Medi-Cal Provider Training 2016

Medical Transportation Services

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

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

Free Services for Providers

Provider Seminars and Webinars

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

Regional Representatives

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

Small Provider Billing Unit

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

All of the aforementioned services are available to providers at no cost!

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Medical Transportation Services

Introduction

Purpose

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

Module Objectives

- Identify Medi-Cal transportation policy for Medi-Cal recipients and California Children's Services clients.
- Define "emergency medical service."
- Detail appropriate emergency service documentation requirements.
- Explain emergency and non-emergency transportation.
- List the medical transportation HCPCS Level II codes and modifiers.
- Examine the policy and billing requirements for medical transportation.
- Describe the field requirements of the *CMS-1500* and *UB-04* claim forms.
- Illustrate medical transportation claim examples.
- Provide TAR/eTAR documentation examples.

Resource Information

Medi-Cal Subscription Service (MCSS)

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

References

The following reference materials provide Medi-Cal program and eligibility information.

Provider Manual References

Part 1

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

Part 2

Ancillary Codes (ancil cod)
CMS-1500 Completion (cms comp)
Medical Transportation – Air (mc tran air)
Medical Transportation – Air: Billing Codes and Reimbursement Rates (mc tran air cd)
Medical Transportation – Air: Billing Examples (mc tran air ex)
Medical Transportation – Ground (mc tran gnd)
Medical Transportation – Ground: Billing Codes and Reimbursement Rates (mc tran gnd cd)
Medical Transportation – Ground: Billing Examples (mc tran gnd ex)
Modifier Approved (modif app)
Revenue Codes for Inpatient Services (rev cd ip)
TAR and Non-Benefit List (tar and non)
TAR Completion (tar comp)
UB-04 Completion: Inpatient Services (ub comp ip)
UB-04 Completion: Outpatient Services (up comp op)

Other References

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

Acronyms

A list of current acronyms is located in the *Appendix* section of this workbook.

Program Coverage

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

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

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

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

Medi-Cal Emergency Medical Condition

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

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

CCS Emergency Medical Condition

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

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

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

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

Eligibility Verification

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

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

Message	Eligibility
"Subscriber is Medi-Cal Eligible with No Share of Cost/Spend Down."	Full-scope
"Medi-Cal Eligible for Emergency Services."	Restricted *

* Restricted to emergency services

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

NOTE

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

NOTES

Policies

Medical Transportation Code Conversion

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

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

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

Mileage Billing Policy Update

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

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

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

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

HCPCS Code	Current Billing (through June 30, 2016)	New Billing (on or after July 1, 2016)
A0425	Wheelchair and litter van mileage	Ambulance mileage for both emergency and non-emergency services
A0380	Ambulance Basic Life Support (BLS) mileage	Wheelchair and litter van mileage for non-emergency services only
A0390	Ambulance Advanced Life Support (ALS) mileage	Discontinued

TAR Policy Update

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

Retroactive and Deferred TARs

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

Bypassing Medical Authorization/Replacement TARs

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

TARs Submitted After July 1, 2016

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

SAR Policy Update

SARs Extending After June 30, 2016

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

SARs Previously Submitted with Through Dates Beyond June 30, 2016

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

SARs Submitted After July 1, 2016

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

NOTE

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

Reminders

1. If a HCPCS Level II code is used on the claim multiple times, the HCPCS Level II code is entered only once on the TAR with the total number of units in the *Units of Service* field (Box 10B) of the TAR.
2. Providers are not required to use modifiers on TARs. However, providers must provide details related to the requested services in the *Medical Justification* field (Box 8C) on the paper TAR or in the **Enter Miscellaneous TAR Information** field of the eTAR.
3. If a TAR or SAR is submitted for the purpose of updating codes in the same authorization period, it will not be reviewed for medical necessity.

Acute Care Hospital/Long Term Care Facility

TAR Exceptions

For non-emergency transportation to move a recipient from an acute care hospital to a Long Term Care (LTC) facility, a TAR is not required. This is the only exception to the TAR requirement for non-emergency medical transportation and is indicated by the use of the HN + QN modifier on the claim form. It is important that the HN modifier is the first modifier listed. This policy applies to transportation for recipients who receive acute care as hospital inpatients and who are being transferred to a Nursing Facility (NF) Level A or B.

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

NOTES

TAR Completion and Submission Information

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

eTARs

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

Paper TARs

Follow these tips to submit TARs correctly.

