



INDIANA HEALTH COVERAGE PROGRAMS

PROVIDER REFERENCE MODULE

Transportation Services

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1.1	Policies and procedures as of April 1, 2016 Published: September 13, 2016	Semiannual update: <ul style="list-style-type: none"> • Added information about base rate, mileage, and wait time in the Advanced Life Support (ALS) Ambulance Service and Basic Life Support (BLS) Ambulance Service sections • Made clarifications to Table 1 – Fee-for-Service Member Transportation Copayments • Added new heading, Billing and Reimbursement Guidelines, and reorganized and modified text as needed for better flow and clarity throughout module • Added Family Member Transportation section • Added Other Transportation Services section • Removed provider specialty code sets (former Tables 11–17) from the end of the module and replaced them with references throughout the module to the Code Sets page on indianamedicaid.com 	FSSA and HPE
1.2	Policies and procedures as of April 1, 2016 (CoreMMIS updates as of February 13, 2017) Published: April 11, 2017	<ul style="list-style-type: none"> • Replaced Web interChange references with Provider Healthcare Portal (Portal) • Added Portal instructions for billing or PA requests as needed • Replaced AVR system references with IVR system • Changed RID reference to Member ID • Removed ICD-9 diagnosis codes • Clarified how to designate that transportation was an emergency in the Emergency Transportation Services and Prior Authorization for Rotary Air Ambulance Transportation sections 	FSSA and HPE

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Transportation Services

Note: For policy information regarding coverage of transportation services, see the [Medical Policy Manual](#) at indianamedicaid.com.

Introduction

The Indiana Health Coverage Programs (IHCP) reimburses for transportation of members to or from an IHCP-covered service, subject to the guidelines and limitations described in this document.

Providers must enroll in the IHCP and obtain a separate Provider ID to bill transportation services. The [Provider Enrollment](#) module includes detailed information about IHCP enrollment and certification requirements and responsibilities for transportation providers. The IHCP may refer providers that fail to maintain the required documentation to the appropriate governing agencies.

All transportation services must be billed on the professional claim (*CMS-1500* claim form, Provider Healthcare Portal professional claim, or 837P electronic transaction). Specific billing information for transportation services is provided in this document. For general information about claim form submission and processing, see the [Claim Submission and Processing](#) module.

Note: For members enrolled in managed care programs, including Healthy Indiana Plan (HIP), Hoosier Care Connect, and Hoosier Healthwise, the member's managed care entity (MCE) is responsible for transportation services. Providers must contact the appropriate MCE for more information about transportation guidelines. For MCE contact information, see the [IHCP Quick Reference Guide](#) available at indianamedicaid.com.

Level of Service Rendered versus Level of Response

Providers must bill all transportation services according to the level of service rendered and not according to the provider's level of response or vehicle type.

Advanced Life Support (ALS) Ambulance Service

Indiana Code IC 16-18-2-7 and the Indiana Emergency Medical Services Commission (EMSC) define advanced life support (ALS) as follows:

Care given at the scene of an accident, act of terrorism, or illness, care given during transport, or care given at the hospital by a paramedic, emergency medical technician-intermediate, and care that is more advanced than the care usually provided by an emergency medical technician or an emergency medical technician-basic advanced.

The term *advanced life support* may include any of the following acts of care:

- Defibrillation
- Endotracheal intubation
- Parenteral injection of appropriate medications

- Electrocardiogram interpretation
- Emergency management of trauma and illness

The IHCP provides reimbursement for medically necessary emergency and nonemergency ALS ambulance services when the level of service rendered meets the EMSC definition of ALS. Base rate, mileage, and wait time are reimbursed. Codes for the ALS base rate include reimbursement for supplies and oxygen; therefore those items are not separately reimbursed.

Note: In accordance with IC 16-31-3-1, vehicles and staff that provide emergency services must be certified by the EMSC to be eligible for reimbursement for transports involving either advanced life support (ALS) or basic life support (BLS) services.

Basic Life Support (BLS) Ambulance Service

IC 16-18-2-33.5 defines basic life support (BLS) as follows:

- Assessment of emergency patients
- Administration of oxygen
- Use of mechanical breathing devices
- Application of antishock trousers
- Performance of cardiopulmonary resuscitation (CPR)
- Application of dressings and bandage materials
- Application of splinting and immobilization devices
- Use of lifting and moving devices to ensure safe transport
- Use of an automatic or semiautomatic defibrillator
- Administration of epinephrine through an auto-injector

The EMSC has provided in *Indiana Administrative Code 836 IAC 1-1-1(12)(K)* that an emergency medical technician-basic advanced may perform electrocardiogram (ECG) interpretation, manual external defibrillation, and intravenous fluid therapy. BLS services do not include invasive medical care techniques or advanced life support.

The IHCP provides reimbursement for medically necessary emergency and nonemergency BLS ambulance services when the level of service rendered meets the EMSC definition of BLS. Base rate, mileage, wait time, and oxygen are separately reimbursable for BLS ambulance services.

Commercial or Common Ambulatory Service (CAS) Transportation

The IHCP provides reimbursement for transportation of ambulatory (walking) members to or from an IHCP-covered service. Commercial or common ambulatory service (CAS) transportation may be provided in any type of vehicle; however, providers must bill all transportation services according to the level of service rendered. For example, if an ambulance provides transportation of an ambulatory member but no ALS or BLS services are medically necessary for the transport of the member, the ambulance provider must bill the CAS charges.

For CAS transportation, providers can bill separately for base rate, waiting time, and mileage, and receive reimbursement.

