

THE PRUDENTIAL INSURANCE COMPANY OF AMERICA

NEW JERSEY HEALTH SERVICES PROGRAM

Governmental Health Programs Department, P.O. Box 1900, Millville, N. J. 08332

May 1, 1973

TO: ALL TRANSPORTATION PROVIDERS

The New Jersey Health Services Program has developed a new Ambulance and Other Transportation Claim (MC-12C2) to simplify the prior authorization procedures by eliminating the need for the "Request For Authorization" (form 33030).

The major change in the MC-12C2 is the inclusion of item 11 which is the prior authorization portion of the claim. This obviates the need for the provider to prepare both the request for authorization (33030) and a claim form. The new claim form will be both the request for authorization and the billing form.

New prior authorization procedures are explained in the attached page revisions to the Transportation Manual (See page 14, Section 203.1). A sample of the new claim (MC-12C2) is shown as Exhibit I (page 21) of the attached manual revisions.

Please pay particular attention to page 18 Section 304 on Combination Medicare/Medicaid claims as the prior authorization procedure has been modified.

A supply of new claim forms (MC-12C2) may be obtained by contacting:

The Prudential Insurance Company of America
Medical Administration Division
P. O. Box 1900
Telephone Numbers: 609-825-8700 Ext. 357 or
201-621-6960 Ext. 357

Please remove pages 11, 14, 15, 16, 17, 18, 19, 20 and 21 from your Transportation Manual and insert the attached pages in their place.

Contact your Local Medical Assistance Unit if you have any questions.

A REMINDER ! !

When using the old forms which are marked MC-12AC1 in the lower left hand corner, you must use the 33030 to obtain prior authorization as in the past.

THE PRUDENTIAL INSURANCE COMPANY OF AMERICA

NEW JERSEY HEALTH SERVICES PROGRAM

Governmental Health Programs Department, P.O. Box 1900, Millville, N. J. 08332

May 1, 1972

ATTENTION: Transportation Providers

SUBJECT: MEDICAID PROVIDER MANUAL REVISION

A revised manual page is attached to up-date the Transportation Manual to conform with a new Welfare regulation concerning transportation services not available under Medicaid.

Please remove and destroy page 13. Replace with the attached page.

TRANSPORTATION 13

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THE PRUDENTIAL INSURANCE COMPANY OF AMERICA

NEW JERSEY HEALTH SERVICES PROGRAM

Governmental Health Programs Department, P.O. Box 1900, Millville, N. J. 08332

May 1, 1971

ATTENTION: Transportation Providers

Chapters II and III of the Transportation Manual should be removed and replaced with the attached pages which have been revised.

We are also enclosing fifty (50) revised claim forms to replace your existing supply.

PAGES 11-20 AND EXHIBIT I (P. 21)

LATER REVISION:

10/1/71 PAGES 14+15

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STATE OF NEW JERSEY
 Department of Human Services
 Division of Medical Assistance and Health Services

New Jersey Health Services Program NEWSLETTER

Volume P - 189

July 25, 1977

TO: TRANSPORTATION PROVIDERS

**SUBJECT: UPDATED TRANSPORTATION FEE SCHEDULE
CHANGE IN PRIOR AUTHORIZATION REQUIREMENTS**

A complete revision to the New Jersey Medicaid Program's Transportation Manual will be published and disseminated late in the year 1977 or early in 1978 in conjunction with a revised Ambulance and Other Transportation Claim Form (MC-12). The revised Claim Form allows billing of multiple trips on a single claim, thereby saving time and paperwork for the Transportation Provider.

Effective August 1, 1977 the updated Transportation Fee Schedule printed below, as well as policy changes outlined in this Newsletter, will be implemented. The changes effect primarily the BASIS OF PAYMENTS Section 204.1 and 204.2 and PRIOR AUTHORIZATION, Section 203. of your current Transportation Manual.

<u>DESCRIPTION</u>	<u>MAXIMUM ALLOWANCE</u>
<u>Ambulance</u>	
Ambulance — One Way	\$24.00
Ambulance — Round Trip	48.00
Mileage	.80 per loaded mile
<u>Invalid Coach — Non Dialysis Patients</u>	
*Invalid Coach — One Way, First Patient	\$17.00
Invalid Coach — Round Trip, First Patient	34.00
Invalid Coach — One Way, each additional Patient	14.00 per patient
Invalid Coach — Round Trip, each additional Patient	28.00 per patient
Mileage	.80 per loaded mile
(If multiple load, mileage reimbursement will be made only for the one patient who travels the greatest distance.)	
<u>Invalid Coach — Dialysis Patients</u>	
First Patient, One Way	\$14.00
First Patient, Round Trip	28.00
Additional Patient, One Way	11.00
Additional Patient, Round Trip	22.00
Mileage	.80 per loaded mile
(If multiple load, mileage reimbursement will be made only for the one patient who travels the greatest distance.)	

No waiting time reimbursement will be made for dialysis patients.

*Maximum of three patients for Invalid Coach at one time, except for Dialysis Trips where a maximum of four patients is allowed.

(over)

THE PRUDENTIAL INSURANCE COMPANY OF AMERICA

NEW JERSEY HEALTH SERVICES PROGRAM

Governmental Health Programs Department, P.O. Box 1900, Millville, N. J. 08332

November 21, 1977

TO: TRANSPORTATION PROVIDERS

SUBJECT: REVISED MEDICAID TRANSPORTATION MANUAL, CHAPTERS II & III: REVISED TRANSPORTATION CLAIM FORM (MC-12-C4), EFFECTIVE DECEMBER 1, 1977

Please examine the contents of this package carefully. Your package should consist of the following:

1. Revised Medicaid Transportation Manual, Chapters II & III
2. A supply of revised MC-12 Transportation Claim Forms
3. A claim reorder form to expedite the reorder of claims

Effective December 1, 1977, destroy all of your old claim forms and the outdated Chapters II and III and begin using the new claim forms in accordance with the policy and billing procedures in your revised chapters.

The revised Chapters II & III reflect the updated Fee Schedule as published in Newsletter Volume P-189, July 25, 1977. Other major changes are highlighted below.

Revised definitions and/or policy:

- "Transportation means the use of an approved carrier to move the sick, injured or disabled person from place to place when considered medically necessary. Prior authorization is required except where specifically stated." (See Section 201.1)
- "Ambulance Service. . .The medical condition is to be such that one normally would expect the need for the medical assistance of a second person within the ambulance after the patient has been placed into the vehicle." (See Section 201.2A)
- "Invalid Coach. . .The patient's medical condition is to be such that one normally would not expect the need for the medical assistance of a second skilled person or more than one person in attendance once the patient has been placed into the vehicle." (See Section 201.2B)
- "Multiple Loading. . .*Maximum of three patients for Invalid Coach at one time-except for patients transported to receive dialysis treatments, where a maximum of four patients is allowed." (See Section 201.4 & Procedure Code - Fee Schedule)
- "Retroactive Request (Administrative Emergency). . .When communication between the provider and the LMAU could not be established (e.g., weekend, holiday, evening, etc.) and the provision of the service should not have been delayed, the provider may render the service and request retroactive authorization." (See Section 203.1C)
- "Waiting Time. . .is that period of actual time in increments of 15 minutes and beyond 30 minutes following delivery of the patient to his destination i.e., hospital, X-ray department, Long Term Care Facility, emergency room, doctor's office, etc., which may be considered as an added charge. There will be no reimbursement for waiting time on round trips and it is limited to a maximum of one hour on one way trips. An explanation of the need for waiting time must be attached to the MC-12 Claim Form." (See Section 204.3)
- "Multiple Authorization - See Section 201.5 for policy regarding prior authorization of more than one trip based upon a single physician's prescription. Invalid Coach Transportation for patients receiving dialysis treatment may be authorized for a period of up to three (3) calendar months. Transportation for non-dialysis patients may be authorized for a period of up to one (1) calendar month.