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

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

NOTE

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

Documentation Example for eTAR

Night Call HCPCS Code A0428

Second Destination

Street Address (25 characters accepted)

City | State | Zip Code | Miles One Way

Return Miles

Transportation service codes & Total Units

* Code	* Units	Code	Units
Code	Units	Code	Units

Enter Miscellaneous TAR Information (500 characters accepted)

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

Documentation Example for Paper TAR

Share Ride HCPCS Code A0130

STATE USE ONLY

SERVICE CATEGORY

5

TYPEWRITER ALIGNMENT Elite Pica

CONFIDENTIAL PATIENT INFORMATION

1 FOR F.I. USE ONLY

CCN

F.I. USE ONLY 40 41 42 43

TYPEWRITER ALIGNMENT Elite Pica

TREATMENT AUTHORIZATION REQUEST

STATE OF CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES

(PLEASE TYPE) FOR PROVIDER USE (PLEASE TYPE)

VERBAL CONTROL NO.

TYPE OF SERVICE REQUESTED 2 DRUG OTHER

REQUEST IS RETROACTIVE? YES NO

IS PATIENT MEDI-CARE ELIGIBLE? YES NO

PROVIDER PHONE NO. ( )

PLEASE TYPE YOUR NAME AND ADDRESS HERE

PROVIDER NAME AND ADDRESS

3. PROVIDER NUMBER

NAME AND ADDRESS OF PATIENT

PATIENT NAME (LAST, FIRST, M.I.) 4

MEDI-CAL IDENTIFICATION NO. 5 CO. AID CODE 6

SEX 7 AGE DATE OF BIRTH 8

STREET ADDRESS

CITY, STATE, ZIP CODE

PHONE NUMBER AREA ( )

PATIENT STATUS: HOME BOARD & CARE SNF/ICF ACUTE HOSPITAL

DIAGNOSIS DESCRIPTION:

ICD-9-CM DIAGNOSIS CODE

MEDICAL JUSTIFICATION: **Transport (3 patients) Happytown Village to Dialysis. Clinic Time: (19:00). Wheelchair Van Night Call. Required Mod. UP and UJ.**

PATIENT'S AUTHORIZED REPRESENTATIVE (IF ANY) ENTER NAME AND ADDRESS:

FOR STATE USE

33 PROVIDER; YOUR REQUEST IS:

1 APPROVED AS REQUESTED DENIED DEFERRED

2 APPROVED AS MODIFIED (ITEMS MARKED BELOW AS AUTHORIZED MAY BE CLAIMED) JACKSON VS RANK PARAGRAPH CODE

BY MEDI-CAL CONSULTANT

I.D. # 34 DATE 35 REVIEW COMMENTS INDICATOR 44

COMMENTS/EXPLANATION

RETROACTIVE AUTHORIZATION GRANTED IN ACCORDANCE WITH SECTION 51003 (b)

36 1 2 3 4 5 6

Medical Transportation – Ground

Program Coverage

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

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

Transport Type

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

Maintaining Transportation Records

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

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

Emergency Ground Medical Transportation

Transportation to Nearest Hospital

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

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

NOTE

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

Transportation to a Second Facility

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

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

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

NOTE

For complete information about ground medical transportation, please refer to the *Medical Transportation – Ground* (mc tran gnd) section in the appropriate Part 2 provider manual.

Emergency Statement

All emergency medical transportation requires that the *CMS-1500* claim form or the *UB-04* claim form state that the service provided was for an emergency. The statement must indicate that an emergency existed and must include the following:

- Name of the person or agency who requested the service
- Nature of the emergency
- Name of the hospital to which the Medi-Cal recipient or CCS client was transported
- Clinical information about the condition of the Medi-Cal recipient or CCS client
- Reason the services were considered to be immediately necessary (medical necessity)
- Time and date of the transport
- Typed or printed name of the physician accepting responsibility for the Medi-Cal recipient or CCS client

