Kansas Medical Assistance Program

August 2006 **Provider Bulletin Number 651**

Commercial Non-Emergency Medical Transportation Providers

Physician Certification Form Renewal for Level II Transportation Services

Certification forms signed by a physician that indicate a beneficiary meets criteria for Level II transportation services are generally valid for one year, unless the physician has indicated on the form the beneficiary is "permanently confined to a wheelchair." The initial expiration date for all forms was scheduled to occur between January 7, 2006, and May 6, 2006. However, this date has been extended until September 30, 2006, to allow time for changes to be implemented to the Internet, Automated Voice Response System (AVRS), faxback system, and Provider Electronic Solutions (PES).

A field has been added to the Beneficiary Eligibility Verification window on the Internet to display the expiration date for the transportation certification form. The recertification date field will read, as an example, "The Level II transportation certification form expires on 12/31/2006." Commercial Non-Emergency Medical Transportation (C-NEMT) providers can also obtain this information by using the AVRS or faxback system.

It is the C-NEMT providers' responsibility to check eligibility for each beneficiary prior to each transport and to provide the beneficiary with a new certification form in a timely manner. This timeliness is necessary to allow the form to be completed by the physician and returned to the fiscal agent before the expiration date. Failure to obtain a new certification form will cause claims to deny.

Information about the Kansas Medical Assistance Program as well as provider manuals and other publications are on the KMAP Web site at https://www.kmap-state-ks.us. For the changes resulting from this provider bulletin, please view the *Commercial Non-Emergency Medical Transportation Provider Manual*, pages 7-2 through 7-13, 8-2 through 8-7, 8-9 through 8-11, AI-1, and *Certification by Medical Provider* form.

If you have any questions, please contact the KMAP Customer Service Center at 1-800-933-6593 (in-state providers) or (785) 274-5990 between 7:30 a.m. and 5:30 p.m., Monday through Friday.

7000 Updated 8/06

Field 11 **Insured's Policy Group or FECA Number:**

This field should be completed if the patient has insurance primary to Medicaid. If yes, also complete fields 11a-d.

Field 21 **Diagnosis or Nature of Illness or Injury:**

Commercial NEMT providers should enter diagnosis code 780.99.

Field 22A **Original Ref. No:**

If this is a resubmission of a claim, enter the previous ICN.

Field 23 **Prior Authorization Number:**

Enter the prior authorization (PA) number from NEMT PA team if procedure was prior authorized.

Field 24A **Date(s) of Service:**

Enter date of service in MM/DD/YY format. ***Each date of service must be billed as separate line items with NO date range on each line***.

Field 24B **Place of Service:**

Commercial NEMT providers should enter 99 as place of service.

Field 24D **Procedures, Services, or Supplies:**

Enter the correct five-digit code listed below that corresponds to the service provided. Enter only one code per detail line for a single date of service. To submit a claim, enter the correct **base** code and, if applicable, enter the mileage code. It is not acceptable for Commercial NEMT providers to submit a claim with only the mileage code (A0425). ~~and per line. You can use each HCFA-1500 Claim form for six separate dates of service or for up to six codes. Commercial NEMT providers must bill using at least a base code. It is not acceptable for Commercial NEMT Providers to bill only the mileage code (A0425).~~

- T2002* (base code for Level 1, ambulatory services, for providers whose physical address is in one of the following counties only: Johnson, Leavenworth, Wyandotte, Sedgwick, Shawnee, or Douglas) **Note*: Use of procedure code T2002 is restricted to two (2.0) units per day per beneficiary. If services provided exceed two (2.0) units per day per beneficiary, use procedure code T2003 on a separate detail line of the claim form to indicate units greater than two (2.0).

- T2003 (base code for Level 1, ambulatory services, for providers whose physical address is in any Kansas county, not referenced with procedure code T2002, even if the provider is transporting a beneficiary into one of the six counties identified with procedure code T2002).
- A0130 (base code for Level II, non ambulatory Services.)
- A0425** (mileage code, to be reported only for mileage greater than 10 miles one-way or greater than 20 miles round-trip) **Note: Reporting odometer mileage on NEMT transportation forms or on claims is not acceptable. Commercial NEMT providers must use mapping software that provides a "shortest distance" option between the origin and destination addresses.

~~Field 24D cont.~~

~~You must complete and mail the NEMT Transportation forms to the NEMT PA unit if you provided more than one round trip (level I or level II) on any given day for an individual beneficiary. If the NEMT PA unit does not receive the supporting documentation within 30 days of the claim, the claim will be denied.~~

~~For providers whose physical address is in Leavenworth, Douglas, Wyandotte, Shawnee, Sedgwick, or Johnson county, enter the correct five-digit code from the following list that corresponds to the service provided. ***Note:*** Modifier KX is not valid for transportation services.~~

- ~~T2002 (base code for level I). Only providers whose physical address is in one of the following counties can use this code: Leavenworth, Sedgwick, Wyandotte, Shawnee, Johnson, and Douglas. Do not use this procedure code for more than 2.0 units (one round trip) per beneficiary, per day. Providers whose physical address is not in one of the identified counties cannot use this code even when transporting a beneficiary into one of the identified counties.~~
- ~~T2002 and A0425 (mileage greater than 10 miles one way or 20 miles round trip).~~
- ~~T2003 (base code for level I for providers in the following counties when billing for subsequent trips on the same date of service for the same beneficiary: Leavenworth, Sedgwick, Wyandotte, Shawnee, Johnson, and Douglas). You must complete and return the NEMT Transportation forms to the NEMT PA unit if you provided more than one round trip (level I or level II) on any given day for an individual beneficiary. If the NEMT PA unit does not receive the supporting documentation within 30 days of the claim, the claim will be denied.~~

Modifier Usage:

- TK – Use modifier "TK" to identify extra beneficiaries being transported with either the same pick-up address or the same destination address. For example, two Medicaid eligible beneficiaries live at the same address and they each have an appointment on the same date to see a physician, but not the

same physician. Since the appointments are scheduled for approximately the same time, the transportation provider should pick them up at the pre-arranged time and drop them at each of their respective medical appointments. The provider must submit a claim for each beneficiary. Claim 1 must be submitted with the correct base code and mileage if applicable. Claim 2 (and any other claims for additional beneficiaries on the same transport) must be submitted with the correct base code plus the "TK" modifier, for example T2003 TK. If mileage is applicable for the service provided, the mileage procedure code can only be submitted on claim 1 and is not payable or applicable to any other claims where beneficiaries are being transported together. If the pick-up address is different for multiple beneficiaries, but the destination is the same, the provider must submit a claim for each beneficiary being transported. Claim 1 would be submitted for the beneficiary who is transported the greatest distance. Subsequent claims, for example 2, 3… must be submitted with the TK modifier to indicate the correct service provided. Again, mileage can only be submitted for claim 1 and only if applicable (greater than 10 miles one way or greater than 20 miles on a round trip).

- **UK** – Use modifier "UK" to identify a transportation service provided on behalf of the beneficiary to someone other than the beneficiary. Modifier "UK" can only be reported with procedure codes T2002, T2003, or A0130, for up to one round-trip service (for example 2.0 units) per beneficiary, per day, and for only one parent or guardian, even if two or more people accompany the beneficiary. Reimbursement can be made for modifier "UK" only if it is attached to a base code and on the same claim form as the beneficiary who is being accompanied.

Note: Do not submit a claim with a base code plus the TK modifier on the same claim with a base code and the UK modifier or vice versa. If submitted in this manner, the claim will deny.

- ~~Use modifier TK when the pick up and drop off destinations are the same for two or more eligible beneficiaries *or* if the pick-up point is the same but you drop off one of the two eligible beneficiaries before the final destination of the second beneficiary. If the mileage is greater than 10 miles one way or 20 miles round trip, calculate the mileage from the beginning pick up point to the ending destination point (as per MapQuest©) and enter the mileage on detail line 2 of the submitted claim without attaching the modifier. Bill for the first beneficiary using the appropriate procedure code (T2002, T2003, or A0130) plus mileage, if applicable. Use modifier TK to bill for subsequent beneficiaries (T2002 TK, T2003 TK, or A0130 TK). For examples, see the following chart. Reimbursement will be made for modifier TK only if it is attached to a base code (T2002, T2003, A0130) and on a separate claim for a separate beneficiary for the same date of service, i.e. the second or subsequent beneficiary being transported. Do not bill for more than one beneficiary on any single claim form.~~

Example: Provider picks up two brothers at their home, takes them to a Medicaid-covered medical service at the same location, and then returns them to their home.

BROTHER 1 (County Specific)*				**BROTHER 2 (County Specific)***			
T2002		**A0130**		**T2002 "TK"**		**A0130 "TK"**	
1.0 unit	2.0 units	1.0 unit	2.0 units	1.0 unit	2.0 units	1.0 unit	2.0 units
$12.50	$25.00	$20.00	$40.00	$2.50	$5.00	$2.50	$5.00
plus mileage > 10	plus mileage > 20	plus mileage > 10	plus mileage > 20	No mileage allowed	No mileage allowed	No mileage allowed	No mileage allowed

** County Specific: Leavenworth, Douglas, Sedgwick, Wyandotte, Shawnee, Johnson*

BROTHER 1 (Not County Specific)				BROTHER 1 (Not County Specific)			
T2003		**A0130**		**T2003 "TK"**		**A0130 "TK"**	
1.0 unit	2.0 units	1.0 unit	2.0 units	1.0 unit	2.0 units	1.0 unit	2.0 units
$10.00	$20.00	$20.00	$40.00	$2.50	$5.00	$2.50	$5.00
plus mileage > 10	plus mileage > 20	plus mileage > 10	plus mileage > 20	No mileage allowed	No mileage allowed	No mileage allowed	No mileage allowed

- Modifier UK is defined as services provided on behalf of the client to someone other than the client. You can only use modifier UK with procedure codes T2002, T2003, or A0130 for **one** round trip service, per beneficiary, per day and for only one parent or guardian, even if two or more persons accompany the beneficiary. Reimbursement will be made for modifier UK only if it is attached to a base code (T2002, T2003, A0130) and on the same claim form as the beneficiary who is being accompanied. Note: Do not bill a base code with the TK modifier on the same claim with a base code and the UK modifier or vice versa. If submitted in this manner, the claim will deny.

Field 24E **Diagnosis Code:**

Enter the numeral one (1).
Commercial NEMT providers should enter diagnosis 780.99

Field 24F **Charges:**

Enter the ~~your~~ usual and customary charge for each service. For example, if the usual and customary rate is established at $8 for a round-trip, enter $8 in this field. ~~If you provide transportation services to the public, enter the dollar amount in this field for the trip provided. For example, if you normally charge any person $35 for a round trip, enter $35 in this field. You will be paid the Medicaid rate for each procedure code listed.~~

7000 Updated 8/06

Field 24G **Days or Units:**

Enter the number of units for the services rendered, as applicable to each detail line.

- Base code (1 unit = 1 way, 2 units = round-trip)
- Mileage code (1 unit = 1 mile). If total mileage is less than 10 miles one way or 20 miles round-trip, mileage is not billable separately because it is included in the base code.

Use the following formula to calculate mileage if total mileage exceeds 10 miles for a one way transport or 20 miles for a round-trip transport.

Round-Trip: Total miles minus 20 miles = number of billable miles **One Way Trip:** Total miles minus 10 miles = number of billable miles *Note*: A provider may not bill for mileage alone. A claim with mileage billed must also have a base code billed.

