle insurance that complies with state law

- For all driver(s):

    – Driver's name

    – California driver's license

- Legible copies of all of the following documents for all drivers:

    – California DMV driving record

    – California driver's license

    – Motor Carrier Safety Administration (MCSA) 5875 and MCSA 5876

Note: This listing is informational. Field labels on forms DHCS 6206 and 6209 differ from the above.

NMT Recipient Attestations

All requests for NMT will require the recipient to provide either a written or verbal attestation to the NMT provider, that she or he has an unmet transportation need and currently available resources have been reasonably exhausted. The NMT provider must maintain historical and current recipient attestation documentation in the recipient's file, available to DHCS upon request.

Recipient attestations may be for a single-time use, and a record of each attestation – past and current – must be maintained in the recipient's file. Alternatively, recipient attestations may be for a period not to exceed one month when regular, periodic NMT is required. When regular, periodic NMT is required, an attestation form must be kept in the recipient's file. At the expiration of one month and every month thereafter, the NMT provider must have the recipient complete a new attestation demonstrating a continued need for NMT.

Billing NMT

NMT must be billed with the following HCPCS codes:

‹‹HCPCS Code Table: NMT››

HCPCS Code	Description
A0120	Non-emergency transportation: mini-bus, mountain area transports, or other transportation systems
A0390	ALS mileage (per mile)

HCPCS code A0120 is the base rate for all NMT transports and represents a one-way transport. HCPCS code A0390 is used to bill NMT transport, per mile.

When billing any medically necessary service during pregnancy or the postpartum period, providers must include a pregnancy diagnosis code on all claims. Claims submitted without a pregnancy diagnosis code may be denied.

HCPCS code A0120 is limited to a maximum reimbursable unit of eight per month. This maximum may be overridden with documentation on the claim form or an enclosure stating that the beneficiary required the transport to obtain necessary Medi-Cal medical, mental health, substance use, or dental care.

For information on billing trips with multiple recipients, round-trips, night calls and dry runs for NMT, refer to the appropriate headings under the "Billing Information" subsection on a previous page.

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

‹‹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.