Tips

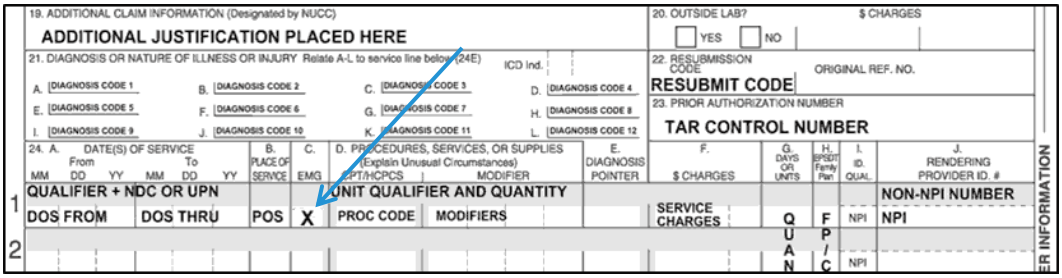
- The emergency statement must be typed or printed. Do not use a pre-printed checklist.
- Clearly label any attachments to the emergency statement. Enter a note in the *Additional Claim Information* field (Box 19) of the *CMS-1500* claim form or in the *Remarks* field (Box 80) of the *UB-04* claim form.
- A mere statement that an emergency existed is insufficient. If the Emergency Certification Statement does not fit on the claim form, provide the statement as an attachment to the claim.
- The emergency indicator must be marked or emergency claims will be denied.
- Both the emergency certification and the emergency indicator must be present on the claim or the claim may be denied.
- Claims with both emergency and non-emergency services will be denied.

CMS-1500 Claim Form

Box #	Field Name	Instructions
19	Additional Claim Information	Use this area for procedures that require additional information, justification or an Emergency Certification Statement. An Emergency Certification Statement must be attached to the claim or entered in the *Additional Claim Information* field (Box 19) of the claim form.
24C	EMG	Enter an “X” if an Emergency Certification Statement is attached to the claim or described in Box 19. Only one emergency indicator is allowed per claim. Place the emergency indicator in the unshaded, bottom portion of Box 24C. If more than one indicator is present, the first occurrence will be applied to the entire claim. For information about completing the *CMS-1500* claim form, refer to the *CMS-1500 Completion* (cms comp) section in the appropriate Part 2 provider manual.

CMS-1500 Emergency Services Documentation

Enter “Emergency Certification Statement” in the *Additional Claim Information* field (Box 19). Enter “X” in field 24C.



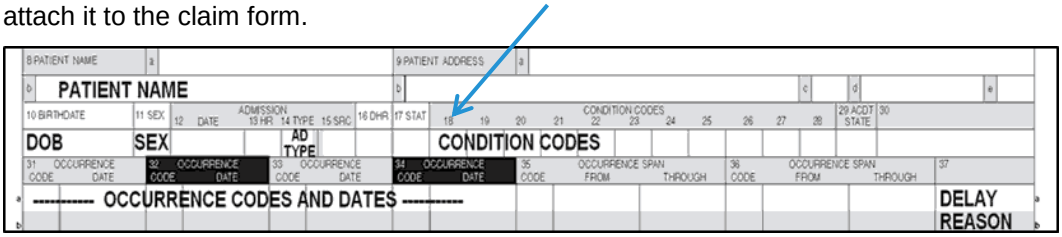
***CMS-1500* with Instructions for Emergency Transportation**

UB-04 Claim Form

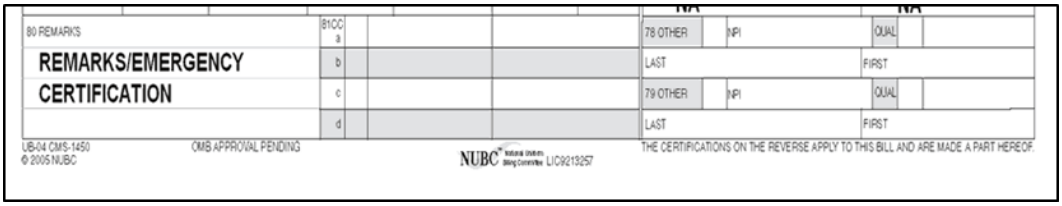
Box #	Field Name	Instructions
14	Type of Admission	Enter a “1” indicating that it was necessary to admit the recipient to the hospital because it was an emergency.
18 – 24	Condition Codes	Condition codes identify conditions relating to the recipient’s bill that may affect payer processing. Enter these codes from left to right in numeric-alpha order, starting with the lowest value. For example, if billing for two condition codes, “80” and “81”, enter “80” in Box 18 and “81” in Box 19.
80	Remarks	Enter an Emergency Certification Statement.

UB-04 Emergency Services Documentation

Enter code “81” in the *Condition Codes* field (Box 18) when billing for emergency services. Enter the Emergency Certification Statement in the *Remarks* field (Box 80) or attach it to the claim form.