~~Example: If a transport is a round-trip, and the total miles are 36, calculate the mileage as follows: 36 minus 20 = 16. Enter 16 for the number of miles with the A0425 (mileage) code. If a transport is one-way, and the total miles are 36, calculate the mileage as follows:~~
~~36 minus 10 = 26. Enter 26 for the number of miles with the A0425 (mileage) code.~~

Note: You cannot bill for mileage without also using the Level I or II base code.

Field 24K **Reserved for Local Use:**

Leave this field blank.

Field 26 **Your Patient's Account Number**

Optional: Any alpha/numeric character entered in this field will be referenced on the Remittance Advice. No special characters allowed, for example: *, @, -, #, etc.

Field 27 **Accept Assignment**

Leave blank. All providers of KMAP services must accept assignment in order to receive payment on a Medicare-related claim

7000 Updated 8/06

Field 28 **Total Charge**

Enter total of all itemized charges on this page of the claim. If filing more than one claim page for the same beneficiary, total each claim page separately

Field 29 **Amount Paid**

Enter any amount paid by insurance or other third-party sources known at the time claim is submitted. If the amount shown in this field is the result of other insurance, attach documentation of the payment. (Field 11 must identify other insurance source). Refer to Sections 3200 and 3300 of the *General Provider Manual* for more specific information.
Do not enter co-payment or spenddown payment amounts. **They are deducted automatically.**

Field 30 **Balance Due:**

Subtract block 29 from 28 and enter balance here.

Field 31 **Signature of Physician or Supplier:**

Read statement on back of claim form, sign, and date.
* Provider's name typed or stamped is acceptable.

Field 32 **Name and Address of Facility Where Services Rendered:**

Enter name and address of facility (if other than patient's home or provider's facility).

Field 33 **Physician's or Supplier's Name, Address, ZIP Code and Telephone Number:**

Enter provider name, address, ZIP code, and telephone number.

Grp #:

Enter Medicaid provider number.

SUBMISSION OF CLAIM:

Send completed first page of each claim and any necessary attachments to:

Kansas Medical Assistance Program
Office of the Fiscal Agent
P.O. Box 3571
Topeka, KS 66601-3571

7000 Updated 8/06

Introduction to the NEMT Transportation Form

Commercial NEMT providers must complete the NEMT Transportation form for **each** one-way or round-trip provided to a Medicaid beneficiary regardless of the Level of service provided. An example of the NEMT Transportation form is in the *Forms Section* at the end of this manual. Completing the form in its entirety **AND** obtaining the beneficiary's signature for each trip provided, at the time it is provided, is mandatory and must be kept on file at each provider's office. The provider must make the form available to the Kansas Health Policy Authority, or its designee, by copying and mailing the form upon request. ~~Completion of the NEMT Transportation form is mandatory and must be kept on file at each provider's office and be made available to Health Care Policy/Medical Policy, or its designee, by copying and mailing the form, upon request.~~

Note: If you provide more than one round-trip per day for any one eligible beneficiary, in addition to completing the NEMT Transportation forms for your own records, you must mail copies of the completed NEMT Transportation forms, within 30 days of providing the service ~~that document the trips provided, you must mail a copy of the completed documentation supporting the NEMT Transportation forms~~ to the following address: NEMT PA Team, P.O. Box 3571, Topeka, KS 66601-3571. ~~The form must be received within 30 days of the service provided or the claim will be denied.~~

COMPLETE THE FOLLOWING NEMT TRANSPORTATION FORM FIELDS:

1. **Provider Name/Number:**
   Enter your commercial provider name exactly as it is registered with Provider Enrollment (such as Wheels 4 You) and the provider number assigned to you by Provider Enrollment. Do not use abbreviations.
2. **Date:**
   Enter the date (month, day, year) the service was provided.
3. **Time:**
   Enter the time the driver arrived to pick up the beneficiary, for example, 9:15 AM or 2:23 PM
4. **Beneficiary Name:**
   Enter the Medicaid beneficiary's name as it appears on the Medicaid card.
5. **Beneficiary Medicaid Number:**
   Enter the beneficiary's Medicaid number as it appears on the Medicaid card.
6. **Signature of Beneficiary:**
   At the time of **each** transport, have the beneficiary sign his or her name. If the beneficiary is unable to sign due to medical condition or due to the beneficiary being too young to sign, and a guardian is not available, the driver should write the words "Unable to Sign" on this line and place the driver's initial next to the line.
   ~~Have the beneficiary sign his or her name. If unable to sign, due to age and/or medical condition, write the words, Unable to Sign.~~

7000 Updated 8/06

7. **Signature of Guardian/Relationship:**

   At the time of **each** transport, if the beneficiary is unable to sign and a guardian is available to sign, have the guardian sign this line and write what his or her relationship is to the beneficiary: for example, John Doe/grandfather.

   ~~If beneficiary is unable to sign, a guardian may sign this line and add his or her relationship to the beneficiary, (for example, John Doe/grandfather). If a child is being transported and cannot print his or her name, a parent or guardian can sign this line.~~

8. **Address where Beneficiary is Picked Up or Dropped Off:**

   Enter the complete address where the beneficiary is picked up or dropped off. A complete address consists of a street number, street name and city name. A ZIP code is not mandatory.

   ~~Enter the complete address either where the beneficiary is picked up or dropped off.~~

9. **Name of Medical Provider/Medical Facility Where Beneficiary is Being Transported To or From:**

   Enter the name of the medical facility or medical provider where you are transporting the beneficiary (such as Topeka Dialysis Clinic, Smile Medical Plaza, or Dr. Goods Office).

10. **Address of Medical Provider/Medical Facility Where Beneficiary is Being Transported To or From:**

    Enter the complete address of the medical building or office where beneficiary is ~~taken.~~ transported to. A complete address consists of a street number, street name and city name. A ZIP code is not mandatory.

11. **Driver's Name:**

    Enter the name of the person driving the Commercial NEMT vehicle.

12. **One-Way ____ Round-Trip ____:**

    Enter a check mark or X on the corresponding line indicating whether driver is transporting beneficiary one-way or round-trip.