(continued)

Revised Claim Form

The MC-12 Claim Form has been revised to allow for billing of up to five (5) trips on a single claim and to facilitate billing for dialysis patients. See Section 305.1 of the revised Chapter III for instructions for completion of the revised Transportation Claim Form.

MMIS RELATED REVISIONS TO THE MC-12 CLAIM FORM

Some of the revisions to the Claim Form were necessary in order for our Medicaid Program to meet Federal requirements for an approved Medicaid Management Information System (MMIS). Please refer to Newsletter Volume P-195 dated September 12, 1977 which announces a January 1, 1978 implementation date for MMIS.

The MMIS related changes to the form, (items 10, 12C, 13A & B) are explained below, in order to assist you in completing your claims.

Item 10: EPSDT Program Referral - It is not necessary for you to complete this item at this time. Leave it blank.

Item 12C: Identify the place of origin, by selecting the appropriate code as listed on the form under item 12 REPORT OF SERVICES.

IMP Number: One of the most significant changes to the claim form is the requirement to identify practitioners by an Individual Medicaid Practitioner (IMP) Number. Item 13A on the revised claim form refers to an IMP Number. Each Medicaid Practitioner has been assigned a unique IMP Number and has been advised of the requirement to make it available to other Medicaid providers when prescribing a service.

Item 13A: Practitioner ordering transportation

If transportation was ordered by a practitioner, his/her name and Individual Medicaid Practitioner (IMP) Number must be entered in item 13A.

In the event that you are unable to obtain the IMP Number directly from the prescribing practitioner, you may call (800) 322-8051 or (800) 322-8052 toll-free for the information. You will need the name and address of the practitioner in order to obtain the IMP Number. It is recommended that you record the IMP Numbers of practitioners as you receive them, so you will have them available for future claims.

If the practitioner who ordered the transportation does not have an IMP Number, insert the name only and write "NON-PAR" next to the practitioner's name. You are cautioned that the term "NON-PAR" is used only when an IMP Number has not been assigned and is unavailable through the toll-free numbers mentioned above.

NOTE: In emergency situations, where a non-practitioner initiated the transportation, identify the individual who ordered the transportation and the circumstances of the emergency in item 13D on the claim.

Item 13B: Diagnosis

Obtain the diagnosis from the practitioner who ordered the transportation. A diagnosis is required.

If there are questions regarding the revised manual or claim forms, please contact your Local Medical Assistance Unit for assistance.



STATE OF NEW JERSEY

DEPARTMENT OF INSTITUTIONS AND AGENCIES

DIVISION OF MEDICAL ASSISTANCE

AND

HEALTH SERVICES

HEALTH SERVICES PROGRAM

TRANSPORTATION MANUAL

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FOREWORD

The New Jersey Medical Assistance and Health Services Act (Chapter 413, Laws of 1968) established a program of assistance and services for defined groups of persons to enable them to secure quality medical care. This is the New Jersey version of a program commonly known as "Medicaid" or "Title XIX". In identifying persons eligible for such assistance and services this will be known as the New Jersey Health Services Program.

This manual is designed for use by providers billing for services furnished under the Program. It contains informational and procedural material needed to assist the provider in prompt and efficient payment of claims and to answer questions which patients may ask about the program. The procedures described in this manual have been devised to achieve the goals of the Program with due consideration to the needs of the covered persons and effective relationships with providers.

A careful effort has been made to insure that the provisions of the law and the regulations are accurately reflected. This issuance should help to assure that the law is uniformly applied without regard to where covered services are furnished.

The manual is designed to accommodate new pages as administrative changes in procedure are made. Accordingly, revised sections, pages, or chapters will be issued as the need presents itself.

CHAPTER I

GENERAL INFORMATION ABOUT THE PROGRAM

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CHAPTER I

GENERAL INFORMATION ABOUT THE PROGRAM

100. WHO IS ELIGIBLE

In general, Medical Assistance will be available to the following individuals:

All individuals receiving financial assistance under the State programs of Old Age Assistance, Assistance for Dependent Children, Aid to the Blind and Assistance to the Permanently and Totally Disabled. (These are referred to as "categorical assistance" programs.)

Persons who would be eligible for financial assistance under one of the above programs except for a requirement that is specifically prohibited by Federal law or regulations, such as execution of a reimbursement agreement.

Persons who meet the standard of need applicable to their circumstances under one of the categorical assistance programs, but who are not receiving and do not apply for such assistance.

Children between 18 and 21 who, except for school attendance requirements, would be eligible for the State program of Assistance for Dependent Children.

Children under 21 years of age in foster placement under supervision of the Bureau of Children's Services for whom maintenance is being paid in whole or in part from public funds.

The spouse of a recipient of old age assistance, assistance for the permanently and totally disabled, or assistance for the blind who is living with such recipient and whose needs are taken into account in determining the amount of financial assistance for the recipient.

GENERAL INFORMATION

101. HOW TO IDENTIFY A COVERED PERSON

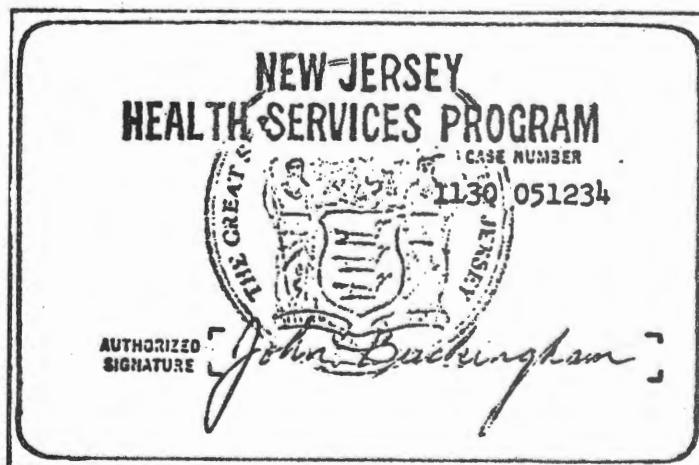
101.1 Plastic Identification Card (Exhibit I)

This card identifies an individual or head of a family group found eligible for payment for authorized health services under the New Jersey Health Services Program administered by the Division of Medical Assistance and Health Services, Department of Institutions and Agencies. It will contain the name of the individual or head of the household and the Health Services Program Case Number. This card is issued by the Division of Medical Assistance and Health Services. It will serve as an identification card only.

NOTE: THIS CARD IS NOT A GUARANTEE OF ELIGIBILITY, BUT MUST BE ACCOMPANIED BY A CURRENT MONTH VALIDATION FORM ISSUED BY A COUNTY WELFARE BOARD OF THE STATE OF NEW JERSEY (SEE SECTION 101.2).

A plastic identification card must be retained by the person to whom it is issued, and no provider shall retain an identification card for the purpose of rendering a service in the future.

Exhibit I



101.2 Validation Form (Exhibit II)

This validation for health services form is issued by the appropriate County or State Agency monthly and indicates the individual is currently eligible for coverage.

NOTE: THIS FORM IS THE SOLE INDICATOR OF ELIGIBILITY. THE PLASTIC IDENTIFICATION CARD ALONE IS NOT SUFFICIENT. The validation form must be retained by the person to whom it is issued, and no provider shall retain the form for the purpose of rendering a service in the future.

The sample shown contains all of the required information. However, the form itself may vary from county to county.

IMPORTANT: Be sure to enter name, H.S.P. Case Number, and Person Number, EXACTLY as it appears on the Validation form on all Requests for Authorization and claim forms.