Nonambulatory Service (NAS) Transportation (Wheelchair Van)

The IHCP reimburses for nonambulatory services (NAS) or wheelchair services when a member must travel **in a wheelchair** to or from an IHCP-covered service. Providers must bill claims for ambulatory members transported in a vehicle equipped to transport nonambulatory members according to the CAS level of service and rate, and they must not bill according to the vehicle type.

For NAS transportation, providers can bill separately for base rate, waiting time, and mileage, and receive reimbursement.

Member Copayments

The IHCP requires a copayment for transportation services. *405 IAC 5-30-2* provides that, in accordance with *IC 12-15-6*, a copayment will be required for transportation services as follows:

- (1) The copayment shall be made by the recipient and collected by the provider at the time the service is rendered. Medicaid reimbursement to the provider shall be adjusted to reflect the copayment amount for which the recipient is liable.
- (2) In accordance with *Code of Federal Regulations 42 CFR 447.15*, effective October 1, 1991, not including tertiary citations therein, the provider may not deny services to any eligible individual on account of the individual's inability to pay the copayment amount. Under this federal requirement, this service guarantee does not apply to an individual who is able to pay, nor does an individual's inability to pay eliminate his or her liability for the copayment.
- (3) The provider shall collect from the recipient a copayment amount equal to the following:
 - (A) Fifty cents (\$0.50) for services for which Medicaid pays ten dollars (\$10) or less.
 - (B) One dollar (\$1) for services for which Medicaid pays ten dollars and one cent (\$10.01) to fifty dollars (\$50).
 - (C) Two dollars (\$2) for services for which Medicaid pays fifty dollars and one cent (\$50.01) or more.
 - (D) No copayment will be required for an accompanying adult traveling with a minor recipient or for an attendant.
- (4) The following transportation services are exempt from the copayment requirement:
 - (A) Emergency ambulance services.
 - (B) Services furnished to individuals less than eighteen (18) years of age.
 - (C) Services furnished to pregnant women.
 - (D) Services furnished to individuals who are inpatients in hospitals, nursing facilities, intermediate care facilities for the mentally retarded,* or other medical institutions.

** Intermediate care facilities for the mentally retarded are now referred to as intermediate care facilities for individuals with intellectual disability.*

The IHCP determines the member's copayment amount based on the reimbursement for the base rate or loading fee only. Transportation providers may collect a copayment amount from the IHCP member equal to those listed in Table 1. No copayment is required for an accompanying parent or attendant.

Table 1 – Fee-for-Service Member Transportation Copayments

Transportation Service	Member Copayment
Medicaid pays \$10.00 or less	\$0.50 each one-way trip
Medicaid pays \$10.01 to \$50.00	\$1.00 each one-way trip
Medicaid pays \$50.01 or more	\$2.00 each one-way trip

Exemptions to Copayments for Transportation Services

The IHCP exempts the following services from the copayment requirement:

- Emergency ambulance services
- Services furnished to members younger than 18 years old
- Services furnished to pregnant women
- Services furnished to members who are in hospitals, nursing facilities, intermediate care facilities for individuals with intellectual disability (ICFs/IID), or other medical institutions (including instances where a provider transports a member for the purpose of admission or discharge)
- Services furnished to members of the Indiana Breast and Cervical Cancer Program (regulation 42 CFR 447.56)

Note: Contact the appropriate MCE for information about transportation copayment requirements for managed care members.

Federal Guidelines Regarding Inability to Afford Copayment

42 CFR 447.15 mandates that a provider may not refuse to provide services to a member who cannot afford the copayment. IHCP policy is that the member remains liable to the provider for the copayment, and the provider may take action to collect it. The provider may bill the member for that amount and take action to collect the delinquent amount in the same manner that the provider collects delinquent amounts from private-pay customers.

Providers may set office policies for delinquent payment of incurred expenses, including copayments. The policy must apply to private-pay patients as well as IHCP members. The policy should reflect that the provider will not continue serving a member who has not made a payment on past due bills for “X” months, has unpaid bills exceeding “Y” dollars, and has refused to arrange for or not complied with a plan to reimburse the expenses. Notification of the policy must be done in the same manner that notification is made to private-pay customers.

Retroactive Eligibility

If a member becomes retroactively eligible for IHCP coverage and notifies the provider of retroactive eligibility, the provider must follow guidelines outlined in the [Member Eligibility and Benefit Coverage](#) module. When notified of member eligibility, the provider must refund any payments by the member for covered services (other than the IHCP Package C copayments) rendered on or after the eligibility effective date.

Billing and Reimbursement Guidelines

Transportation must be the least expensive type of transportation available that meets the medical needs of the member. Providers must bill ground trips according to the level of service rendered and not according to the vehicle type. Providers must bill for all transportation services provided at the same level of service, to the same member, on the same date of service on one claim form.

The IHCP limits transportation providers to specific codes based on the provider specialty listed on the provider enrollment file. See the *Transportation Services Codes* on the [Code Sets](#) page at indianamedicaid.com for complete lists of the procedure codes allowed for each provider specialty under provider type 26 – *Transportation*.

Definition of a Trip

For billing purposes, the IHCP defines a *trip* as transporting a member from the initial point of pickup to the drop-off point at the final destination. On the professional claim, providers must enter the base code along with a **1** for the units of service to indicate a one-way trip, or a **2** to indicate a two-way trip. The provider must use the transportation modifiers to indicate the place of origin and destination for each service.

If the provider makes a round trip for the same member, same date of service, and same level of base code, the provider should submit both runs on the same detail with two units of service to indicate a round trip. Additionally, the provider must bill all mileage for the trip on the one detail with the total number of miles associated for the round trip.