13. **Total Miles Traveled for Trip:**

    Enter the total number of miles traveled with the Medicaid beneficiary in the vehicle.

14. **Check One of the Following Types of Vehicle Used to Transport Medicaid Beneficiary:**

    Automobile, SUV, Minivan ___ or ADA Approved Wheelchair Van ___: Check the line that best describes the type of vehicle used to transport the Medicaid beneficiary to a Medicaid-covered service.

7000 Updated 8/06

Introduction to the KMAP Certification by Medical Providers for Transportation Services Form

Effective with dates of service beginning January 7, 2005, the primary care physician (beneficiary's main doctor) must mail or fax a completed Certification by Medical Provider for Transportation Services form to the NEMT PA team so that C-NEMT providers can submit claims using the Level II (non-ambulatory) procedure code, A0130. The form is available in the Appendix of this manual. Providers should photocopy the form and distribute to each beneficiary that meets the criteria for Level II transportation services as stated in Section 8400, (Level II NEMT Services) of this Manual. The beneficiary is responsible to give this form to the primary care physician for completion. The physician needs to complete the form and return it to the NEMT PA team according to the instructions at the bottom of the form.

7000 Updated 8/06
Introduction cont.

Providers can determine the effective dates and whether an individual beneficiary is qualified to receive ambulatory (Level I) or non-ambulatory (Level II) services by accessing the Beneficiary Eligibility Verification window via the secure KMAP Web site, calling the Automated Voice Response System (AVRS), or using either the faxback or PES systems. At the bottom of the Beneficiary Eligibility Verification window is a section called NEMT where the provider can view the following fields: NEMT Level (Level I or Level II), effective date, end date, and recertification date. The same information is provided on the AVRS, faxback, and PES systems. Providers who access the beneficiary eligibility information should be aware the system only displays or speaks the most current NEMT eligibility level. For example, if a provider enters a date range that crosses from one month to the next, such as October 19 through November 12, the system reflects only the most current month (October in the example). Since Medicaid eligibility can change frequently, C-NEMT providers must always check both benefit eligibility and NEMT eligibility for the specific date they will provide services. If the NEMT PA team does not receive a completed and signed certification form from the primary care physician indicating a beneficiary is eligible for Level II (non-ambulatory) transportation service, the beneficiary's level will be defaulted to Level I (ambulatory) status.

Note: **Unless the beneficiary is described by the primary care physician as "permanently confined to a wheelchair," the C-NEMT provider must have the beneficiary annually request a renewal of the Certification by Medical Provider for Transportation Services form. It is the responsibility of the C-NEMT provider to ascertain the form is submitted before the recertification date of the existing form. Failure to obtain a new certification form will cause claims to deny.**

Prior authorization (before transporting) is required in the following circumstances and must be obtained by contacting the NEMT PA team.

- Beneficiary qualifies for Level I transportation services, but due to injury or other reason, needs temporary Level II transportation services.
- C-NEMT provider receives request for transportation services from beneficiary who has not been transported previously and beneficiary indicates that he or she needs Level II (non-ambulatory) services.

When the C-NEMT provider contacts the NEMT PA team to request prior authorization for transportation services, the NEMT PA team enters the request. This request is placed in a pending status for up to 30 days while awaiting receipt of a completed Certification by Medical Provider for Transportation Services Form from the primary care physician. If a completed form is not received from the primary care physician within 30 days to validate the need for Level II transportation services, the NEMT provider and beneficiary will receive a denial letter. If the completed form is received and the physician has determined the beneficiary qualified for Level II services, the NEMT PA team changes the pending PA to an approved PA and the provider and beneficiary will receive an approval letter.

7000 Updated 8/06

The C-NEMT provider can not submit claims for reimbursement until an approved prior authorization is on file.

See *Section 8400, Covered Services* and *Section 8500, Prior Authorization* of this manual for further information on services that require prior authorization.

Note: A transition period for providers and beneficiaries exists from January 7, 2005, through May 6, 2005. During the transition period, beneficiaries who are known to currently receive level II transportation services as of January 1, 2005, will be entered automatically into the system as qualifying for level II services. The beneficiary will not be qualified *officially* for level II services until the NEMT PA unit receives a completed Certification by Medical Provider for Transportation Services form from the primary care physician. If the NEMT PA unit does not receive the form by May 6, 2005, the NEMT PA unit enters the beneficiary on the Eligibility Verification window as qualifying for level I services. Any payment that was made to the C-NEMT provider for level II services that is not validated by a completed Certification by Medical Provider for Transportation Services form during this transition time will be recouped. The provider may then submit claims for the services provided using the appropriate level I procedure code. Providers can view the level of transportation services and the effective dates for an individual beneficiary by accessing the Beneficiary Eligibility Verification window via the secure Web site or by calling the Automated Voice Response System (AVRS). At the bottom of the Beneficiary Eligibility Verification window is a section called NEMT. Providers who access the Beneficiary Eligibility Verification window or AVRS should be aware that the system only shows or speaks the most current NEMT eligibility. For example, if a provider enters a date range that crosses from one month to the next, such as October 19 - November 12, the system reflects only the most current month (October in the example). Because Medicaid eligibility can change frequently, C-NEMT providers should always check both benefit eligibility and NEMT eligibility for the specific date on which they will provide services. Additionally, the Web site provides an effective and end date. **If the NEMT PA unit does not receive a completed form by May 6, 2005, for a beneficiary who receives level II transportation services prior to January 7, 2005, the beneficiary automatically is identified as meeting criteria for level I services.**

With these changes to the C-NEMT program, prior authorization is not needed for all level II transportation services. Prior authorization will continue to be required for the following situations:

- *Beneficiary qualifies for level I transportation services, but due to injury or other reason, needs temporary level II transportation services.*
  The primary care physician must complete and send the Certification by Medical Provider for Transportations Services form to the NEMT PA unit within two months from the date services are to begin. If a completed form is not received within two months to validate the need for level II transportation services, adjustments are made to any paid claims, and the claims are reimbursed at level I rates.