GENERAL INFORMATION

102. AUTHORIZED SERVICES FOR COVERED PERSONS

The items and services provided to covered persons will not normally be limited in duration or amount. Any limitations imposed will be consistent with the medical necessity of the patient's condition, as determined by the attending physician or other practitioner, in accordance with standards generally recognized by health professionals and promulgated through the Division of Medical Assistance and Health Services. The following items and services, more specifically defined in subsequent sections of the appropriate manual, are authorized under the Program:

- (a) Inpatient hospital services, other than services in an institution for tuberculosis or mental diseases;
- (b) Inpatient hospital services for persons 65 and older in a public institution for tuberculosis or mental diseases;
- (c) Outpatient hospital services;
- (d) Clinic services, i.e., health services provided by an outpatient facility not administered or operated by a hospital;
- (e) Laboratory and x-ray services;
- (f) Skilled nursing home services;
- (g) Physicians' services, whether furnished in the office, patient's home, hospital, skilled nursing home or elsewhere;
- (h) Other practitioners' services, limited by State law to podiatrists and optometrists;
- (i) Dental services, including dentures;
- (j) Home health care services;
- (k) Pharmaceutical services - prescribed drugs (legend and non-legend)
- (l) Prosthetic devices and appliances, medical supplies and equipment; eyeglasses and hearing aids;
- (m) Rehabilitation services;
- (n) Transportation, i.e., ambulance service to and from a medical facility when the patient's condition precludes the use of other means of transportation.

GENERAL INFORMATION

103. ELIGIBLE PROVIDERS

Providers of services means any individual, partnership, association, corporation, institution, or public agency designated below, meeting applicable requirements and standards for participation in the Program:

Medical and Surgical Supply Dealers;
Certified Independent Clinical laboratories;
Dentists;
Hearing Aid Dealers;
Home Health Agencies;
Hospitals;
Skilled Nursing Homes;
Opticians;
Optometrists;
Approved Clinics (Independent Outpatient Health Facilities);
Certified Orthotists;
Pharmacies;
Physicians;
Podiatrists;
Certified Prosthetists; (excluding dental)
Providers of Medical Transportation.

104. FREE CHOICE BY COVERED PERSONS

A covered person is free to choose qualified facilities, practitioners and providers of service which meet the Program standards. In the event that the patient has no personal practitioner, or none is available, the Local Medical Assistance Unit may assist in obtaining an appropriate practitioner or health resource.

GENERAL INFORMATION

105. CONTRACTORS

The Division of Medical Assistance and Health Services will process and make payment of claims for services by skilled nursing homes and eligible state and county mental and tuberculosis hospitals.

Contracts have been negotiated on behalf of the State of New Jersey with the Hospital Service Plan of New Jersey and the Prudential Insurance Company of America to function as its contractors.

The Hospital Service Plan of New Jersey will be responsible for the processing and payment of hospital inpatient, hospital outpatient, and home health agency claims for those providers who have selected the Plan as their intermediary under Title XVIII (MEDICARE). In addition, the Hospital Service Plan of New Jersey will process and pay all pharmaceutical services claims (i.e., legend and non-legend drugs), and claims for out of state hospitals and home health agencies. Hospitals who have not participated in Title XVIII are assigned to the Hospital Service Plan.

The Prudential Insurance Company of America will handle the processing and payment of hospital inpatient, outpatient and home health agency claims for those providers who have selected Prudential as their intermediary under Title XVIII (MEDICARE). In addition, the Prudential Insurance Company will process and make payment for all other health services covered by the program.

106. PRIOR AUTHORIZATION

Under the Program, payment for certain services will require prior authorization from the Local Medical Assistance Unit, except in an emergency. It is the responsibility of the specified person or institution providing such service to obtain prior authorization before furnishing or rendering service. Specific instructions are detailed in the appropriate manual sections.

107. POLICY ON OUT OF STATE MEDICAL CARE AND SERVICES

Prior approval of the Local Medical Assistance Unit shall be required for medical care and services which are to be provided outside New Jersey, except in the following situations:

1. Where necessary medical care is provided to a patient who is temporarily absent from the state.

GENERAL INFORMATION

2. When it is customary for persons in the area generally to use medical care resources and facilities outside the State of New Jersey.
3. When out of state care was provided in an emergency.

108. GENERAL EXCLUSIONS

The items listed here are general exclusions. There are certain additional specific exclusions and limitations which are detailed in the appropriate manual sections.

Payment is not made for:

1. Any service, admission or item which is not medically required for diagnosis or treatment of a disease, injury or condition;
2. Any services or items furnished in connection with elective cosmetic procedures;

Note: There are certain exceptions to this rule.

A written certification of medical necessity and a treatment plan must be submitted by the practitioner to the Local Medical Assistance Unit for consideration, and Prior Authorization is required.

3. Private duty nursing service;
4. Services or items furnished for any sickness or injury occurring while the Covered Person is on active duty in the military;
5. Services or items furnished for any condition or accidental injury arising out of and in the course of employment, for which any benefits are available under the provisions of any Workmen's Compensation Law, Temporary Disability Benefits Law, Occupational Disease Law or similar legislation, whether or not the Covered Person claims or receives benefits thereunder, and whether or not any recovery is had against a third party for resulting damages;
6. That part of any benefits which are covered or payable under any health, accident, or other insurance policy, any other private or governmental health benefit system, or through any similar third party liability;
7. Services or items furnished prior to January 1, 1970, or prior to the period for which the patient presents evidence of eligibility for coverage;

GENERAL INFORMATION

8. Services or items furnished after the last day of the month in which the patient ceases to be eligible for coverage;
9. Any services or items furnished for which the Provider does not normally charge;
10. Any admission, service or item requiring Prior Authorization, where authorization has not been obtained or has been denied;
11. Services furnished by an immediate relative or member of the covered person's household.

109. CONFIDENTIALITY OF RECORDS

All individual medical records of covered persons acquired under this Program shall be confidential and shall not be released without the written consent of the covered person or his personal representative. This shall not preclude the release of statistical or summary data or information in which covered persons are not, and cannot be, identified, nor shall it preclude exchange of information between individuals or institutions providing care, Contractors and State or local official agencies.

110. UTILIZATION OF INSURANCE BENEFITS

Health, hospital, workmen's compensation, or accident insurance benefits shall be used to the fullest in meeting the medical needs of the covered person. Supplementation of available benefits shall be as follows:

1. Title XVIII

The Program, in most instances, shall cover the amount of any deductible or co-insurance liability under Title XVIII of the Social Security Act for all covered persons 65 years of age or older.

2. Workmen's Compensation

No Program payments shall be made for a patient covered by workmen's compensation.

3. Other Health Insurance

When a covered person has other health insurance, the Program requires that such benefits be used. Supplementation shall be made by the Program when necessary, but the combined total shall not exceed the amount payable under the Program in the absence of other coverage.

GENERAL INFORMATION

111. MEDICAL REVIEW AND EVALUATION (by Local Medical Assistance Units)

Under the provisions of Federal and State Law, the Division of Medical Assistance and Health Services must provide for continuing review and evaluation of the care and services provided in the Program. This will include review of utilization of services of practitioners and other providers.

112. PROVISION FOR APPEALS - FAIR HEARING

All providers of service or covered persons will be given the opportunity for a fair hearing concerning grievances arising from the claims payment process.

113. FRAUD

The State Agency will establish and maintain methods for identifying situations in which a question of fraud in the program may exist, and referring to law enforcement officials situations in which there is valid reason to suspect that fraud has been practiced.

114. CIVIL RIGHTS

Federal regulations require that services provided to covered persons are given without discrimination on the basis of race, color, religious belief, or national origin. Therefore, payments are limited to providers of service who are in compliance with the non-discrimination requirements of Title VI of the Civil Rights Act.