Multiple Levels of Service for Same-Day Trips

If the provider transports a member on the same date of service but with different trip levels (for example, the *to* trip was a CAS trip, and the *return* trip was an NAS trip with mileage for each base), the provider must bill these base trips on two different claim forms with the corresponding mileage for each base.

Multiple Destinations

If the provider transports a member to multiple points in succession, the provider cannot bill for a trip between each point of the destination. The following examples explain this concept:

- *Example 1:* A vehicle picks up a member at home and transports the member to the physician's office. This transportation is a one-way trip.
- *Example 2:* A vehicle picks up a member from home and transports the member to the physician's office. The provider leaves, and later the same vehicle picks up the member from the physician's office and transports the member back to the member's home. This transportation is considered two one-way trips.
- *Example 3:* A vehicle picks up the member from the physician's office and transports the member to the laboratory for a blood draw, waits outside the laboratory for the member, and then transports the member home. This transportation is a one-way trip, even though there was a stop along the way. A stop along the way is not considered a separate trip.
- *Example 4:* A vehicle picks up Member A at the member's home and begins to transport Member A to the dialysis center. Along the way, the vehicle stops to pick up Member B at a nursing home and transports Member A and Member B to the dialysis center. The stop at the nursing home is not considered a separate trip, and the transportation of Member A from home to the dialysis center is considered a one-way trip.

Note: [Table 4](#) includes information about the policy for multiple passengers.

Transportation Origin and Destination Modifiers

When billing transportation services, append both origin and destination modifiers to the base rate and mileage procedure codes. The first character indicates the transport’s place of origin, and the second character indicates the destination. Table 2 lists the modifiers used for transportation. These modifiers are not used in prior authorization (PA) requests.

Table 2 – Transportation Origin and Destination Modifiers

Modifier	Description
D	Diagnostic or therapeutic site, other than P or H
E	Residential, domiciliary, or custodial facility (nursing home, not skilled nursing facility)
G	Hospital-based dialysis facility (hospital or hospital-related)
H	Hospital
I	Site of transfer between types of ambulance (for example, airport or helicopter pad)
J	Nonhospital-based dialysis facility
N	Skilled nursing facility (SNF)
P	Physician’s office – Includes health maintenance organization (HMO) nonhospital facility, clinic, and so forth
R	Residence
S	Scene of accident or acute event
X	Intermediate stop at physician’s office <i>en route</i> to the hospital (can only be used as a designation code in the second position of a modifier)

Mileage

The IHCP expects transportation providers to transport members along the shortest, most efficient route to and from a destination. All transportation providers must document mileage on the driver’s ticket using odometer readings or mapping software programs.

Covered Mileage

The IHCP reimburses for mileage, in addition to the base rate, under the following circumstances:

- The IHCP reimburses ambulance providers for loaded mileage for each mile of the trip, regardless of the type or level of service being billed.
- The IHCP reimburses CAS and NAS providers for loaded mileage when they transport a member more than 10 miles one way.
- The IHCP does not reimburse taxi providers for mileage and does not require them to submit mileage with their claims. However, providers must document mileage on the driver’s ticket using odometer readings or mapping software, as outlined in the [Documentation Requirements for Transportation Services](#) section.
- Although the IHCP automatically deducts the first 10 miles of a CAS or NAS trip from each one-way trip, CAS and NAS providers must bill for all mileage (including the first 10 miles) to ensure proper reimbursement. For trips less than 10 miles, the IHCP does not require the provider to bill mileage; however, if the provider does bill mileage, the IHCP processes the mileage as a denied line item.

- For trips and associated mileage in excess of 50 miles one way, the IHCP requires PA. If the provider has not obtained PA, the IHCP denies reimbursement for mileage, the base rate, and any other transportation services related to the trip.
- Providers must bill for all transportation services provided to the same member on the same date of service on one claim form.

Mileage Procedure Codes

To report ground transportation mileage, providers must use procedure code A0425 and the appropriate U modifier in conjunction with ALS, BLS, CAS, or NAS base rates. Providers must not fragment mileage. Providers must submit mileage for round trips on one detail line using the appropriate code and modifier listed in Table 3.

Procedure code S0215 – *Nonemergency transportation; mileage, per mile* is nonreimbursable. Providers must bill the appropriate mileage code listed in Table 3. For proper reimbursement, providers must not report procedure code S0215 with the codes listed in Table 3.

Table 3 – Ground Transportation Mileage Procedure Code and Modifiers

Code	Description
A0425 U1	ALS ground mileage, per statute mile
A0425 U2	BLS ground mileage, per statute mile
A0425 U3	CAS ground mileage, per statute mile
A0425 U5	NAS ground mileage, per statute mile

Mileage Units and Rounding

Providers must bill the IHCP for whole units only. For partial mileage units, round to the nearest whole unit. For example, if the provider transports a member between 15.5 miles and 16.0 miles, the provider must bill 16 miles. If the provider transports the member between 15.0 and 15.4 miles, the provider must bill 15 miles.

Multiple Passengers

When providers transport two or more members simultaneously from the same county to the same vicinity for medical services, the IHCP reimburses for the second and subsequent member transported for medical services in a single CAS or NAS vehicle at one-half the base rate. The IHCP reimburses the full base code, mileage, and waiting time for the first member only. For example, providers should bill no mileage in conjunction with T2004 – *Nonemergency transport; commercial carrier, multipass* provided to more than one patient in the same setting.