***UB-04* with Instructions for Emergency Transportation**



***UB-04* with Instructions for Emergency Transportation**

Non-Emergency Ground Medical Transportation

Non-Emergency Coverage

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

NOTE

Reimbursement for NEMT services is only for benefits covered by Medi-Cal.

NOTES

Medical Transportation – Air

Provider Enrollment Requirements

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

NOTE

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

Air Ambulance

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

Transport Type

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

Maintaining Transportation Records

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

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

Emergency Air Medical Transportation

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

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

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

NOTE

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

Medical Transportation Modifiers

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

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

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

Modifier 99

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

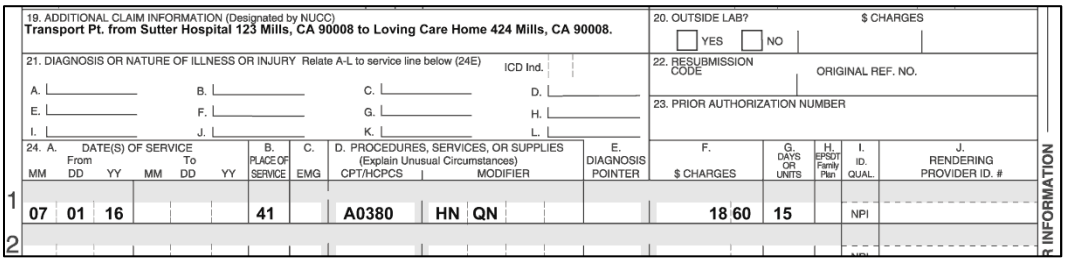
Destination and Location Modifiers

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

Combination Modifier Codes: HN and QN

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

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


19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)
Transport Pt. from Sutter Hospital 123 Mills, CA 90008 to Loving Care Home 424 Mills, CA 90008.

20. OUTSIDE LAB? ☐ YES ☐ NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.
A. B. C. D.
E. F. G. H.
I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

	24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER			E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1	07	01	16				41		A0380	HN	QN			18 60	15		NPI	
2																		

Sample: Partial *CMS-1500* claim form

NOTE

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

Night Calls

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

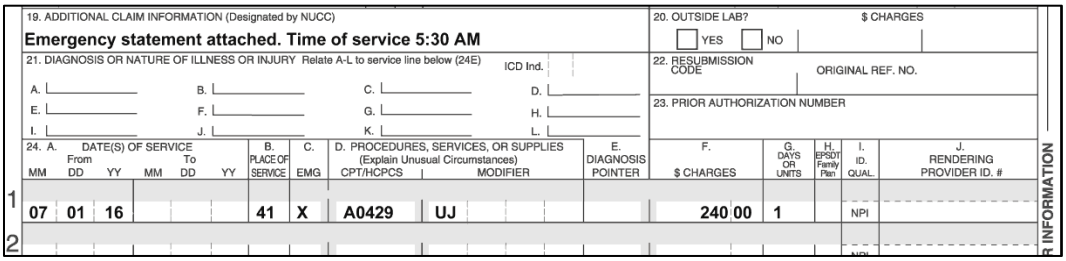
HCPCS Code			
A0130	A0427	A0430	A0434
A0225	A0428	A0431	T2005
A0426	A0429	A0433	

Claim Documentation

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

TAR documentation

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


19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)
Emergency statement attached. Time of service 5:30 AM

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.
A. B. C. D.
E. F. G. H.
I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

	24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1	07	01	16				41	X	A0429	UJ		240 00	1		NPI	
2																

Sample: Night Call, Partial *CMS-1500* claim form

Dry Run

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

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

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

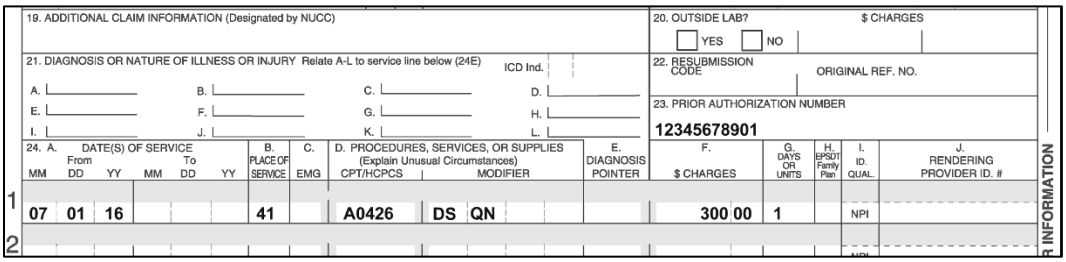
When billing a dry run with HCPCS code A0130, A0426, A0428 or T2005 for a non-emergency patient transfer from an acute care hospital to a nursing facility level A/B, modifiers HN and QN must be on the claim form. Modifier HN must be in the first modifier position. To signify this is a dry run, no other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