115. OBSERVANCE OF RELIGIOUS BELIEF

Nothing in the Program shall be construed to require any person to undergo any medical screening, examination, diagnosis, or treatment or to accept any other health care or services provided under the Program for any purpose (other than for the purpose of discovering and preventing the spread of infection or contagious disease or for the purpose of protecting environmental health) if such person or his parent or guardian objects thereto on religious grounds.

116. NEW JERSEY SALES TAX EXEMPTION

All items and services provided to covered persons under this program are exempt from the New Jersey Sales Tax, by virtue of N.J.S.A. 54:32B-9.

CHAPTER II

TRANSPORTATION

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CHAPTER II

TRANSPORTATION

200. TRANSPORTATION

This Manual describes the policies and procedures of the New Jersey Medicaid Program for reimbursement of providers of transportation services. Questions about this Manual may be directed to any Local Medical Assistance Unit listed in Section 305.3 or to the Division of Medical Assistance and Health Services, P.O. Box 2486, Trenton, N.J. 08625.

201. DEFINITIONS

201.1 Transportation

A. "Transportation" means the use of an approved carrier to move the sick, injured or disabled person from place to place when considered medically necessary. Prior authorization is required except where specifically stated.

B. Provider Approval By Medicaid Agency

Each Transportation Carrier must be individually approved by the New Jersey Department of Human Services, Division of Medical Assistance and Health Services as a provider before it can be reimbursed for transportation services rendered to Medicaid eligible persons.

Prerequisite for a New Jersey based Ambulance or Invalid Coach service for Title XIX (Medicaid) approval is possession of a Certificate of Need and License issued by the New Jersey Department of Health (when required) and the stipulation if any, that transportation services be limited to the area covered by the Certificate of Need. Ambulance carriers must also be approved by the Title XVIII (Medicare) Program before they will be considered eligible for Medicaid reimbursement. Transportation carriers in states other than New Jersey must be approved by their state's Medicaid Program and by the Medicare Program if they desire reimbursement for Ambulance services. All vehicles must meet the specifications described in Sections 201.2A and B of this Manual.

Provider Application (form FD-20) and Provider Agreement (form FD-62) forms may be obtained from the Medical Administration Division, Prudential Insurance Company of America, P.O. Box 471, Millville, New Jersey 08332 or from the Chief, Provider Enrollment Unit, Medical Care Administration, Division of Medical Assistance and Health Services, P. O. Box 2486, Trenton, New Jersey 08625.

For Medicaid approval the completed Provider Application and Agreement forms are to be submitted to:

Chief, Provider Enrollment Unit
Medical Care Administration
Division of Medical Assistance & Health Services
P.O. Box 2486
Trenton, New Jersey 08625

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TRANSPORTATION

201.2 Carrier

A. Ambulance Service

"Ambulance Service" means the professional transportation of the sick, injured, infirm or otherwise disabled person from place to place in a vehicle specifically designed and equipped for such transportation, and operated by trained personnel. "Operated by trained personnel" means that at least one member of the ambulance crew is in possession of a current certificate of completion of the advanced Red Cross First Aid Courses or equivalent, e.g., Emergency Medical Technician (EMT) course. The medical condition is to be such that one normally would expect the need for the medical assistance of a second person within the ambulance after the patient has been placed into the vehicle.

The vehicle utilized to provide the ambulance service and the personnel whose duties involve care of the individual to be transported must meet the requirements specified in the definition stated above and the standards for ambulances set by "The American College of Surgeons and the Federal Highway Act".

B. Invalid Coach Service

"Other medically indicated transportation service" means a form of transportation of sick, infirm or otherwise disabled persons, who are under the care and supervision of a physician, and who require transportation from place to place for medical purposes and whose use of a lesser form of transportation, i.e., cab, bus, or private vehicle would create a serious risk to life or health. For purposes of this manual, the invalid coach is defined as a vehicle for non-emergency, supervised health care transportation, which provides a driver compartment and a patient compartment which can accommodate an ambulatory, wheelchair or litter patient, which carries equipment and supplies as listed and which is designed and constructed to afford maximum safety and comfort to avoid aggravation of the patient's condition and exposure to complications. The patient's medical condition is to be such that one normally would not expect the need for the medical assistance of a second skilled person or more than one person in attendance once the patient has been placed into the vehicle.

Prior authorization is required for all invalid coach services (except as defined under 204.10)

The following are the equipment, supplies, personnel and vehicle requirements for Invalid Coach:

1. Equipment and Supplies

Walk-in type van equipped and supplied as follows:

- a) Padded interior roof with sufficient head clearance for wheelchair patient.

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- b) Floor and/or wall locks with safety straps for wheelchair.
 - c) Two exterior amber signal lights mounted on the back of the roof and wired in conjunction with the four-way flashing hazard warning light signal system.
 - d) Rear view truck type mirror on each side of vehicle.
 - e) Aspirator.
 - f) First aid kit.
 - g) A fire extinguisher having a laboratory reading of 5BC or more.
 - h) Approved oxygen tank of sufficient supply to provide one-half hour's oxygen with pin-indexed oxygen regulator.
 - i) Litter locks.
 - j) Ramp or lift for wheelchair patients.
 - k) Exterior identification of vehicle as a carrier of invalid persons.
2. Personnel Requirements
- a) Uniformed driver-attendant.
 - b) Driver-attendant to have certified Advanced First Aid Training by the American Red Cross or equivalent, e.g., Emergency Medical Technician (EMT) course.
 - c) Driver-attendant to have current motor vehicle operator's license issued by the New Jersey Division of Motor Vehicles or a valid non-resident Driver's License meeting the requirements of that State.
3. Other Vehicle Requirements
- a) Vehicle currently licensed by the New Jersey Division of Motor Vehicles.
 - b) Vehicle be maintained in safe operating condition and have a current New Jersey Motor Vehicle inspection sticker.
 - c) Vehicle be equipped with heater and air conditioning unit to maintain a constant temperature of approximately 72°F.
 - d) Vehicle to be of sufficient size to accommodate a one-man litter or stretcher as may be required.
 - e) Vehicle and occupants be covered by liability and other insurance in adequate amounts.

CHAPTER II

TRANSPORTATION

C. Transportation By Air

Helicopters or aircraft, under extenuating circumstances, may be used as a carrier to transport the sick, injured or disabled Medicaid eligible patient. (See Section 202.3)

201.3 Emergency Conditions

"Emergency Condition" means an illness or injury of such magnitude and gravity as to constitute an imminent threat to life or limb or where there may be intractable pain.

201.4 Multiple Loading

The Invalid Coach is limited to carrying no more than three patients at any one time. (Exception: Section 204.10). Ambulance to be limited to one patient per trip, except in extreme emergency situations.

201.5 Multiple Re-Authorizations on a Single Physician's Prescription - Invalid Coach Only

Prior authorization may be given for more than one trip on a single physician's prescription when in the opinion of the Local Medical Consultant the diagnosis is such that multiple trips would be required in a short period of time and the condition set forth would adopt itself to reasonable controls. A single authorization is limited to a maximum time period of one calendar month. Such authorizations require an attending physician's request (prescription) and verification of duration and time involved and number of pick-ups required and the reason, with the exception of Invalid Coach Services to patients receiving dialysis treatments which may be authorized up to three calendar months.

202. GENERAL POLICIES

202.1 Service Without Cost

If a transportation service is operated by an organization which has established a policy of providing service without cost for a specific class of individual, or individuals living within a given area, then it shall be understood that such service is also available without cost to patients falling within such category who are covered under the New Jersey Medicaid Program.

202.2 Ambulance Service

Ambulance service is reimbursable only under the following conditions:

- A. When the use of any other method of transportation is medically contraindicated; or
- B. When such service is not free and available in the community (See Section 202.1).