- ~~***C-NEMT provider receives request for transportation services from beneficiary who has not been transported previously and beneficiary indicates that he or she needs level II services.***~~

  ~~The NEMT PA unit will change the level of transportation service in the system for the beneficiary for a maximum of two months with the expectation that the C-NEMT provider will give the beneficiary a copy of the Certification by Medical Provider for Transportation Services form to be completed by the primary care physician. If the NEMT PA unit does not receive the completed form within two months to validate the need for level II services, adjustments are made to any paid claims, and the claims are reimbursed at level I rates.~~

~~See the Prior Authorization Section of this manual for further information on services that require prior authorization.~~

BENEFITS AND LIMITATIONS

8300 Benefit Plan Updated 8/06

Kansas Medical Assistance Program beneficiaries are assigned to one or more medical assistance benefit plans. The assigned plan or plans are listed on the beneficiary ID card. These benefit plans entitle the beneficiary to certain services. From the provider's perspective, these benefit plans are very similar to the type of coverage assignment in the previous MMIS. If there are questions about service coverage for a given benefit plan, contact the Medical Assistance Customer Service Center at 1-800-933-6593 or (785) 274-5990.

Providers should check eligibility for each beneficiary who requests transportation services. The following eligibility guidelines are general in nature and providers must ensure that beneficiaries meet all of the qualifying criteria prior to transporting KMAP beneficiaries.

If a beneficiary has TXIX (Title 19) listed under the benefit plan, the beneficiary qualifies for commercial transportation services. If eligibility indicates QMB (qualified Medicare beneficiary) and this is the *only* benefit plan listed, the beneficiary does not qualify for transportation services. If eligibility indicates QMB and TXIX, transportation services are covered. If eligibility indicates MKN (MediKan), the beneficiary does not qualify for transportation services. If eligibility indicates HW21/TXXI (HealthWave 21) or HW19(HealthWave 19 - MCO Title XIX), the beneficiary should be instructed to contact FirstGuard.

If eligibility indicates MN (medically needy), the beneficiary is on a spenddown plan. Services are not covered until the spenddown is met. Once the spenddown is met, the beneficiary qualifies for transportation services. If the spenddown is not met, KMAP does not cover the trip, and the provider may charge the beneficiary for the trip. If the beneficiary pays for the trip, the provider should submit a claim to KMAP so the amount incurred by the beneficiary will be used to reduce the beneficiary's spenddown. If KMAP reimburses the provider for a trip, and the beneficiary has paid for that trip, it is the provider's responsibility to reimburse the beneficiary. If a provider is seeking prior authorization for transportation services, a prior authorization will be started regardless of whether the beneficiary has met their spenddown.

Note: Effective July 1, 2006, a new program is being implemented via a pilot project called Presumptive Eligibility. If someone requests transportation to a medical facility for the purpose of having their presumptive eligibility determination appointment, the transportation to this appointment is not a billable KMAP service.

BENEFITS AND LIMITATIONS

8400. Updated 8/06 MEDICAID

Benefits - Covered Services

Commercial Non-Emergency Medical Transportation (C-NEMT) is covered when provided for medical purposes for Medicaid beneficiaries. Transportation is covered only when an eligible Medicaid beneficiary is in the vehicle. Transportation must be to Medicaid-covered medical services from Medicaid enrolled providers.

General NEMT Requirements

- Non-emergency medical transportation (NEMT) is covered for Medicaid beneficiaries for medical purposes only and when no other less expensive mode of transportation is available. It is the responsibility of the transportation provider to question the beneficiary about the availability of other means of transportation that are available to the beneficiary (such as, is there someone who could provide the ride to the beneficiary for free - a neighbor, relative or friend?).
- The beneficiary must have ~~a~~ current Medicaid coverage ~~card~~ and must be in the provider's vehicle.
- The least expensive means of transportation (appropriate to the beneficiary's medical need) must be used.
- Transportation is available for services received within the State of Kansas or within 50 miles of the Kansas border provided that the beneficiary is traveling to the closest available provider for his or her medical condition. Reimbursement is not made if the beneficiary chooses to travel to another community for a service that is already available in his or her community.
- Transportation must be provided by an enrolled transportation provider in accordance with Medicaid rules and *Commercial NEMT Provider Manual* guidelines.
- Emergency ambulance transportation is the ONLY transportation service covered for MediKan beneficiaries.
- Medically necessary transportation services are covered for beneficiaries receiving hospice services.
- As a commercial NEMT provider, transporting a relative is not a covered service. If you are transporting a relative, you must enroll as a non-commercial NEMT provider.

COVERED SERVICES

- Transportation is available to receive prenatal services for pregnant women.
- Transportation to Kan Be Healthy (KBH) beneficiaries for medically necessary services as well as transportation to KBH screens for children seeking participation in the KBH program. Transportation for the beneficiary and for one parent or guardian accompanying a KBH beneficiary when necessary.

8400. Updated 8/06

- ~~Transportation is available for services received in Kansas or within 50 miles of the border.~~
- The Medical Necessity Form for NEMT (transportation) services ~~is necessary~~ must be completed, prior to the trip, for specialized medical services that require transportation ~~services to travel~~ to a qualifying medical appointment more than 50 miles in distance one-way. See the *Forms Section* at the end of this manual.
- Providers who wish to provide transportation for out-of-state medical services must submit a prior authorization request, which will be approved or denied by the NEMT PA Team. ~~receive prior authorization.~~
- Prior authorization from the beneficiary's physician is not required for the medical service if the medical service is provided at no charge to the state, such as service provided at a Shriner's Burn Center or Indian Health Center, or if services provided are covered by another insurance company. If a beneficiary requests transportation to a "free" service, the provider must check with the PA team to see if the transportation to the free service is reimbursable by KMAP.