Transport and Mileage Same Day

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

NOTE

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


19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.
A. B. C. D.
E. F. G. H.
I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER
12345678901

	24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER			E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1	07	01	16				41		A0426	DS	QN			300 00	1		NPI	
2																		

Sample: Dry Run Ground Transportation, Partial *CMS-1500* claim form

Waiting Time – Ground Transportation

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

Miscellaneous Codes

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

New Medical Transportation Code Benefits

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

Medical Transportation Code Conversion Crosswalk

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

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

Medical Transportation Code Conversion FAQs

1. **What does the conversion from HCPCS Level III codes to HCPCS Level II codes mean?**

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

2. **What is HIPAA and how does it relate to HCPCS Level II codes?**

   HIPAA is the acronym for the Health Insurance Portability and Accountability Act that was passed by Congress in 1996. HIPAA does the following:

   - Provides the ability to transfer and continue health insurance coverage for millions of American workers and their families when they change or lose their jobs;
   - Reduces health care fraud and abuse;
   - Mandates industry-wide standards for health care information on electronic billing and other process; and;
   - Requires the protection and confidential handling of protected health information.

3. **Why is the conversion happening?**

   California has historically used thousands of HCPCS Level III or local (also known as interim) codes for billing and reimbursement of services and supplies. National codes, such as Current Procedural Terminology (CPT) codes and Healthcare Common Procedural Coding System (HCPCS) codes, are typically more general in nature compared to local codes. Using CPT and HCPCS Level II codes will:

   - Simplify processes and decrease the costs associated with payment for health care services;
   - Improve the efficiency and effectiveness of the health care system and decrease administrative burdens on providers (i.e., medical practices, hospitals and health care plans);
   - Provide standardization and consistency in medical service coding; and
   - Characterize a general administrative situation, rather than a medical condition or service, by using non-clinical or non-medical code sets.

4. **When will this conversion take place?**

   The effective date of service for this conversion from HCPCS Level III codes to HCPCS Level II codes is July 1, 2016.

5. **Who is affected by the conversion?**

   Any provider submitting medical transportation claims for emergency or non-emergency services with dates of service on or after July 1, 2016, or *Treatment Authorization Requests* (TARs) or Service Authorization Requests (SARs) with requested dates of service on or after July, 1, 2016, will be required to use HCPCS Level II codes identified in the Medical Transportation Code Conversion Table.

6. **How will the conversion impact my TARs on or after the effective date?**

   Effective for dates of service on or after July 1, 2016, TARs and SARs using HCPCS Level III local medical transportation codes and HCPCS Level III local modifier Z1 will no longer be permitted. All TARs and SARs submitted with dates of service on or after July 1, 2016, will require the HCPCS Level II national medical transportation service codes.

7. **How will the conversion impact claims billed with dates of service on or after the effective date?**

   Effective for dates of service on or after July 1, 2016, all claims billed with HCPCS Level III local medical transportation codes and HCPCS Level III local modifier Z1 are no longer eligible for reimbursement.

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

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

8. **What do I do if my end-dated TAR had a medical authorization assigned to it?**

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

9. **If I submit a new TAR/SAR on or after July 1, 2016, which HCPCS Level codes do I use – Level II or Level III?**

   Providers submitting new TARs and/or new SARs for service periods on or after July 1, 2016, should no longer use the discontinued HCPCS Level III codes for medical transportation services. New TARs and SARs must use the HCPCS Level II national codes for service periods on or after July, 1, 2016.

10. **How do I use combination modifier codes?**

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

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

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

    (Example: A0426 HN + QN OR A0426 + DS + QN)

    NOTE

    A TAR is not required for non-emergency transportation when the transportation is from an acute care hospital to a skilled nursing facility and is indicated by the use of the HN + QN modifier.