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202.3 Transportation By Air

Reimbursement is restricted to the emergency condition where transportation by air is medically considered the only acceptable form of travel and the conditions are such so that its implementation is feasible. The Division of Medical Assistance and Health Services retains the option to utilize this form of transportation in such situations where, at its discretion, it could represent a significant cost of savings factor when compared to ambulance or invalid coach service involving trips covering similarly long distances.

202.4 Non-Eligible Transportation Services

Services not directly reimbursable by the New Jersey Medicaid Program includes transportation by taxi, train, bus, and other public conveyances. Inquiry should be made to the County Welfare Agency for reimbursement in accordance with the Public Welfare Financial Assistance Standards Handbook.

202.5 Other Modes of Transportation

The Division of Medical Assistance and Health Services retains the right to consider on an individual basis other modes of transportation as the needs occur.

202.6 Transportation to Facilities Outside the Community

Eligible transportation cost for covered persons who are required to make regular visits to medical facilities outside the immediate community are reimbursable only if the required services are not available within the community.

The licensed attending physician or a licensed physician knowledgeable about the case must recommend the mode of transportation to be used, and certify the special circumstances.

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TRANSPORTATION

203. PRIOR AUTHORIZATION

Prior authorization from the patient's Local Medical Assistance Unit is required for transportation except in emergency conditions (See 201.3)

203.1 Procedures for Obtaining Prior Authorization (See pertinent prior Authorization Procedure throughout this Chapter)

A. Written Request

Submit an Ambulance and Transportation Claim MC-12 together with a certification of medical necessity (Prescription) from the prescribing physician or practitioner. Upon receipt of this information, the Local Medical Assistance Unit Medical Consultant will review the date submitted, check the mode of transportation (Ambulance or Invalid Carrier) and if authorized will sign the MC-12 in item 17. If denied, however, the Medical Consultant will indicate in the provided space, the reason for the denial. The Local Medical Assistance Unit will retain the third copy for its files and forward the Contractor and Provider copies to the provider. After rendering the authorized service, the provider will forward the completed claim (Contractor's copy) within 90 days to the Contractor for payment. (See Chapter III Billing Procedures).

B. Telephone Request

If time does not allow for a written authorization (203.1 A above) the provider or attending physician should call the patient's Local Medical Assistance Unit, explain the circumstances (e.g., medical reason requiring this mode of transportation, patient's diagnosis, destination, etc.) and request a verbal authorization. If authorization is granted the provider may perform the authorized service, but must then submit the MC-12 and Practitioner's Certification (Prescription) to the Local Medical Assistance Unit for written authorization as in 203.1 A above.

Note: For combination Medicare/Medicaid patients refer to the note under Section 304.

C. Retroactive Request (Administrative Emergency)

When communication between the provider and the LMAU could not be established (e.g., weekend, holiday, evening, etc.) and the provision of the service should not have been delayed, the provider may render the service and request retroactive authorization. This is not to be confused with medical emergencies as described in 201.3. In such instances the request for retroactive authorization must be submitted to the LMAU within five (5) calendar days after the service is provided. If a verbal authorization is obtained under these circumstances, confirming written documentation must follow. The service rendered must be medically necessary and will be evaluated in the same way as a prior authorization request by the Medical Consultant.

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TRANSPORTATION

204. BASIS OF PAYMENT

204.1 Transportation Charge

"Transportation Charge" is an all-inclusive sum to cover the placing and removal of a patient into and out of the vehicle (ambulance or invalid coach) at the point of origin and the point of destination. This is not related to the medical condition of the patient. It is the medical state of the patient which determines the type of transportation required, i.e., ambulance or invalid coach and not the number of persons required to place or remove a patient into or out of a vehicle at his point of origin and the point of destination. By definition it also covers the time and expense involved in the pick-up by the transportation carrier as well as the time and expense in returning him to the ambulance or invalid coach and from there to his point of origin. It shall include a waiting period at the pick-up point and/or the destination, i.e., hospital, emergency room, X-ray department, etc., of up to 30 minutes per patient. It does not cover mileage based on a loaded mile.

204.2 Loaded Mile (Ambulance or Invalid Coach)

"Loaded mile" is mileage accrued when vehicle actually is carrying a patient.

204.3 Waiting Time (Ambulance or Invalid Coach)

"Waiting time" is that period of actual time in increments of 15 minutes and beyond 30 minutes following delivery of the patient to his destination i.e., hospital, X-ray department, Long Term Care Facility, emergency room, doctor's office, etc., which may be considered as an added charge. There will be no reimbursement for waiting time on round trips and it is limited to a maximum of one hour on one way trips. A detailed explanation of the need for waiting time must be attached to the MC-12 Claim Form.

204.4 Ambulance

Ambulance Service shall be reimbursed on the basis of customary charge, not to exceed the following maximum:

- A. Transportation charge - One way - \$24.00
- Transportation charge - Round trip - \$48.00

A carrier when performing round trip services shall be responsible for completing each round trip obligation by honoring the return trip if occurring within 24 hours from the original pick-up time. This responsibility is interpreted to include the carrier's guarantee that if he does not perform the return trip himself that arrangements are to be made with another transportation company to do so with no additional expense to the Medicaid program.

- B. Mileage - \$0.80 per loaded mile

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- C. Waiting Time - \$10.00 per hour maximum waiting time is payable only on one way trips and only after 30 minutes has elapsed. It is payable in 1/4 hour increments, e.g., 1/4 hour \$2.50, 1/2 hour \$5.00, 3/4 hour \$7.50 and 1 hour \$10.00.

204.5 Invalid Coach

Invalid Coach Service shall be reimbursed on the basis of customary charge not to exceed the following maximum: Except as defined in Section 204.10

- A. Transportation charge - One way, one patient - \$17.00
Transportation charge - Round trip, one patient - \$34.00
Transportation charge - One way, each additional patient - \$14.00 per patient
Transportation charge - Round trip, each additional patient - \$28.00 per patient

The limit as to the number of patients being carried at one time is three. A carrier when performing round trip services shall be responsible for completing each round trip obligation by honoring the return trip if occurring within 24 hours from the original pick-up time. This responsibility is interpreted to include the carrier's guarantee that if he does not perform the return trip himself that arrangements are to be made with another transportation company to do so with no additional expense to the Medicaid Program.

- B. Mileage - \$0.80 per loaded mile

Charges when multiple loading occurs are limited to the mileage incurred by the patient whose point of origin and point of destination represents the greatest distance. No mileage charges are permitted for patients whose distance traveled lies in between these two points.

- C. Waiting Time - \$5.00 per hour maximum waiting time is payable only on one way trips and only after 30 minutes has elapsed. It is payable in 1/4 hour increments, e.g., 1/4 hour (\$1.25), 1/2 hour (\$2.50), 3/4 hours (\$3.75) and 1 hour (\$5.00). One hour is the maximum reimbursable waiting time. Waiting time is not payable for patients transported to receive dialysis services.

204.6 Aircraft

Aircraft transportation service shall be reimbursed on the basis of negotiated rate not to exceed the charge made to non-eligible recipients for the same service.

204.7 Hospital-Owned Service

If the patient is admitted to the hospital, the ambulance charges are billed as part of the inpatient hospital service. If the patient is not admitted, (See Section 204.10) the ambulance charge is billed as a hospital outpatient service.

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204.8 Long Term Care Facility (LTC) - Owned Services

If the carrier is owned by the Medicaid participating LTC Facility, and the service is required by an inpatient of that LTC Facility, reimbursement is considered as part of the per diem rate. No further reimbursement is allowed.

204.9 Medical Supplies and Equipment

No additional payment is made for the use of medical supplies and/or equipment. Exception: Oxygen may be reimbursed at \$6.00 per 1/2 hour with a 1/2 hour minimum in an ambulance or invalid coach.

204.10 Invalid Coach (Dialysis Treatments)

The Medicaid Program has special allowances for Invalid Coach services for patients receiving Dialysis treatments who require Invalid Coach transportation.