TRANSPORTATION SERVICES NEVER COVERED INCLUDE, BUT ARE NOT LIMITED TO:

- Transportation for residents of nursing facilities or adult care homes is NOT covered. This includes new admissions to the nursing facility.
  Note: Transportation is included in the services provided by an adult care home/nursing facility.
- Local Education Agency~~ies~~ (LEA) providers may NOT bill Medicaid for Transportation.
- Waiting time is NOT covered.
- Attendants to assist drivers for beneficiaries with restrictive disabilities are NOT covered.
- Trips to educational classes or daycare services are NOT covered.
- Trips to schools where the majority of the day will be spent for educational purposes are NOT covered. Transportation for educational purposes in the above example, would be the responsibility of the school.
- Trips to pick up anything (including medications, prosthetics, medical equipment, glasses, etc.) are NOT covered.
- Errands or shopping are NOT covered
- Trips of a recreational or activity nature (or to or from such events) are NOT covered.
- Trips to attend nutrition, diabetic, or any other kind of informational classes are NOT covered.
- Trips to the YMCA or similar facility for the purpose of physical exercise/aquatic therapy are NOT covered.

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- Trips to a chiropractor, podiatrist or for acupuncture, biofeedback, relaxation therapy, or hypnosis are NOT covered.
- Trips to WIC clinics or to pick up durable medical equipment are NOT covered.
- Transportation related to non-medical services are NOT covered.
- Trips to the optometrist or dentist, for non KAN Be Healthy beneficiaries are usually NOT covered.
- Transportation for local appointments for residents of Level V or Level VI residential treatment centers are NOT covered.
- Transportation of relatives are NOT covered.
- ~~For beneficiaries who are residents of level V or level VI residential treatment centers, transportation for local appointments is not allowed.~~

Note: If you have questions, contact the Provider Assistance team.

LEVEL I NEMT SERVICES

Beneficiaries who are able to ambulate on their own or with ~~minimal~~ assistance and do not require a wheelchair for the trip, or who do not have specialized medical equipment that cannot be removed during transit, qualify for Level I NEMT services. In general, most KMAP beneficiaries ~~meet the criteria~~ qualify for Level I transportation services.

LEVEL II NEMT SERVICES

Beneficiaries who meet the following criteria qualify for Level II NEMT services:

- Beneficiary is non-ambulatory requiring a wheelchair or stretcher for transportation, or beneficiary is ambulatory but unable to complete the trip without the use of a wheelchair. Use of a walker or cane does not necessitate Level II services.
- Beneficiary has the following medical equipment which cannot be removed during transit:
    1) Ventilator
    2) IV fluids
    3) Peritoneal dialysis fluids
- Beneficiaries who receive treatments resulting in a *disabling* physical condition. For example, the beneficiary is incapable of ambulating due to a weakened condition caused by a medical condition/treatment. Examples of treatments that **might** result in a disabling physical condition include outpatient surgery, radiation therapy, chemotherapy, or dialysis.

  Note: Just because a beneficiary receives one of the above listed examples (outpatient surgery, radiation therapy, chemotherapy, or dialysis) does not mean they qualify for Level II reimbursement.

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Prior Authorization

Prior authorization (PA) means the provider must request authorization through the NEMT Prior Authorization team at EDS for services to the beneficiary **prior to or before** the provider transports the beneficiary.

Receipt of a PA number does not guarantee payment for a transportation service nor does it prevent recoupment if a transportation service is determined to have occurred for a non-covered medical service or if the service was reimbursed incorrectly.

Prior authorization is required by C-NEMT providers for the following situations:

- Beneficiary is currently eligible for Level I (ambulatory) transportation services but due to an injury or other medical reason, the beneficiary needs temporary Level II (non-ambulatory) transportation services. PA will be approved for up to two months, awaiting validation from physician for Level II services.
- Beneficiary is a new customer for the C-NEMT provider and states that they are non ambulatory or meet one of the other criteria for Level II transportation services. The PA request will be in pending status for up to 30 days, awaiting the completed and signed Certification Form from the primary care physician to validate the level of transportation services required for the beneficiary. ~~approved for up to two months, awaiting validation from physician for level II services.~~
- Transportation related to out-of-state medical services. The out-of-state medical service requires prior authorization before the transportation PA. Transportation PA will not occur until the *medical service is approved. PA will be approved for up to six months.*
  Note: It is the C-NEMT provider's responsibility to track the effective dates for a prior authorization and to request an extension for the prior authorization if needed.

The information required to obtain PA for transportation services are as follows:

- Provider name and number
- Beneficiary name and KMAP number
- Date(s) beneficiary is requesting transportation services
- Address where beneficiary will be picked up
- Address where beneficiary is scheduled to receive medical services and name of provider and/or medical facility where services are scheduled
- Completed/signed certification form from primary care physician, if beneficiary qualifies for Level II transportation services.
- ~~Criteria that qualifies the beneficiary for level II services~~
- Total number of miles to be traveled as per shortest distance mapping software
- Whether the scheduled transportation is one-way or round-trip
- ~~Date provider will give beneficiary a copy of the Certification by Medical Provider for Transportation Services form~~

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There are ~~three~~ two ways for providers to access the NEMT PA team ~~Prior Authorization unit~~: telephone, ~~e-mail,~~ or fax. The telephone number for the NEMT PA team ~~Prior Authorization unit~~ is 1-800-285-4978. The telephone line is available from 7:30 a.m. - 5:30 p.m., Monday through Friday. An answering machine is available after hours and on holidays and weekends. When the telephone number is dialed, an announcement menu gives you the option to press a number ~~(currently #4)~~ for transportation reservations. ~~Providers may choose to use e-mail to send in prior authorization requests. Before e-mailing for prior authorization requests, the provider must contact the Prior Authorization unit to get instructions on how to use the e-mail system. The e-mail address is nemtadmin@ksxix.hcg.eds.com.~~ The fax number for the NEMT PA team ~~Prior Authorization unit~~ is 1-800-913-2229.