11. **Where do I put the modifier on the TAR?**

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

    NOTE

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

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

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

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

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

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

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

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

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

HCPCS Level II Codes	HCPCS Level II Code Descriptions	Modifiers, Instructions and Clarification
A0380	BLS mileage (per mile) (use for wheelchair and litter van transports only)	Modifier HN + QN is to be used for non-emergency wheelchair or litter-van transportation from an acute care hospital to a skilled nursing facility. A TAR is not required for non-emergency wheelchair or litter-van transportation from an acute care hospital to a skilled nursing facility. Example: A0380 + HN + QN (mileage from an acute care hospital to a skilled nursing facility). **NOTE** Used to bill for non-emergency medical transportation mileage only.
A0390	ALS mileage (per mile)	Discontinued for dates of services on or after July 1, 2016.

HCPCS Level II Codes	HCPCS Level II Code Descriptions	Modifiers, Instructions and Clarification
A0425	Ground mileage, per statute mile (use for ambulance transports only)	Modifier HN + QN is to be used for non-emergency ambulance transportation from an acute care hospital to a skilled nursing facility. A TAR is not required for non-emergency ambulance transportation from an acute care hospital to a skilled nursing facility. Example: A0425 + HN + QN (mileage from an acute care hospital to a skilled nursing facility) **NOTE** can be used to bill for emergency or non-emergency ambulance mileage only.
A0433	Advanced life support, level 2 (ALS2)	Modifier UN is to be used for two patients served. Modifier UJ is to be used for night calls, 7 p.m. to 7 a.m. Modifier DS + QN is to be used for no transport (dry run). Examples: A0433 + UN (two patients served) A0433 + UJ (services provided at night) A0433 + UN (two patients served) +UJ (services provided at night) A0433 + DS + QN (ambulance response, no transport) **NOTE** should be used to bill for emergency ambulance transportation only.

HCPCS Level II Codes	HCPCS Level II Code Descriptions	Modifiers, Instructions and Clarification
A0434	Specialty care transport (SCT)	Modifier UN is to be used for two patients served. Modifier UJ is to be used for night calls, 7 p.m. to 7 a.m. Modifier DS + QN is to be used for no transport (dry run). Examples: A0434 + UN (two patients served) A0434 + UJ (services provided at night) A0434 + UN (two patients served) + UJ (services provided at night) A0434 + DS + QN (ambulance response, no transport) **NOTE** should be used to bill for emergency ambulance transportation only.

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

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

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

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

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

    To indicate the number of patients receiving emergency services, use the appropriate modifiers on the claim form.

17. **Where do I find more information related to the medical transportation conversion from Level III HCPCS codes to Level II HCPCS codes?**

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

    For additional information, providers may:

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

Learning Activity

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

   True ☐ False ☐

2. An “emergency medical condition” is defined as acute symptoms of sufficient severity, including pain that, in the absence of medical treatment, could result in any of the following:

   a._____

   b._____

   c._____

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

   True ☐ False ☐

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

   a._____

   b._____

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

   True ☐ False ☐

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

   _____ — _____

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

   a._____

   b._____

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

   a._____

Answer Key: 1) True; 2a) Placing the patient’s health in serious jeopardy, 2b) Serious impairment to bodily functions, 2c) Serious dysfunction to any bodily organ or body part; 3) False; 4a) “X” in *CMS-1500* claim form *Emergency Indicator* field (Box 24 C) and Emergency Statement in the *Additional Claim Information* field (Box 19), 4b) *UB-04* claim form Condition Codes Field “81” and include Emergency Statement in Box 80; 5) True; 6) UJ—include the time of service in the *Remarks* field (Box 80); 7) TAR Box 8c *Medical Justification* field; Enter Miscellaneous TAR Information field on eTAR; 8) Transportation from an acute care hospital to a skilled nursing facility.

Appendix

Acronyms

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

Medical Transportation Code Conversion

Discontinued Billing Codes		New Billing Codes		
Interim Code	**Description**	**National Code or Modifier**	**Description**	**Instructions and Clarifications**
X0002	Response to call, two patients, each patient	A0427§ **and** UN **or** A0429§ **and** UN **or** A0427§ **and** UN **and** UJ **or** A0429§ **and** UN **and** UJ	Ambulance service, advanced life support, emergency transport, level 1 (ALS1-emergency) Two patients served Ambulance service, basic life support, emergency transport (BLS-emergency) Two patients served Services provided at night Services provided at night	Billing for two patients applies to emergency transportation only. Modifier UJ is to be used for night calls, 7 p.m. to 7 a.m. A0427+UN, A0429+UN, A0429+UN+UJ, and A0429+UN+UJ should be used to bill for emergency medical transportation only.
X0006	Emergency run	**No New Code(s) Available**		