Transportation charge - First patient, one way	\$14.00
Transportation charge - First patient, round trip	\$28.00
Transportation charge - Additional patient, one way	\$11.00 per patient
Transportation charge - Additional patient, round trip	\$22.00 per patient

- A. The Medicaid Program does not pay for waiting time for patients transported to receive Dialysis treatments.

Prior authorization is required for Invalid Coach services for patients receiving Dialysis treatments, however services may be authorized for up to three calendar months at a time.

The Program limits the number of persons in a multiple load for Dialysis treatments to four.

A carrier when performing round trip services shall be responsible for completing each round trip obligation by honoring the return trip if occurring within 24 hours from the original pick-up time. This responsibility is interpreted to include the carrier's guarantee that if he does not perform the return trip himself that arrangements are to be made with another transportation company to do so with no additional expense to the Medicaid Program.

- B. Mileage - \$0.80 per loaded mile

Charges when multiple loading occurs are limited to the mileage incurred by the patient whose point of origin and point of destination represents the greatest distance. No mileage charges are permitted for patients whose distance traveled lies in between these two points.

- C. Waiting Time - None

STATE OF NEW JERSEY
DEPARTMENT OF HUMAN SERVICES
DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES

TRANSPORTATION SERVICES, MAXIMUM ALLOWABLE FEES

The following procedure codes, description and maximum allowances are recognized for reimbursement by the New Jersey Medicaid Program.

<u>PROCEDURE CODES</u>	<u>DESCRIPTION</u>	<u>MAXIMUM ALLOWANCE</u>
	<u>Ambulance</u>	
6101	Ambulance - One way	\$24.00
6102	Ambulance - Round Trip	\$48.00
	<u>Invalid Coach - Non Dialysis Patients</u>	
6111	*Invalid Coach - One way, First Patient	\$17.00
6113	Invalid Coach - Round Trip, First Patient	\$34.00
6112	Invalid Coach - One way, each additional pt.	\$14.00 per patient
6114	Invalid Coach - Round trip, each additional pt.	\$28.00 per patient
	<u>Invalid Coach - Dialysis Patients</u>	
6115	First Patient, One way	\$14.00
6117	First Patient, Round trip	\$28.00
6116	Additional Patient, One way	\$11.00
6118	Additional Patient, Round trip	\$22.00
6103	<u>Mileage -</u>	
	Mileage - Ambulance	\$ 0.80 per loaded mile
	*Mileage - Invalid Coach	\$ 0.80 per loaded mile
	*Mileage - Invalid Coach	\$ 0.80 per loaded mile
6109	<u>Waiting Time - Ambulance-One Way Trip Only</u>	
	1/4 hour	\$ 2.50
	1/2 hour	\$ 5.00
	3/4 hour	\$ 7.50
	1 hour	\$10.00
6119	Oxygen 1/2 hour minimum	\$ 6.00 per 1/2 hour
6110	<u>Waiting Time - Invalid Coach-One Way Trip Only</u>	
	1/4 hour	\$ 1.25
	1/2 hour	\$ 2.50
	3/4 hour	\$ 3.75
	1 hour	\$ 5.00
6119	Oxygen 1/2 hour minimum	\$ 6.00 per 1/2 hour

*Maximum of three patients for Invalid Coach at one time-except for patients transported to receive dialysis treatments where a maximum of four patients is allowed. Medicaid will pay mileage for only one patient in a multiple load from the farthest location to the destination (and back if a round trip). Provider must submit all claims for multiple load patients together and certify on the claim forms that they are charging mileage only for the one patient who is being transported the farthest distance.

NOTE: No waiting time reimbursement will be made for dialysis patients.

CHAPTER III

TRANSPORTATION

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CHAPTER III

TRANSPORTATION BILLING PROCEDURES

300. BILLING PROCEDURES

This Chapter contains basic information for the submission of a claim. Included is a sample claim form approved for use in submitting bills for covered services, and appropriate instructions for the proper completion of the form. (See Exhibit I)

301. GENERAL POLICY

Billing should be done on a monthly basis. In all cases, claims must be submitted to the Prudential Insurance Company no later than ninety (90) days after the last date services were rendered. Always furnish the prescription of the physician or practitioner.

302. PATIENT IDENTIFICATION

Verify that the patient is a Medicaid eligible person at the time of each trip. Eligibility is verified by viewing the patient validation form which is issued on the first day of each month for AFDC eligible individuals and quarterly for SSI eligibles. It is especially important to review a patient's validation form on each trip when extended plans of treatment have been authorized. Prior authorization is no guarantee that an individual is covered.

303. PRIOR AUTHORIZATION (SEE CHAPTER II - SECTION 203.)

Services requiring prior authorization should not be provided until the authorization is granted. When submitting claims for payment make certain that item 17 on form MC-12 C4 is signed by a Medicaid Medical Consultant and that the appropriate mode of transportation (Ambulance or Invalid Carrier) has been checked off. To assure prompt claim consideration and to avoid claim rejection, always furnish the prescribing physician's or practitioner's name and individual Medicaid practitioner's number.

Since no prior authorization is required for emergency, provider must submit those claims directly to Prudential for reimbursement.

304. COMBINATION MEDICARE/MEDICAID CLAIMS

Services covered under Medicare to a Medicare/Medicaid eligible person shall be billed on Form SSA-1491, REQUEST FOR MEDICARE PAYMENT, and the claims sent directly to the Medicare Intermediary, Prudential, Medicare B Division, P.O. Box 3000, Linwood, New Jersey 08221. The provider MUST record the Health Insurance Claim Number in Item 2 and the New Jersey Health Services Case and Person Number in Item 5 on the SSA-1491 Form.

NOTE: In cases where prior authorization is required for Medicaid (non-emergency), submit three copies of the SSA-1491 (2/73) and the physician's order (prescription) to the appropriate Local Medical Assistance Unit for authorization. If authorized, the Medicaid Medical Consultant will describe the terms of the authorization and affix his signature and date to the 1491 in item 5, and return two copies and the prescription to the provider. The provider submits the original authorized copy of the 1491 and the prescription to the Medicare Intermediary for Payment. (See Exhibit II for sample of a properly completed Medicare/Medicaid claim).

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CHAPTER III

BILLING PROCEDURES

If denied the Medical Consultant will notify the provider of the reason(s) will write "Medicaid Authorization Denied" and sign his name in item 5, and return two copies of the claim and the prescription to the provider. If the provider renders the service when the authorization request has been denied, the claim may be submitted to Medicare for consideration, but there will not be any payment forthcoming from Medicaid.

305. AMBULANCE AND OTHER TRANSPORTATION CLAIM (MC-12 C4)

This form should be used when submitting a claim for transportation services, including the providing of oxygen when necessary.

305.1 Instructions for Completion of Form MC-12 C4 (Exhibit I)

1. - 4. NAME, ADDRESS, HEALTH SERVICES PROGRAM CASE NUMBER, AND PERSON NUMBER - Copy the Patient's Name, H.S.P. Case Number and Patient Person Number EXACTLY as it appears on the validation form.
5. - 6. Self-explanatory; must be completed.
7. OTHER INSURANCE OR LIABILITY COVERAGE - Check appropriate block to indicate whether the patient has other health insurance, liability coverage or No Fault Auto Coverage. If yes, you must attach a copy of the decline notice or a copy of the explanation of payment from carrier. (When the recipient is covered by both Medicare and Medicaid, see Section 304. of his manual.)
8. EMPLOYMENT RELATED - Check as appropriate; if patient's illness or injury is work related, enter name and address of employer.
9. PROVIDER NAME AND ADDRESS (This information may be preprinted.)
10. EPSDT PROGRAM REFERRAL - Early Periodic Screening Diagnosis and Treatment is the Medicaid Program wherein children under 21 are referred for additional services by the primary physician as medical necessity dictates. Indicate if this patient is such a referral by checking the appropriate block.
11. Indicate whether injury resulted from a automobile accident, by checking appropriate block.
12. REPORT OF SERVICES - This must be completed as part of your request for Prior Authorization.
 - A. Date of Service.
 - B. Insert the Procedure Code as specified in Chapter II of this Manual. It is understood that the Procedure Code used must accurately reflect the service provided.
 - C. Place of Origin - as printed directly above, select the applicable place of origin and insert the corresponding number under C.