The IHCP does not provide reimbursement for multiple passengers in ambulances or family member vehicles. The IHCP does not provide additional reimbursement for multiple passengers when the billing provider does not bill non-IHCP customers for these services. Table 4 shows the correct coding methods for multiple passengers.

Table 4 – Coding Transportation for Multiple Passengers

Type of Transportation	First Member	Second and Subsequent Members
Commercial ambulatory services	T2003 for base rate A0425 U3 for mileage T2007 U3 for waiting time, if applicable	T2004 for base rate No reimbursement for mileage No reimbursement for waiting time
Nonambulatory services	A0130 for base rate A0425 U5 for mileage T2007 U5 for waiting time, if applicable	A0130 TT for base rate No reimbursement for mileage No reimbursement for waiting time
Taxi, nonregulated, 0-5 miles	A0100 UA (no mileage)	A0100 UA TT (no mileage)
Taxi, nonregulated, 6-10 miles	A0100 UB (no mileage)	A0100 UB TT (no mileage)
Taxi, nonregulated, 11 or more miles	A0100 UC (no mileage)	A0100 UC TT (no mileage)

Note: PA for a base code includes the base code and the multiple-passenger code that corresponds to the approved base code. When last-minute changes in scheduling modify the service from a single passenger to a multiple passenger, the provider must use the appropriate code.

Accompanying Parent or Attendant

When members younger than 18 years of age need an adult to accompany them to a medical service, or when adult members need an attendant to travel or stay with them due to medical necessity, the provider should bill the appropriate accompanying parent or attendant code.

The following are guidelines for billing the accompanying parent or attendant codes:

- Bill the procedure code for the base rate and the accompanying parent or attendant under the IHCP Member ID (also known as RID).
- The IHCP does not provide additional reimbursement for accompanying parent or attendant when the billing provider does not bill non-IHCP customers for like services.
- The provider must maintain documentation on the driver’s ticket to support that the accompanying parent or attendant was transported with the IHCP member. This documentation must include the name, signature, and relation of the accompanying parent or attendant.

Table 5 lists the base codes and the applicable accompanying parent or attendant code. The provider must bill the base code and the accompanying parent or attendant code using the member’s information.

Table 5 – Procedure Codes for Accompanying Parent or Attendant

Type of Transportation	Base Code	Accompanying Parent/Attendant
Commercial ambulatory services	T2003	T2001
Nonambulatory services	A0130	A0130 TK
Taxi, nonregulated, 0-5 miles	A0100 UA	A0100 UA TK
Taxi, nonregulated, 6-10 miles	A0100 UB	A0100 UB TK
Taxi, nonregulated, 11 or more miles	A0100 UC	A0100 UC TK

Additional Attendant

Transportation providers sometimes need to employ an additional attendant to help load a member. In situations where the driver cannot load the member without help, such as when a wheelchair-bound member lives upstairs and the residence has no wheelchair ramp, the provider needs an additional attendant. The additional attendant who assists must be an employee of the billing provider and is not required to remain for the trip.

Providers must document the need for an additional attendant on the driver's ticket. The IHCP may subject the documentation to postpayment review. For trips that exceed 50 miles one way, the IHCP requires prior authorization for all procedure codes, including additional attendant codes.

The IHCP limits the number of additional attendants to a maximum of two extra units, although usually one attendant is sufficient. The IHCP limits reimbursement for an additional attendant to NAS or wheelchair van and ambulance transportation. For ambulance providers, the additional attendant is the third or fourth attendant, because the IHCP requires ambulances to have two attendants.

Table 6 – Procedure Codes for an Additional Attendant

Type of Transportation	Procedure Code	Description
Nonambulatory or wheelchair van transportation	A0130 U6	Nonambulatory transportation; wheelchair van, U6 = extra attendant
Ambulance transportation (ALS and BLS)	A0424	Extra ambulance attendant, ground (ALS or BLS) or air (fixed or rotary winged); (requires medical review)

Waiting Time

The IHCP reimburses for waiting time in excess of 30 minutes only when the provider parks the vehicle outside the medical service provider, awaiting the return of the member to the vehicle, **and** if the member is transported 50 miles or more one way. The provider must obtain PA for all codes associated with trips of 50 miles or more one way, including waiting time. The IHCP does not cover the first 30 minutes of waiting time; however, the provider must include the total waiting time or the IHCP cannot pay the claim appropriately.

For all procedure codes that providers use to bill waiting time, providers should use one unit of service for every 30 minutes of waiting time. When providers wait between 15 to 30 minutes, they should round up the partial 30-minute increments to the next unit. For example, if providers wait 45 minutes, they should bill the units of service as 2 or 2.0. For partial 30-minute increments of less than 15 minutes, providers must round down. For example, if providers wait one hour and 10 minutes, providers must bill the units of service for waiting time as 2, or 2.0. Providers must maintain documentation, including start and stop times, on the driver's ticket to support the waiting time billed.

Transportation Diagnosis Coding

Diagnosis codes are required on all claims. Transportation providers should bill ICD-10 diagnosis code R69 – *Illness, unspecified* as the primary diagnosis code for claim submissions when the actual diagnosis is not known. Claims submitted without a valid diagnosis code will be denied.

Twenty One-Way Trip Limitation and Exemptions

The IHCP limits transportation to 20 one-way trips per member, per rolling 12-month period for CAS. (See the [Definition of a Trip](#) section for a full explanation of how the IHCP defines a trip.)

