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Healthy is for everyone

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NEMT Prior Authorization Requirements FAQ

The Health Plan of San Mateo (HPSM) requires prior authorization for nearly all Non-Emergency Medical Transport (NEMT) services, including, but not limited to litter/gurney van, wheelchair van, or ambulance medical transportation for non-emergency care. Please check the most up-to-date prior authorization list to confirm whether the specific code requires a prior authorization: **https://www.hpsm.org/provider/authorizations**

Here are some frequently asked questions (FAQs) related to HPSM's NEMT policies and procedures. This information does not apply to Non-Medical Transport (NMT).

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What qualifies as Non-Emergency Medical Transportation (NEMT)? Non-Emergency Medical Transportation (NEMT) is an ambulance, litter/gurney van, wheelchair van or air transportation requested by a provider. NEMT is not a car, bus, or taxi.

NEMT can be used when all of the following conditions are met:

(1) Medically necessity is demonstrated (I.e., the member cannot use a bus, taxi, car or van to get to the appointment) using HPSM's Physician Certification Statement (PCS) form;
(2) Services are requested by an HPSM in-network provider, using HPSM's Prior Authorization form; and
(3) Services are authorized by HPSM (retroactive authorization requests may be submitted up to a year after the date of service).

What action is needed from in-network NEMT providers to be paid for services rendered?

Requirement #1: Prior Authorization Form

NEMT providers are required to obtain prior authorization for the majority* of NEMT services (i.e., trips/rides) for these services to be reimbursed by HPSM. NEMT providers are also required to submit a physician certification statement (PCS) form. These two forms have been combined into a single document, which is available on our website here: **https://www.hpsm.org/provider/authorizations/specialty-provider#nemt.**

Exceptions to this include:

(1) HPSM requires prior authorization of NEMT services in all cases except for rides to and from the following destinations:
    - Hospital to nursing facility (modifier HN);
    - Hospital to custodial facility (modifier HE);
    - Hospital to residence (HR); and
    - Hospital to hospital (modifier HH).

Retro-Active Prior Authorizations (PA) are Acceptable: Authorizations do not need to be submitted and/or approved prior to the date of service. In other words, NEMT providers can submit the PA & PCS form after the services have been rendered. Prior authorization requests submitted after the date of service may take up to 30 business days to process and approve.

Requirement #2: Submit Claims

Please submit claims using the CMS 1500 form for all NEMT services. Payment for claims that do not conform to the requirements below are subject to payment delays or denials:

- Each leg of the trip must be submitted on a separate service line.
- Claims for mileage must be submitted with the corresponding origin and destination modifier, and the total unit value should reflect the total miles from the point of recipient pick-up to destination for a single leg of the trip.
- The complete origination and destination addresses, including city and ZIP code, must be indicated in the Additional Claim Information field (Box 19) of the claim.
- Night Calls (i.e., services between the hours for 7 p.m. and 7 a.m.) – append modifier UJ (services provided at night) in the primary position and indicate the start and stop time of the service in the Additional Claim Information field (Box 19) of the CMS-1500 claim form.

Please do not submit claims until after you receive a PA approval number. HPSM requires the PA approval number be included on the claim in order for the claim to be paid. Please wait for your prior authorization to be approved before submitting claims. If you submitted a claim before your authorization was approved and your claim is denied, please rebill after obtaining authorization.

Rides exceeding 75 miles on-way must include pick-up and drop-off address – HPSM requires that claims submitted for more than 75 miles for a one-way trip include the pick and drop off address on the claim form (Box 19).

Who needs to be involved to complete the prior authorization and physician certification statement (PCS) form? All the fields on the prior authorization request form and PCS form must be type-written except for the "Staff/Physician's Signature" fields.

On page one of the prior authorization request form, please note that the NEMT provider will need to:

- Obtain information on the member's diagnosis. This can be done by asking the referring provider, or person who books the ride, or from member. Please note that the field must be populated with a valid ICD-10 code.
- Calculate an estimate of the total number of units requested for authorization, which is dependent on the requested time frame (I.e., the fields at the top of page 2: "Dates

of Service Needed"). For requests for "Ongoing" dates of service, the units requested for mileage should be an estimate of the total number of miles that would be driven for that member for all services provided within the time span specified in the fields at the top of page 2.