CHAPTER III

BILLING PROCEDURES

- D. Under Origin and Destination give the provider name, street address and city. Indicate other services rendered; e.g., oxygen. When submitting your claim for payment show the distance traveled one way, from the origin to the destination. Indicate waiting time, if any, in accordance with Chapter II and attach an explanation of the need for waiting time to the MC-12 C4 Claim Form.
- E. Fee requested - Indicate here your usual and customary charge.

13. INFORMATION REQUIRED - 13A, B and C must be completed as part of the request for Prior Authorization.

- A. Self-explanatory. The claim will be rejected without the name and Individual Medicaid Practitioner Number of the physician ordering transportation.
- B. Indicate the primary diagnosis.
- C. Reason for transportation should indicate the nature and degree of the limitation(s) which necessitates such mode of transportation and the specific purpose of the trip(s).
- D. Self-explanatory. (For the definition of emergency conditions see Section 201.3 of the Chapter II of this Manual.)
- E. Self-explanatory.

14. AUTHORIZATION REQUEST INFORMATION

Written requests are mandatory for multiple trips and for individual trips known in advance. The number of trips you are requesting must correlate with item 12. Transportation requests are authorized on a calendar month basis.

Transportation for dialysis patients may be authorized for up to three (3) calendar months. Indicate the number of dialysis trips you are requesting, as well as the calendar months during which the services will be provided. In requesting authorization for dialysis trips, the provider should request authorization on the claim form covering the first trip; claims for subsequent trips covered by that authorization should be sent directly to Prudential.

Telephone authorization requests will only be accepted in unusual circumstances where time does not allow written requests. In those cases of approval, you must indicate the LMAU assigned authorization number on the blank provided in item 14.

Multiple load claim forms must be collated as follows:

1. Providers must submit all claims for multiple load patients batched together in one envelope.
2. A separate claim form is to be submitted for each patient whether involved in a single or a multiple load situation. In multiple loadings the charge for loaded mileage and the waiting time charge (if any) is to be applied to only one patient claim form.

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BILLING PROCEDURES

3. All other patient claim forms in a multiple load situation will include only a loading charge.
4. In all instances, the multiple load claim submitted for each Medicaid patient must have prior authorization by the Medical Consultant.

Occupancy - Indicate the number of patients in the vehicle. Circle 4 only if all patients in the multiple load are being transported for dialysis treatment.

15. **PATIENT'S CERTIFICATION** - Under ordinary circumstances, the patient must sign the claim form when services have been received. The claim form to be signed should indicate service rendered, and the patient must not sign a blank claim form prior to receiving services or as a condition for receiving services.

However, when the patient's signature is unobtainable, the following procedures may be used:

A. Illiterate Patient

The patient may sign by mark (X), and the signature must be witnessed by another person who signs his name and address on the same line.

B. Other

If a patient is physically or mentally incapable of signing, or if patient is a minor child or deceased, the form may be signed on his behalf by:

1. A parent, or
2. A legal guardian, or
3. A relative, or
4. A friend, or
5. An individual provider, or
6. A representative of an institution providing care or support, or
7. A representative of a governmental agency providing assistance.

Attached to the claim form or written directly on the form should be a brief explanation of reason patient was not personally able to sign and relationship of signee to the patient-recipient.

16. **PROVIDER CERTIFICATION AND PENALTIES FOR FRAUD**

Please read the Provider Certification carefully. Note that the certification states that mileage can be charged only for one patient in a multiple load. The Provider must sign and date the claim. Note that the billing date is the date the claim is mailed.

CHAPTER III

BILLING PROCEDURES

NOTE: Payments for services rendered to Medicaid eligible persons will be from both Federal and State funds and any false claims, statements, or documents, or concealment of a material fact, is punishable under Federal and State laws.

Under Federal law, whoever furnishes items or services to an individual for which payment is or may be made in whole or in part out of Federal funds under a State Medicaid plan approved under Title XIX of the Social Security Act, and who solicits, offers, or receives any:

- (a) kickback or bribe in connection with the furnishings of such items or services or the making of receipt of such payment, or
- (b) rebate or any fee or charge for referring any such individual to another person for the furnishing of such items or services, shall be guilty of a misdemeanor and upon conviction thereof shall be fined not more than \$10,000 or imprisoned not more than one year, or both.

17. FOR DIVISION USE ONLY - Authorization or denial - Make certain that you have obtained the approval of the Medicaid Medical Consultant for those claims requiring prior authorization, before submitting the claim for payment.

305.2 MAILING INSTRUCTIONS - REQUEST FOR AUTHORIZATION

The first two digits of the recipient's Health Services Program Identification Number indicate the Local Medical Assistance Unit having jurisdiction. Requests for Authorization and any other reports required by the Local Medical Assistance Unit are to be sent to the Unit indicated. For patients in nursing homes, request for authorization should be sent to the LMAU serving the county in which the nursing home is located.

NOTE: Inquiries concerning eligibility and applications for eligibility are to be sent to the County Welfare Board of patient's residence.

305.3 DIRECTORY OF LOCAL MEDICAL ASSISTANCE UNITS

<u>COUNTY CODE</u>	<u>COUNTY</u>	<u>STREET ADDRESS</u>	<u>MUNICIPALITY</u>	<u>ZIP CODE</u>	<u>P.O. BOX</u>	<u>TELEPHONE</u>
01	Atlantic	1601 Atlantic Ave.	Atlantic City	08404	1709	609-344-2861
05	Cape May	" " "	" "	"	"	" " "
02	Bergen	50 Main Street	Hackensack	07601		201-488-5667
03	Burlington	Chesley & Alloway Bldg., Rt. 38 & Eayrestown Road	Mt. Holly	08060		609-261-0448
04	Camden	530 Cooper Ave.	Camden	08101	1089	609-757-2870
06	Cumberland	501 Landis Ave.	Vineland	08360		609-696-0521
07	Essex	155 Washington St.	Newark	07102		201-648-2470
08	Gloucester	Southwood Shopping Center	Woodbury	08096		609-845-7185
17	Salem	" " "	"	"	"	" " "
09	Hudson	880 Bergen Ave.	Jersey City	07306		201-792-6390
10	Hunterdon	79 Main Street	Flemington	08822		201-782-1130
18	Somerset	" " "	"	"		" " "
21	Warren	" " "	"	"		" " "
11	Mercer	1424 S. Broad St.	Trenton	08610		609-292-7315
12	Middlesex	75 Paterson St.	New Brunswick	08903	1274	201-246-0653
13	Monmouth	1200 Memorial Drive	Asbury Park	07712		201-775-5700
14	Morris	4 Court Street	Morristown	07960		201-267-1700
19	Sussex	" " "	"	"		" " "
15	Ocean	1861 Hooper Ave.	Toms River	08753		201-255-6226
16	Passaic	100 Hamilton Plaza	Paterson	07505		201-523-2800
20	Union	333 N. Broad St.	Elizabeth	07208		201-355-8860



STATE OF NEW JERSEY
Department of Human Services
Division of Medical Assistance and Health Services

TRANSPORTATION CLAIM

1. Patient's Last Name First Name 2. Patient's Street Address Telephone Number
3. Health Services Program Case No. 4. Patient Person No. 5. Age 6. Sex Male Female
7. Other Health Insurance or Liability Coverage? Yes No
8. Was Patient's Illness or Injury connected with employment? Yes No
10. Was this service performed as a result of an EPSDT Program Referral? Yes No
11. Did injury result from automobile accident? Yes No
12. REPORT OF SERVICES
13. INFORMATION REQUIRED
14. AUTHORIZATION REQUEST INFORMATION (PRACTITIONER PRESCRIPTION MUST BE ATTACHED)
15. PATIENT'S CERTIFICATION. Authorization to Release Information, and Payment Request.
16. PROVIDER CERTIFICATION. I certify that the foregoing information is true, accurate and complete;
17. FOR DIVISION USE ONLY

REQUEST FOR MEDICARE PAYMENT—AMBULANCE

EXHIBIT II

MEDICAL INSURANCE BENEFITS—SOCIAL SECURITY ACT (See Instructions on Back—Type or Print Information)

Form Approved
OMB No. 72-R0922

NOTICE—Anyone who misrepresents or falsifies essential information requested by this form may upon conviction be subject to fine and imprisonment under Federal Law.