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

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

Discontinued Billing Codes		New Billing Codes		
Interim Code	**Description**	**National Code or Modifier**	**Description**	**Instructions and Clarifications**
X0008	Neonatal intensive care incubator	A0225§ **or** A0225§ **and** UJ	Ambulance service; neonatal transport, base rate, emergency transport, one way Services provided at night	There is no national code for compressed air or for a neonatal incubator. Since compressed air is used in conjunction with a neonatal incubator, this service is to be included with overall neonatal transport. Modifier UJ is to be used for night calls, 7 p.m. to 7 a.m. A0225 and A0225+UJ should be used to bill for emergency medical transportation only.
X0010	Ground ambulance waiting time over 15 minutes; each 15 minutes	A0420†§	Ambulance waiting time (ALS or BLS), one-half (1/2) hour increments	Medi-Cal will reimburse up to 90 minutes, three units, of waiting time in excess of the first 15 minutes. In cases where a recipient is a neonate, Medi-Cal will reimburse up to 8 hours, 16 units, in excess of the first 15 minutes for documented waiting time needed to stabilize prior to transport. A0420 may be used to bill for either emergency or non-emergency services.

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

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

Discontinued Billing Codes		New Billing Codes		
Interim Code	**Description**	**National Code or Modifier**	**Description**	**Instructions and Clarifications**
X0012	Compressed air for infant respirator	A0225§ **Or** A0225§ **and** UJ	Ambulance service; neonatal transport, base rate, emergency transport, one way Services provided at night	There is no national code for compressed air for a neonatal incubator. Since compressed air is used in conjunction with a neonatal incubator, this service is to be included with overall neonatal transport. Modifier UJ is to be used for night calls, 7 p.m. to 7 a.m. A0225 and A0225+UJ should be used to bill for emergency medical transportation only.
X0014	Extra attendant – RN/EMT first hour	A0424†§	Extra ambulance attendant, ground (ALS or BLS) or air (fixed or rotary winged); (requires medical review)	A0424 may be used to bill for either emergency or non-emergency services.
X0016	Extra attendant – RN/EMT 2nd and 3rd hour each	A0424†§	Extra ambulance attendant, ground (ALS or BLS) or air (fixed or rotary winged); (requires medical review)	A0424 may be used to bill for either emergency or non-emergency services.
X0018	Extra attendant – RN/EMT (each additional hour)	A0424†§	Extra ambulance attendant, ground (ALS or BLS) or air (fixed or rotary winged); (requires medical review)	A0424 may be used to bill for either emergency or non-emergency services.
X0020	Cost of I.V. fluids (invoice must be attached)	**No New Code(s) Available**		This code is deactivated due to low utilization.

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

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

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

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

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

Discontinued Billing Codes		New Billing Codes		
Interim Code	**Description**	**National Code or Modifier**	**Description**	**Instructions and Clarifications**
X0200	Response to call – non-litter patient, 1 patient	A0130†	Non-emergency transportation: wheelchair van	A0130 should be used to bill for non-emergency medical transportation only.
X0202	Response to call – non-litter patient, 2 patients, each patient	A0130† **and** UN	Non-emergency transportation: wheelchair van Two patients served	A0130+UN should be used to bill for non-emergency medical transportation only.
X0204	Response to call – non-litter patient, 3 patients, each patient	A0130† **and** UP	Non-emergency transportation: wheelchair van Three patients served	A0130+UP should be used to bill for non-emergency medical transportation only.
X0206	Response to call – non-litter patient, 4 or more patients, each patient	A0130† **and** UQ **or** UR **or** US	Non-emergency transportation: wheelchair van Four patients served Five patients served Six or more patients served	A0130+UQ, +UR, or +US should be used to bill for non-emergency medical transportation only.
X0208	Response to call – non-litter patient, wheelchair use	**No New Code(s) Available**		This code will be deactivated, as it is used to bill for a service that is included as part of the overall transportation service.
X0210	Response to call – litter patient	T2005†	Non-emergency transportation: stretcher van	T2005 should be used to bill for non-emergency medical transportation only.
X0212	Response to call – litter patient, attendant	T2001†	Non-emergency transportation; patient attendant/escort	T2001 should be used to bill for non-emergency medical transportation only.