- For example, for a prior authorization request for a member receiving dialysis, NEMT providers typically request 5,000-8,000 units for the mileage procedure code as an estimate for the number of miles driven for 12 months of service.
- Please note: If the units billed on claims exceeds the amount requested on the prior authorization form, provider should submit a correction request for additional units to be added to the prior authorization.

What are acceptable ways to complete and submit the form? Either the NEMT provider or the servicing provider may send in the completed form. The completed form (including signature and relevant medical records, if necessary) is required for NEMT claims to be paid. Please fax the completed form to 650-829-2079.

HPSM will only accept the prior authorization request and provider certification statement (PCS) form if it is typewritten (except for the signature field; e-signatures and handwritten signatures are both acceptable). Office staff at the servicing provider's office may sign on behalf of the servicing clinician, with the clinician's approval. For example, a clinic might sign the form as follows:

Staff/Physician's Name: Joe Administrator on behalf of Dr. Jane Gonzales
Staff/Physician's Signature: *Joe Administrator*
NPI: <Dr. Jane Gonzales' NPI>

Some providers find it is easiest to use secure email, rather than fax, to send the form between the NEMT provider and servicing provider, so that both parties can fill in their sections electronically by typing in the PDF form.

If secure email is not available, another approach is for the NEMT provider to call the servicing provider to ask for the required information in the PA form. The NEMT provider would then type out the information required on the form and then fax the form to the servicing provider for signature (which does not need to be typed).

Please note:

- The form may be rejected for any of the following reasons:
    - (1) some or all of the fields are handwritten or otherwise not readable;
    - (2) missing required information such as diagnosis codes, procedure codes, NPI, member information and dates of service.
- Authorizations submitted with no end-date will be considered as single-day requests.

Can I request authorization for multiple planned visits in on a single form? E.g., if a member accessing dialysis/wound care/chemotherapy services needs regular NEMT services, is the treating clinician allowed to sign the form once for a series of visits? Yes, with the following conditions:

- One prior authorization form may cover a single member for anticipated rides within a 12-month period.
- One type of ride may be requested in each line available on the prior authorization form. One type of ride is defined as one specific CPT code for one specific ride (i.e., same origin and destination as captured based on the modifiers provided).
- Please use the Units of Service section to indicate the specific number of trips requested and/or the specific number of miles requested.

HPSM's form currently has three lines available to accommodate round-trip requests. A single prior authorization form can be used to request multiple round-trips or multiple one-way trips. Requests for different origin and destinations will need to be requested on separate forms.

Please note: A correction form must be submitted after the total units of service billed via claims exceeds the units of service authorized.

How do I complete the dates of service needed? NEMT rides must be scheduled by HPSM's Integrated Care Management (ICM) team on behalf of the member. When a ride is scheduled, the care manager will inform you of the specific number of rides or if the rides will be needed on a recurring basis. Please be as specific as possible with the dates of service needed by using the information provided by the HPSM care manager:

- For a one-time ride, select the "One-Time Only" box and input the date of the scheduled ride
- For multiple rides, select the "Ongoing" box and use the dates of the first and last appointments as the start- and end-dates, respectively.

- For recurring rides, select the "Ongoing" box and you may use start- and end-dates spanning up to a 12-month timeframe. Please be sure to accurately calculate the total number of miles needed for the requested time frame.
    - *For example, a dialysis patient whose home is 20 miles from the dialysis center and requires dialysis 3 times a week would require 6,240 miles for a year (20 miles per trip x 2 trips per appointment x 3 appointments per week x 52 weeks).*

Please note: for "Ongoing" requests, the through/end date should never go beyond the dates of trips confirmed to be necessary.

What should I enter into the modifier fields of the authorization form and claims? For round trip transport requests, each leg of the trip must be requested separately on a single row as shown in the example below. Providers must include an origin and destination modifier for each trip requested, (otherwise the request will be denied). The total mileage must also be requested in a single row on the form. The units of service requested should be an estimate of the sum total mileage for all legs of the trips requested (I.e., the sum total of the distance between the origin and destination of trip multiplied by the units of service for all requested trips). Please note that the modifier field for mileage must be left blank.