Providers must request PA for members who exceed the 20 one-way trips if the member requires frequent medical intervention. Examples of situations that require frequent medical intervention include, but are not limited to, prenatal care, chemotherapy, and certain other therapy services. The IHCP does not approve additional trips for routine medical services. Providers must document and demonstrate, through the PA process, the medical necessity for additional trips.

However, some services are exempt from the 20 one-way trip limitation. The following sections include information about those services.

Emergency Transportation Services

Emergency ambulance transportation is exempt from the 20 one-way trip limitation. For each service detail of the claim, providers must indicate that the transportation service was an emergency as follows (depending on claim submission format):

- Enter the **Y** indicator in field 24C (EMG) on the *CMS-1500* claim form or in the Emergency Indicator field on the 837P electronic transaction.
- Select the EMG checkbox on the Provider Healthcare Portal professional claim.

Hospital Admission or Discharge

Transportation services for transporting a member to a hospital for admission or for transporting the member home following discharge from the hospital are exempt from the 20 one-way trip limitation. This exemption includes interhospital transportation when the member is discharged from one hospital for the purpose of admission to another hospital. Providers must use the transportation modifiers to indicate the place of origin and destination for each service.

*Note: Transporting an IHCP member to or from a hospital for any reason unrelated to an admission or discharge is **not** exempt from the 20-trip limitation.*

Members on Renal Dialysis or in Nursing Homes

Members on renal dialysis and members residing in nursing homes are exempt from the 20 one-way trip limitation. Providers must file claims for members undergoing dialysis or members in nursing homes with one of the diagnosis codes listed in Table 7. Enter the diagnosis code on the professional claim (*CMS-1500* claim form or electronic equivalent) and use the diagnosis pointer field to indicate the appropriate diagnosis code for the service.

Table 7 – ICD-10 Diagnosis Codes for Transportation of Renal Dialysis Patients and Patients Residing in Nursing Homes

Diagnosis Code	Usage
Z02.89	Encounter for other administrative examinations – Nursing home resident
Z49.01	Encounter for fit/adjst of extracorporeal dialysis catheter
Z49.31	Encounter for adequacy testing for hemodialysis
Z49.32	Encounter for adequacy testing for peritoneal dialysis

Note: The aforementioned renal dialysis and nursing facility diagnosis codes must be used only when appropriate and medically necessary. These diagnosis codes should not be used to circumvent the PA process required for trips exceeding the 20 one-way trip limitation.

Accompanying Parent or Attendant

Procedure codes for accompanying parent or attendant are not applied to the member’s 20 one-way trip limitation. Prior authorization is required for an accompanying parent or attendant only when the trip exceeds 50 miles one way.

Additional Attendant

Procedure codes A0424 – *Extra ambulance attendant, ground (ALS or BLS) or air (fixed or rotary winged)* and A0130 U6 – *Non-emergency transportation: wheelchair van, extra attendant* are not applied to the member’s 20 one-way trip limitation. Prior authorization is required for procedure codes A0424 and A0130 U6 when the trip exceeds 50 miles one way.

Ambulance Transportation Services

The IHCP covers emergency and nonemergency ALS and BLS ambulance transport services. (See the [Level of Service Rendered Versus Level of Response](#) section for definitions.)

The IHCP covers ALS services only when the level of service is medically necessary and BLS services are not appropriate due to the medical conditions of the member being transported. Ambulance providers must bill the IHCP according to the level of service rendered. The following examples explain the level-of-service policy:

- *Example 1:* ALS personnel and ambulance respond to a call. On arrival, the personnel find the member needs emergency medical transport but no ALS services. In this case, the provider must use the BLS emergency transport code. Subsequently, if no emergency is present, providers must use the nonemergency BLS ambulance transport code to transport the member.
- *Example 2:* An ambulance responds to a call to transport a member to a scheduled appointment. On arrival, the ambulance personnel discover that a CAS service or wheelchair van can transport the member. The ambulance provider can either call for the appropriate vehicle or transport the patient in the ambulance. If the ambulance provider transports the member, the provider must bill the IHCP for the appropriate CAS or NAS transportation codes.

The procedure codes listed in Tables 8 and 9 are valid for ambulance providers to bill for CAS or NAS level of service. Ambulance providers must bill the most appropriate CAS or NAS code listed in Tables 8 and 9 if the level of service does not meet the EMSC definition of ALS or BLS services. See *Transportation Services Codes* on the [Code Sets](#) page at indianamedicaid.com for a complete list of transportation codes billable by ambulance providers (specialty 260), CAS providers (specialty 264), and NAS providers (specialty 265).

Table 8 – Valid CAS Procedure Codes for Ambulance Providers

Procedure Code	Description
T2003	Nonemergency transportation, encounter/trip
T2007 U3	Transportation waiting time, air ambulance and nonemergency vehicle, one-half (1/2) hour increments; CAS

Table 9 – Valid NAS Procedure Codes for Ambulance Providers

Procedure Code	Description
A0130	Nonemergency transportation, wheelchair van
A0130 U6	Nonemergency transportation, wheelchair van base rate; extra attendant
T2007 U5	Transportation waiting time, air ambulance and nonemergency vehicle, one-half (1/2) hour increments; NAS

The IHCP exempts emergency ambulance services from the 20 one-way trip limitation. See the [Twenty One-Way-Trip Limitation and Exemptions](#) section of this document for details.

Note: The IHCP requires PA for air ambulance and interstate transportation services. In addition, the IHCP requires PA for any transportation services provided by a provider located in an out-of-state, nondesignated area. (See the [Out-of-State Providers](#) module for more information.)