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

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

Discontinued Billing Codes		New Billing Codes		
Interim Code	**Description**	**National Code or Modifier**	**Description**	**Instructions and Clarifications**
X0214	Waiting time over 15 minutes – each 15 minutes (maximum of 90 minutes)	T2007†§	Transportation waiting time, air ambulance, and non-emergency vehicle, one-half (1/2) hour increments	Medi-Cal will reimburse up to 90 minutes, three units, of waiting time in excess of the first 15 minutes. Used without a modifier, this code is for wheelchair van or litter van transportation only. T2007 may be used to bill for either emergency or non-emergency services.
X0216	Mileage one way – per mile (mileage with patient on board)	A0425†	Ground mileage, per statute mile	This code is used for wheelchair van or litter van transportation only. A0425 should be used to bill for non-emergency medical transportation only.
X0218	Night call – 7 p.m. to 7 a.m.	A0130† **and** UJ **or** T2005† **and** UJ	Non-emergency transportation: wheelchair van Services provided at night Non-emergency transportation: stretcher van Services provided at night	Modifier UJ is to be used for night calls, 7 p.m. to 7 a.m. A0130+UJ and T2005+UJ should be used to bill for non-emergency medical transportation only.
X0220	Oxygen – per tank	A0422†§	Ambulance (ALS or BLS) oxygen and oxygen supplies, life sustaining situation	A0422 may be used to bill for either emergency or non-emergency services.
X0222	Unlisted	A0999†§	Unlisted ambulance service	A0999 may be used to bill for either emergency or non-emergency services.

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

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

Discontinued Billing Codes		New Billing Codes		
Interim Code	**Description**	**National Code or Modifier**	**Description**	**Instructions and Clarifications**
X0400	Response to call, ambulance	A0426 **or** A0428 **and** QN **and** HN	Ambulance service, advanced life support, non-emergency transport, level 1 (ALS1) Ambulance service, basic life support, non- emergency transport (BLS) Ambulance service furnished directly by a provider of services Hospital to skilled nursing facility	All X04XX codes were used for non-emergency patient transfer from acute care facility to nursing facility levels A/B. Modifier HN is H + N. A TAR is not required for non-emergency transportation from an acute care hospital to a skilled nursing facility.
X0402	Ambulance mileage, one way – per mile (mileage with patient on board)	A0380 **or** A0390 **and** QN **and** HN	BLS mileage (per mile) ALS mileage (per mile) Ambulance service furnished directly by a provider of services Hospital to skilled nursing facility	Modifier HN is H + N. A TAR is not required for non-emergency transportation from an acute care hospital to a skilled nursing facility.
X0404	Response to call, litter patient, litter van transportation	T2005 **and** QN **and** HN	Non-emergency transportation: stretcher van Ambulance service furnished directly by a provider of services Hospital to skilled nursing facility	Modifier HN is H + N. A TAR is not required for non-emergency transportation from an acute care hospital to a skilled nursing facility.

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

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

Discontinued Billing Codes		New Billing Codes		
Interim Code	**Description**	**National Code or Modifier**	**Description**	**Instructions and Clarifications**
X0406	Response to call, non-litter patient, wheelchair van transportation	A0130 **and** QN **and** HN	Non-emergency transportation: wheelchair van Ambulance service furnished directly by a provider of services Hospital to skilled nursing facility	Modifier HN is H + N. A TAR is not required for non-emergency transportation from an acute care hospital to a skilled nursing facility.
X0408	Wheelchair/ litter van mileage, one way – per mile (mileage with patient on board)	A0425 **and** QN **and** HN	Ground mileage, per statute mile Ambulance service furnished directly by a provider of services Hospital to skilled nursing facility	Modifier HN is H + N. A TAR is not required for non-emergency transportation from an acute care hospital to a skilled nursing facility.
X0410	Wheelchair use, wheelchair/ litter van	**No New Code(s) Available**		This code will be deactivated, as it is used to bill for a service that is included as part of the overall transportation service.
X0412	Oxygen, per tank	A0422 **and** QN **and** HN	Ambulance (ALS or BLS) oxygen and oxygen supplies, life sustaining situation Ambulance service furnished directly by a provider of services Hospital to skilled nursing facility	Modifier HN is H + N. A TAR is not required for non-emergency transportation from an acute care hospital to a skilled nursing facility.

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

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

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

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

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

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

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

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