PART I—PATIENT TO FILL IN ITEMS 1 THROUGH 6 ONLY

Copy from YOUR OWN HEALTH INSURANCE CARD (See example on back)	1	Name of patient (First name, middle initial, last name)	
		John Doe	
	2	Health insurance claim number	Letter
		1 2 3 4 5 6 7 8 9	A
3 Patient's mailing address	City, State, ZIP code		Telephone Number
	123 Main Street, Anytown, N.J. 55555		
4 Was your illness or injury connected with your employment?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
5 If you have other health insurance or if your State medical assistance agency will pay part of your medical expenses and you want information about this claim released to the insurance company or State agency upon its request, give the following information.			
Insuring organization or State agency name and address		Policy or Medical Assistance Number	
N.J. Medicaid		9999 999 999 01	
6 I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment below.			
Signature of patient (See instructions on reverse where patient is unable to sign)			Date signed
SIGN HERE			11-1-77

PART II—AMBULANCE SUPPLIER TO FILL IN 7 THROUGH 25

Date of Service	<input checked="" type="checkbox"/> Emergency <input checked="" type="checkbox"/> Admission	8. Ordered By	
11-1-77	<input type="checkbox"/> Discharge <input type="checkbox"/> Outpatient visit	Dr. William Williams	
9. Description of Illness or Injury (Describe factors which made ambulance transportation necessary.)			
Fractured Right Femur 11-1-77 a.m.			
10. Name of Treating Doctor		11. Address of Doctor	
William Williams, M.D.		999 W. First St. Anytown, N.J.	
12. Origin of Service		13. Destination of Service	
Any Nursing Home		Memorial Hospital Anytown, N.J.	
14. Number of Miles	15. Cost Per Mile	16. Mileage Charge	
Five Miles (one way)	\$1.00	\$5.00	
22. Describe special service (If none leave blank)		17. Base Rate	
Oxygen supplied in route to hospital		40.00	
		18. Special Serv. Charge (Describe item 22)	
		3.00	
23. Name and Address of Supplier (Number and Street, City, State, Zip Code)		Supplier Code	19. Total Charges
Speedy Ambulance Service Second Street Anytown, N.J. 55555		222222222A	48.00
		Telephone Number	20. Amount Paid
		999-9999	00.00
		21. Any Unpaid Balance Due	48.00

24. Assignment of Patient's Bill		Date Signed
<input checked="" type="checkbox"/> I accept assignment (see reverse) <input type="checkbox"/> I do not accept assignment		11-1-77
25. Signature of Supplier		

TRANSPORTATION SERVICES MANUAL

SUBCHAPTER 3. HCFA COMMON PROCEDURE CODING SYSTEM (HCPCS)

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- 3.2 HCPCS CODES FOR TRANSPORTATION SERVICES
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 - (b) Invalid Coach
 - (c) Mileage
 - (d) Waiting Time - Ambulance -
One Way Trip Only
 - (e) Waiting Time - Invalid Coach -
One Way Trip Only
 - (f) Oxygen

SUBCHAPTER 3. HCFA COMMON PROCEDURE CODING SYSTEM (HCPCS)

10:50-3.1 INTRODUCTION

(a) The New Jersey Medicaid Program adopted the Health Care Financing Administration's (HCFA) Common Procedure Coding System (HCPCS). The HCPCS codes as listed in this Subchapter are relevant to Medicaid transportation services and must be used when filing a claim.

1. The responsibility of the transportation services provider when rendering services and requesting reimbursement is listed in Subchapter 1. and Subchapter 2. of the Transportation Services Manual.

2. The column titled "Medicaid Dollar Value" indicates the amount of reimbursement or the symbol B.R.:

i. "B.R." (By Report) is listed instead of a dollar amount. It means that additional information will be required in order to properly evaluate the service. Attach a copy of the report to the MC-12 claim form.

10:50-3.2 HCPCS CODES FOR TRANSPORTATION SERVICES

<u>HCPCS Code</u>	<u>Description</u>	<u>Medicaid Dollar Value</u>
(a) <u>AMBULANCE</u>		
A0010	Ambulance Service, Basic Life Support (BLS) Base Rate, Emergency Transport, One Way	24.00
A0222	Ambulance Service, Return Trip, Transport	48.00
	<u>NOTE:</u> For Medicaid reimbursement purposes A0222 is applicable to round trips <u>only</u> .	
A0030	Ambulance Service, Conventional Air Service, Transport, One Way	* B.R.
(b) <u>INVALID COACH</u>		
A0130	Non-Emergency Transportation: Wheel-Chair Van	17.00
	<u>NOTE:</u> Invalid Coach, One Way, Per Patient	
Y0060	Invalid Coach - Round Trip, Per Patient	34.00
(c) <u>MILEAGE</u>		
A0020	Ambulance Service, (BLS) Per Mile, Transport, One Way	0.80 per loaded mile
	<u>NOTE:</u> For Medicaid reimbursement purposes, mileage both one way and round trip is payable at \$.80 per loaded mile in both the ambulance and invalid coach. A0020 is to be used to identify all mileage charges.	

* B.R. - By Report

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NOTE: Maximum of three patients for Invalid Coach at one time-except for patients transported to receive dialysis treatments where a maximum of four patients is allowed. Medicaid will pay mileage for only one patient in a multiple load from the farthest location to the destination (and back if a round trip). Provider must submit all claims for multiple load patients together and certify on the claim forms that they are charging mileage only for the one patient who is being transported the farthest distance.

(d) WAITING TIME - AMBULANCE - ONE WAY TRIP ONLY

Y0005	Waiting Time-Ambulance-One Way Trip only	
	1/4 hour	2.50
	1/2 hour	5.00
	3/4 hour	7.50
	1 hour	10.00

NOTE: Payable only on one way trips and only after 30 minutes has elapsed. It is payable in 1/4 hour increments. Maximum waiting time payable is 1 hour.

HCPCS
Code

Description

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Dollar Value

(e) WAITING TIME - INVALID COACH - ONE WAY TRIP ONLY

Y0010	Waiting Time - Invalid Coach - One Way Trip only	
	1/4 hour	1.25
	1/2 hour	2.50
	3/4 hour	3.75
	1 hour	5.00

NOTE: Payable only on one way trips and only after 30 minutes has elapsed. It is payable in 1/4 hour increments. Maximum waiting time payable is 1 hour.

(f) OXYGEN

A0070	Ambulance Service, Oxygen, Administration and Supplies, Life Sustaining Situation	6.00 per 1/2 hour
	Invalid Coach - Oxygen	6.00 per 1/2 hour

NOTE: Payable to ambulance and invalid coach 1/2 hour minimum, payable in 1/2 hour increments.