Ambulance Mileage

The IHCP reimburses for each mile of the trip only for loaded ambulance mileage. The provider’s documentation must contain mileage from mapping software or odometer readings indicating starting and ending trip mileage. Providers must use A0425 U1 – *Ground mileage, per statute mile; ALS* or A0425 U2 – *Ground mileage, per statute mile; BLS* to bill ambulance mileage. The IHCP uses U1 and U2 modifiers to differentiate between ALS and BLS mileage. The IHCP denies claims billed without the U1 or U2 modifier and requires providers to resubmit the claim with the appropriate modifier.

Neonatal Ambulance Transportation

The IHCP makes reimbursement available for specialized neonatal ambulance services especially equipped for interhospital transfers of high-risk or premature infants only when the member has been discharged from one hospital for admission to another hospital. Providers must use procedure code A0225 – *Ambulance service, neonatal transport, base rate, emergency transport, one way only for neonatal ambulance transport.*

Pediatric and Neonatal Critical Care during Interfacility Transportation

The IHCP provides coverage for critical care during a pediatric or neonatal interfacility transport. The following restrictions apply:

- The patient must be 24 months of age or younger.
- The patient must be in critical condition, as determined by a physician using the following guidelines:
 - Patient has a critical illness or injury that acutely impairs one or more vital organ systems.
 - Imminent or life-threatening deterioration of the patient’s condition is highly probable during transport.
- This service must be rendered by a physician or a neonatal nurse practitioner (NNP).

This coverage applies to all IHCP programs, subject to limitations established for certain benefit packages, for dates of service on or after January 1, 2015.

Oxygen and Oxygen Supplies

Providers **must not bill** procedure code A0422 – *Ambulance (ALS or BLS) oxygen, and oxygen supplies, life sustaining situation* with ALS codes A0426, A0427, and A0433. These base codes for ALS transport include the reimbursement for supplies and oxygen in an ALS situation.

Providers can bill procedure code A0422 with BLS codes A0428 or A0429, if medically necessary. Emergency medical technicians (EMTs) and paramedics must document the medical necessity for oxygen use in the medical record maintained by the provider.

Package C Ambulance Transportation

Hoosier Healthwise Package C members are eligible to receive emergency ambulance services, subject to the prudent layperson definition of emergency in *407 IAC 1-1-6* and a copayment of \$10. The IHCP covers nonemergency ambulance transportation between medical facilities when ordered by the treating physician.

Rotary Air Ambulance Transportation

Rotary air ambulance is furnished when the member's medical condition is such that transport by ground ambulance, in whole or in part, is not appropriate.

Generally, transport by rotary wing air ambulance may be necessary because the member's condition requires rapid transport to a treatment facility, and great distances or other obstacles preclude such rapid delivery by ground transport to the nearest appropriate facility. Transport by rotary wing air ambulance may also be necessary because the member is inaccessible by a ground or water vehicle.

Transportation by air ambulance is covered only for transport to a hospital. Air ambulance services are not covered for transport to a facility that is not an acute care hospital. Transport to a nursing facility, a physician's office, or a beneficiary's home by rotary air ambulance is not reimbursable.

Prior Authorization for Rotary Air Ambulance Transportation

Prior authorization (PA) is required for air ambulance services. The IHCP acknowledges that PA for rotary air transport can be requested after services have been rendered, due to the nature of the services. A PA request must include a brief description of the care and description of the clinical circumstances necessitating the need for the transportation. To indicate that the transportation was an emergency, providers must include the emergency indicator for each service detail of the claim.

Medical Necessity for Rotary Air Ambulance Transportation

Rotary air ambulance transport is a covered service when the member has a potentially life-threatening condition that does not permit the use of another form of transportation. The IHCP reimburses rotary air transportation services to a hospital facility under medically appropriate circumstances. Medical necessity is established only when the member's condition is such that the time needed to transport a member by ground, or the instability of transportation by ground, poses a threat to the member's survival or seriously endangers the member's health.

The following list includes examples of medical conditions in which rapid transport may be necessary:

- Intracranial bleeding requiring neurosurgical intervention
- Cardiogenic shock
- Burns requiring treatment in a burn center
- Conditions requiring treatment in a hyperbaric oxygen unit
- Multiple severe injuries
- Life-threatening trauma

This list does not guarantee reimbursement nor is it intended to be all inclusive. Diagnosis alone does not serve as justification for reimbursement.

Air transport must be to the nearest suitable hospital. If the air transport was medically necessary but the member could have been treated at a nearer hospital than one to which they were transported, the air transportation mileage reimbursement is limited to the rate for the distance from the point of pickup to the nearer hospital.

Special Circumstances

Additional information concerning rotary air transportation coverage and billing follows for three special circumstances – hospital-to-hospital transfers, patient expiration, and bad weather.

Hospital-to-Hospital Transfer

Air ambulance transport is covered for transfer of a patient from one hospital to another if the medical appropriateness criteria is met, for example, transportation by ground ambulance would endanger the member's health, and the transferring hospital does not have adequate facilities to provide the medical services needed by the patient. Examples of such specialized medical services that are generally not available at all types of facilities may include, but are not limited to, burn care, cardiac care, trauma care, and critical care.

A patient transported from one hospital to another hospital is covered only if the hospital to which the patient is transferred is the nearest one with appropriate facilities. Reimbursement is not available for transport from a hospital capable of treating the patient because the patient or family prefers a specific hospital or physician.