After a request for prior authorization is submitted, the PA team issues the provider a PA number. It should be noted that receipt of a PA number does not automatically guarantee that the claim for that service will be paid. The PA number is issued to verify that the information was received and documented by the PA NEMT specialists. When the provider submits the claim, the provider must enter the PA number in the appropriate field (box #23) on the HCFA 1500 Claim form

Notify the PA team (within 72 hours) of any deletions, additions, or changes to the service that occurred after the initial PA was obtained. The PA team will document these changes.

If KMAP receives a request for PA **after** the transportation service has been provided, it will not qualify for prior authorization, and KMAP will deny the request. The provider may not bill KMAP for services requested after the fact.

If transportation service was provided in an **emergency** situation and it is after hours or on a weekend or holiday, Commercial NEMT providers have 48 hours to submit their request to the PA team. Commercial NEMT providers may phone the PA team at 1-800-285-4978 and leave a message on the answering machine, which is treated as the providers' intent to begin the PA process. ~~If you have e-mail access established with the NEMT PA unit, you may use the e-mail system.~~ The provider is responsible to check with the NEMT PA team during normal operating hours to ascertain the information was received by EDS. The provider is expected to submit, upon request by the PA team, additional documentation describing the emergency situation.

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MINIMUM DOCUMENTATION REQUIREMENTS

~~The following must be maintained by the provider.~~

All documentation sent to KMAP Provider Enrollment, or to the fiscal or state agency, must include the provider name and assigned provider number.

~~A. The NEMT Transportation form (Forms Section) must be completed in its entirety for each and every transportation service (level I and II) provided for a KMAP beneficiary. It is not acceptable to have the beneficiary sign a form and then photocopy the form for future use.~~

~~B. C-NEMT providers are to keep a paper copy of the completed NEMT Transportation form on file at their office for a minimum of five years. If a utilization review occurs, the provider will be asked to mail a copy of the completed form for identified beneficiaries to the fiscal agent or designee.~~

~~C. Many C-NEMT providers use daily dispatch logs, run/trip sheets, or appointment logs. Submitting copies of these documents will help to support and validate claims submitted during a utilization review. Documentation that validates that a trip has occurred must stand on its own. This means, that any person that looks at the information would be able to determine the following: time of service, date of service (mm/dd/yy), beneficiary name, Medicaid number, total miles traveled, complete address (street number and street name, city , state, and ZIP code) where beneficiary is picked up, complete address where beneficiary is dropped off, whether the transport was one-way or round-trip, and name of physician or medical provider where beneficiary is being transported to and from.~~

~~C-NEMT providers may choose to have the drivers make pen and ink changes directly on these forms (logs and trip sheets) when changes occur, as long as the changes are legible. For further information on medical necessity, refer to the Benefits and Limitations Section of this manual.~~

The following must be maintained by the provider for a minimum of five years from the date of service:

- Completed NEMT Transportation forms for each and every transportation service (Level I and Level II) provided for a KMAP beneficiary. Instructions for completing the form are given on pages 7-7 and 7-8 of this manual. If a utilization review occurs, the provider will be asked to mail copies of their completed transportation forms for identified beneficiaries to the fiscal agent or designee. Failure to keep accurate and complete records of each and every service provided could result in recoupment of payments made by Kansas Medicaid**.**

  Note: **Documentation to validate a trip must be able to stand on its own.** This means, any person that reads and or reviews trip documentation would be able to determine all of the following:

  - Provider name and provider identification number
  - Complete Date (dd/mm/yyyy) and Time of Service (for example 9:15 a.m.)
  - Beneficiary Name
  - Beneficiary Medicaid Number

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- Valid Signature (either beneficiary or guardian/relationship), obtained at the time service was provided
- Complete address where beneficiary is picked up and complete address where beneficiary is dropped off. A complete address includes the street number, street name and city name. The state name and ZIP code must be included if the trip was provided in a state other than Kansas.
- Name of Medical Provider/physician/medical facility where beneficiary is being transported
- Whether trip was a one-way or a round trip
- Total miles traveled (using "shortest distance" option provided by mapping software)
- Driver's name
- Type of vehicle used for transport

- Some C-NEMT providers use daily dispatch logs, run/trip sheets, or appointment logs for logistical purposes. During a utilization review, submitting copies of these documents might help support and validate trips for claims which have been submitted and paid.
- For specialized medical services that require transportation services to transport a beneficiary (Level I or II) more than 50 miles in distance one-way (100 miles round-trip), Commercial NEMT providers must obtain and keep on file:
    - A completed Medical Necessity Form for NEMT Services (see Forms Section). The form must be signed by a physician (MD, DO, ARNP, or PA), kept at the C-NEMT provider location, and made available if requested by KMAP during a utilization review. The provider is expected to obtain the completed Medical Necessity Form for NEMT Services either prior to or within 72 hours of the transportation service being provided. The Medical Necessity Form for NEMT Services is valid for six months.

~~E. KMAP uses mapping software (such as MapQuest® or Expedia™) in post-pay review to determine the shortest distance between pick-up and drop-off locations, and to calculate mileage allowance. All documentation must indicate the **TOTAL** number of miles traveled per trip and whether the trip was one-way or round trip.~~

- The HCFA-1500 Claim form, NEMT Transportation forms, and any other documentation submitted must be legible and must stand on its own.

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PROVIDER PARTICIPATION REQUIREMENTS

The Commercial Non-Emergency Medical Transportation provider must be enrolled as a provider with Kansas Medical Assistance Program (KMAP). Enrollment packets may be obtained by contacting the Provider Enrollment at:

Kansas Medical Assistance Program
Office of the Fiscal Agent
P.O. Box 3571
Topeka, KS 66601-3571
(785) 274-5914

Additional Commercial NEMT provider requirements are as follows:

Upon enrollment, or when staff or vehicle changes occur, the provider must submit the following to the Provider Enrollment team:

A. Make, model, and vehicle identification number (VIN) for each vehicle that will be used to transport Medicaid beneficiaries.