Please see Table 1 at the end of this this document for a list of NEMT modifiers. The example below represents a request for a round trip ride between a patient's residence (Modifier = R) and a physician office (Modifier = P):

Procedure Code	Modifier	Units of Service
A0130	RP	# of trips for leg 1 (if the authorization is for multiple trips)
A0130	PR	# of trips for leg 2 (if the authorization is for multiple trips)
A0380	N/A	Total milage for all trip legs

Using the above example, two claims or four separate service lines would be submitted:

CLAIM 1

Procedure Code	Modifier	Units of Service

A0130	RP	# of trips for leg 1 (if the authorization is for multiple trips)
A0380	RP	Total mileage for leg 1

CLAIM 2 or lines 3 and 4

Procedure Code	Modifier	Units of Service
A0130	PR	# of trips for leg 2 (if the authorization is for multiple trips)
A0380	RP	Total mileage for leg 2

Claims submitted with modifiers that do not match the authorized modifier on the PA form will result in a claims denial. The corresponding modifier must be added to the mileage on the claim form even though it is not required on the authorization.

How soon will I hear back about a decision on my prior authorization request?

Authorization requests submitted in advance of the ride are completed within normal turnaround times (five business days, or 72 hours for urgent requests). If the authorization request is received retroactively to the date of service, turnaround times may be up to 30 days.

Table 1: NEMT Modifiers

A full list of modifiers can be found here: **https://files.medi-cal.ca.gov/pubsdoco/bulletins/docs/medical_transportation_code_conversion.pdf**

D	Diagnostic or therapeutic site other than 'P' or 'H' when these codes are used as origin codes. This modifier is to be used for transports to or from an Ambulatory surgical center (ASC) or a free-standing psychiatric facility.
E	Residential, domiciliary, custodial facility (other than an 1819 facility)
G	Hospital-based dialysis facility (hospital or hospital-related)
GM	Multiple patients on one ambulance trip. Note: Providers need to submit the appropriate origin and destination modifiers in the first modifier position and HCPCS modifier GM in the second modifier position.
H	Hospital. This modifier must be submitted for a psychiatric facility located at a hospital.
I	Site of transfer (e.g., airport or helicopter pad) between types of ambulance vehicles

J	Non hospital-based dialysis facility
N	Skilled nursing facility (SNF) (1819 Facility)
P	Physician's office (includes HMO non-hospital facility, clinic, etc.) For Medicare purposes, urgent care centers, clinics and freestanding emergency rooms are considered physician offices
QL	Patient pronounced dead after ambulance called
R	Residence
S	Scene of accident or acute event
X	(Destination code only) Intermediate stop at physician's office on the way to the Hospital (includes HMO non-hospital facility, clinic, etc.)
GY	Not covered per Medicare policy
UJ	Used for night calls, 7 pm to 7 am

How do I correct my claim when it is denied with claim message 8406 (missing/incomplete/invalid point of pick up)? Some claims processed by HPSM with total mileage beyond the scope of San Mateo County require the pick-up and drop of location for HPSM. Currently, HPSM's web entry form does not allow for this information. Please resubmit the claim using a CMS 1500 or the 837P with the point of pick-up address and drop of location included.

Do I need to request authorization for after-hours transport separately by appending modifier UJ to the authorization? No, separate authorization is not required for after hours. Do not append modifier UJ to the authorization. However, the claim must include modifier UJ in the primary position in addition to the origin/destination modifier and the time of pick up as a claim remark to be reimbursed using the night call rate.

Who should I contact if I have additional questions? For more information, please contact:

- HPSM Provider Services at **PSInquiries@hpsm.org**.
- HPSM Claims at **650-616-2106** or by emailing **ClaimsInquiries@hpsm.org**.

Additional contact information is available online at: **https://www.hpsm.org/contact-us**

If you have not already, at your earliest convenience, please enroll to access HPSM's provider portal here: **https://www.hpsm.org/provider/portal.**