When a Medicaid member is admitted to a hospital, it may become necessary to transport the patient to another hospital for specialized services while the patient maintains inpatient status with the original hospital. Transportation of the patient in this instance is not a separately billable Medicaid transportation service. Payment for the transportation of a patient while still in inpatient status is not payable apart from the inpatient payment for the original inpatient hospital stay. For billing and cost reporting purposes, the admitting hospital should record the services obtained at the other hospital, including transport of the patient, in the appropriate ancillary cost center relating to the services obtained. Providers must not use revenue code 54X (Ambulance) for this transportation service.

Patient Expiration

When the member expires, the IHCP payment amount depends on the time at which the member is pronounced dead by an individual authorized by the State to make such pronouncements. If the member is pronounced dead before takeoff to point of pickup, with notice to the dispatcher and time to abort the flight, no payment is made. This includes scenarios in which the air ambulance has taxied to the runway or has been cleared for takeoff, but has not actually taken off.

If the member is pronounced dead after takeoff to point of pickup, but before the member is loaded, the appropriate air base rate (A0431) with no mileage is reimbursed. The provider should use the QL modifier when submitting such a claim: A0431 QL – *Ambulance service, conventional air service, transport, one way (rotary wing); if the member is pronounced dead after takeoff to point of pickup, but before the member is loaded.* If the provider bills a mileage code in conjunction with a base rate and QL modifier, the mileage code is denied with explanation of benefits (EOB) code 6194 – *Mileage is not payable with this service.*

When the member is pronounced dead after being loaded onboard but before or on arrival at the receiving facility, the provider may bill for the air ambulance base rate and mileage as if the member had not expired.

Bad Weather

Providers should note that if the flight is aborted due to bad weather or other circumstance beyond the pilot's control any time before the beneficiary is loaded onboard, that is, before or after takeoff to point of pickup, the IHCP will not reimburse for the flight. If the flight is aborted due to bad weather after the beneficiary is loaded, the appropriate base and mileage codes may be reimbursed.

Base Rate and Mileage for Rotary Air Ambulance Transportation

The IHCP provides reimbursement for a base rate and mileage for rotary air ambulance transportation. The base rate and mileage are reimbursed at the lower of the usual and customary charge or the IHCP-established maximum fee. The base rate is an all-inclusive rate including coverage of treatments and services that are an integral part of care while in transit; it includes but is not limited to oxygen, drugs, supplies, reusable devices and equipment, and extra attendants. Table 10 shows Healthcare Common Procedure Coding System (HCPCS) codes for rotary air ambulances services.

Table 10 – Rotary Air Ambulance Codes

Procedure Code	Description
A0431	Ambulance service, conventional air services, transport, one way (rotary wing)
A0436	Rotary wing air mileage, per statute mile

The air ambulance mileage rate is calculated to the nearest suitable hospital per actual loaded (patient onboard) miles flown and is expressed in statute miles (not nautical miles). Transportation providers are expected to transport members along the shortest, most efficient route to the nearest suitable hospital. All rotary air transportation providers must document mileage on the trip ticket. Providers must bill the IHCP for whole units only. Partial mileage units must be rounded to the nearest whole unit. For example, if the provider transports a member between 15.5 miles and 16.0 miles, the provider must bill 16 miles. If the provider transports the member between 15.0 and 15.4 miles, the provider must bill 15 miles.

Providers are reminded that additional reimbursement is not available for multiple passengers in a rotary air ambulance, nor is separate reimbursement available for an accompanying parent or attendant in a rotary air ambulance.

See *Transportation Services Codes* on the [Code Sets](#) page at indianamedicaid.com for a complete list of transportation codes billable by air ambulance providers (specialty 261).

Taxi Service

Taxi providers transport ambulatory members and may operate under authority from a local governing body (city taxi or livery license). Taxi providers whose rates are regulated by local ordinance must bill the metered or zoned rate, as established by local ordinance, and the IHCP reimburses them up to the maximum allowable fee. The IHCP reimburses taxi providers whose rates are not regulated by local ordinance at the lower of their submitted charge or the maximum allowable fee based on trip length. The IHCP does not separately reimburse taxi providers for mileage above the maximum allowable rate for the trip; however, providers must have mileage documented on the driver's ticket by odometer readings or mapping software.

See *Transportation Services Codes* on the [Code Sets](#) page at indianamedicaid.com for a complete list of transportation codes billable by taxi providers (specialty 263).

Family Member Transportation

Family members enrolled as transportation providers under *405 IAC 5-4-3* are eligible for reimbursement for mileage only. Reimbursement is determined by the actual loaded mileage multiplied by the rate per mile established by the Indiana legislature for state employees. The local county office of the Division of Family Resources (DFR) in which the member resides must authorize all family member transportation.

See *Transportation Services Codes* on the [Code Sets](#) page at indianamedicaid.com for a complete list of transportation codes billable by family member transportation providers (specialty 266).

Other Transportation Services

IHCP reimbursement is available for other transportation services, including but not limited to intrastate bus or train transportation. IHCP payment for other transportation services will be the fee usually and customarily charged the general public, subject to federal, State, or local law, rule, or ordinance. To be reimbursed, the bus or train company providing services must be enrolled as an IHCP provider.

Intrastate bus or train services (including services provided in designated areas) require authorization by the county office, and interstate bus or train services require authorization from the contractor. Authorization may be given for use of monthly bus passes, in situations where a member has an ongoing medical need, so that purchase of the bus pass is cost effective when compared to the cost of other modes of transportation. Such authorization shall be given only if the member has agreed to use this mode of transportation.

See *Transportation Services Codes* on the [Code Sets](#) page at indianamedicaid.com for a complete list of transportation codes billable by bus transportation providers (specialty 262).