B. Proof of insurance (as required by law) for each vehicle used in your transportation services. The provider must mail to the KMAP Provider Enrollment team (see above address) proof of insurance each time the motor vehicle insurance is updated or renewed.

C. Copy of valid driver's license for all employed drivers. If you hire a new driver, send a copy of the valid driver's license for that employee to the KMAP Provider Enrollment team. Providers do not have to submit a copy of the driver's license for each trip provided.

D. Commercial NEMT providers must have KBI background checks (or the equivalent) on each of their employed drivers. Providers must obtain this information within 60 days from date of hire. Providers must keep this information on file at the providers' location and must make it available for review by KMAP staff or designee.

E. If you are registered with the Kansas Corporation Commission, some of the above requirements may be waived, if approved in writing by the SRS Commercial NEMT program manager.

F. The owner of the Commercial NEMT provider business must disclose to the KMAP Provider Enrollment team, the names and provider numbers of any other businesses, organizations, companies, entities, or associations in which the owner has five percent or greater ownership, that are currently enrolled **or** in the process of enrolling as a KMAP provider.

FAILURE TO COMPLY WITH PROVIDER PARTICIPATION REQUIREMENTS WILL LEAD TO TERMINATION OF THE PROVIDER AGREEMENT. KMAP WILL NOT PAY CLAIMS FOR SERVICES PROVIDED AFTER THE PROVIDER AGREEMENT IS TERMINATED.

APPENDIX I

PROCEDURE CODES AND NOMENCLATURE Updated 8/06

The following codes represent an all inclusive list of Commercial NEMT services billable to the Kansas Medical Assistance Program. Procedures not listed here are considered non-covered.

COMMERCIAL NEMT PROVIDERS

PROCEDURE CODE	NOMENCLATURE
T2003	Commercial NEMT transportation; encounter/trip (Level I) not county specific (includes the first 10 miles on a one-way trip, bill one (1) unit; 20 miles on a round-trip, bill two (2) units)
T2002	Non-emergency transportation; per diem. **This procedure code may only be used by C-NEMT providers whose physical location is in one of the following counties: Leavenworth, Shawnee, Douglas, Wyandotte, Johnson, or Sedgwick. It may only be used for the first trip of the day (units 1 and/or 2).** (includes the first 10 miles on a one-way trip, bill one (1) unit; 20 miles on a round-trip, bill two (2) units)
A0130	Commercial NEMT; wheelchair van (Level II) (includes the first 10 miles on a one-way trip, bill one (1) unit; 20 miles on a round-trip, bill two (2) units)
A0425	Commercial transportation, ground mileage, per statute mile. Only use this procedure code if mileage exceeds 10 miles on a one-way trip or 20 miles on a round-trip. C-NEMT providers cannot submit a claim for this procedure code by itself.

MODIFIERS	
TK	Extra patient or passenger, non ambulance. Use this modifier when a C-NEMT provider transports more than one beneficiary from the same pick-up point to the same destination, or transports more than one beneficiary from the same pick-up point, dropping off one of the beneficiaries at a destination before dropping the remaining beneficiary at the farthest destination. See Section 7000, Field 24D for modifier use. C-NEMT providers must attach modifier TK to one of the following procedure codes for an individual beneficiary (the beneficiary that is not the primary rider): T2002, T2003, and A0130. Use this modifier only for a maximum of 2.0 units per beneficiary, per day. No mileage (A0425) may be billed on a claim that uses this modifier.
UK	Services provided on behalf of the beneficiary to someone other than the beneficiary (collateral relationship). Use this modifier when a C-NEMT provider transports a beneficiary with an accompanying parent, guardian, or designee. C-NEMT providers must attach modifier UK to one of the following procedure codes: T2002, T2003, and A0130. Use this modifier only for a maximum of 2.0 units per beneficiary, per day. Mileage may only be billed for the beneficiary, not the accompanying person.

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Certification by Medical Provider for Transportation Services

This form must be completed and signed by a primary care physician or designee (physician assistant, nurse practitioner, or clinical nurse specialist). Form will be returned and/or invalidated if not completely filled out.

Beneficiary Name: _____ Medicaid ID # _____

Initial all that apply:

	Ambulatory and does not require a wheelchair
	Ambulatory but requires walker, cane, or personal assistance
	Ambulatory but requires wheelchair to travel to and from medical appointments
	Permanently confined to a wheelchair
	Temporarily confined to a wheelchair, *Expected duration:* _____
	Dialysis renders beneficiary to be physically unable to ambulate, *Number of dialysis treatments per week:* _____
	Ventilator dependent or using peritoneal dialysis or IV fluids that cannot be removed during transit
	Scheduled for outpatient surgery, *Date of surgery:*_____
	Receiving radiation or chemotherapy treatments, *Expected duration*:_____
	Nonambulatory, requires a stretcher for transportation
	Other, *Explain:*

I certify that I have reviewed this person's history and condition and the information is accurate and complete.

Prescriber's Name/Credentials: (Physician, Physician Assistant, Nurse Practitioner, or Clinical Nurse Specialist) Please **Print:**	Prescriber's Phone # Prescriber's Fax #
Prescriber's Signature:	Date:

Form is valid for up to one year unless the field indicating permanent wheelchair is checked. If beneficiary's condition changes, complete a new form (for example, condition changes from ambulatory to temporary wheelchair or permanent wheelchair). Forms are available on the KMAP Web site, https://www.kmap-state-ks.us, and in the Appendix of the Commercial NEMT Provider Manual.

Fax completed form to the attention of the NEMT PA Team, 1-800-913-2229 or mail completed form to KMAP, Office of the Fiscal Agent, ATTN: NEMT PA Team, P.O. Box 3571, Topeka, KS 66601-3571.