Prior Authorization for Transportation Services

Specific criteria pertaining to PA of transportation services are found in *405 IAC 5-30*. The following PA requirements should be used as a guideline for determining procedures requiring PA, but the *Indiana Administrative Code (IAC)* is the primary reference.

The IHCP requires PA for the following transportation services:

- Trips exceeding 20 one-way trips per member, per rolling 12-month period, with certain exceptions as described in the [Twenty One-Way-Trip Limitation and Exemptions](#) section
- Trips of 50 miles or more one way, including all codes associated with the trip (wait time, parent or attendant, additional attendant, and mileage)
- Interstate transportation or transportation services rendered by a provider located out-of-state in a nondesignated area
- Train or bus services
 - These services require prior authorization by the local county office of the FSSA Division of Family Resources (DFR) in which the member resides, not the IHCP office or contractor.
- Airline or air ambulance services
- Family member services
 - These services require prior authorization by the county office of the FSSA DFR in which the member resides, **not** the IHCP office or contractor.

The following information should be noted on or attached to a properly completed *Indiana Health Coverage Programs Prior Authorization Request Form* (available on the [Forms](#) page at indianamedicaid.com) or a PA request submitted via the Provider Healthcare Portal:

- Proper procedure codes for the requested services
- Member’s age
- Type of service required (such as NAS, CAS, or taxi)
 - The member’s condition must support the level of service requested.
- Reason for and destination of service (such as dialysis or physical therapy treatments at county hospital or community health clinic)
- Frequency of service and treatment per the physician’s order (such as twice a week)
- Duration of service and treatment per the physician’s order (such as three months)
- Total mileage for each trip (such as 129 miles)
- Total waiting time for each trip (such as two hours)

PA requests must include a brief description of the anticipated care and of the clinical circumstances necessitating the need for the transportation.

The IHCP may grant PA up to one year following the date of service

Note: For managed care members, authorizations for transportation services are the responsibility of the MCE. Additional information about MCE authorization procedures can be directed to the MCE at the telephone number provided through the IHCP Interactive Voice Response (IVR) system, Provider Healthcare Portal, or 270/271 electronic transaction. Another resource is the [IHCP Quick Reference Guide](#) at indianamedicaid.com. The appropriate MCE reviews the PA requests and sends copies of the decisions to the members and the rendering providers.

Noncovered Transportation Services

The IHCP does not reimburse for the following transportation services:

- One-way trips exceeding 20 per member, per rolling 12-month period, unless the provider documents medical necessity for additional trips through the PA process (For exceptions, see the [Twenty One-Way-Trip Limitation and Exemptions](#) section of this document.)
- Trips of 50 miles or more one way, unless the provider obtains PA
- First 30 minutes of waiting time for any type of conveyance, including ambulance
- Nonemergency transportation provided by any of the following:
 - A volunteer with no vested or personal interest in the member
 - An interested individual or neighbor of the member
 - A caseworker or social worker
- Ancillary, nonemergency transportation charges including, but not limited to, the following:
 - Parking fees
 - Tolls
 - Member meals or lodging
 - Escort meals or lodging
- Disposable medical supplies, other than oxygen, provided by a transportation provider
- Transfer of durable medical equipment, either from the member’s residence to place of storage or from the place of storage to the member’s residence
- Use of red lights and siren for an emergency ambulance call
- All interhospital transportation services, except when the member has been discharged from one hospital for admission to another hospital
- Delivery services for prescribed drugs, including transporting a member to or from a pharmacy to pick up a prescribed drug

Documentation Requirements for Transportation Services

Providers must support each claim with the following documentation on the driver’s ticket or run sheet:

- Complete date of service; including day, month, and year of service, such as 9/30/15
- Complete member name and address of pickup, including street address, city, county, state, and ZIP Code
- Member identification number
- Member signature, and if the member is unable to sign, the driver should document that “the patient was unable to sign” and list the reason for the inability
- Waiting time; including the actual start and stop time of the waiting period, such as wait time from 1 p.m. to 3:20 p.m.
- Complete service provider’s name and address, including street address, city, county, state, and ZIP Code

Note: If the service provider's name is abbreviated on the driver's ticket, the provider must document the complete provider name or maintain a facility abbreviation listing. This helps expedite the postpayment review process.

- Name of the driver who provided transportation service
- Vehicle odometer reading at the beginning and end of each trip or mileage from mapping software, including the date that the provider performed the transportation service and the specific starting and destination address
 - If the provider used mapping software, it must indicate the shortest route.

Note: All providers, including taxi providers, must document mileage using either odometer readings or mapping software. Taxi providers must document the distance traveled to support the metered or zoned rate or mileage code billed.

- Indication of a one-way or round trip
- Indication of CAS or NAS transportation
- Name and relationship of any accompanying parent or attendant to support the accompanying parent or attendant code billed, if applicable

Note: When providers bill an attendant or parent as part of the transport, the parent or attendant must also sign the driver's ticket.

Providers are responsible for verifying that they are transporting the member to or from a covered service. Providers are responsible for maintaining documentation that supports each transport and service provided. Transportation providers put themselves at risk of recoupment of payment if they do not maintain the required documentation or cannot verify covered services.

MRT Reimbursement for Transportation

The Medical Review Team (MRT) program reimburses for transportation services, in cases of financial hardship, when no transportation is available for medically necessary examinations or tests; however, the provider must contact the MRT to obtain approval before rendering the service.

Only the following transportation codes are authorized for most MRT trips:

- T2003 SE – *Nonemergency transportation, encounter/trip; \$10 each way, regardless of vehicle type*
- T2007 SE – *Transportation waiting time, air ambulance and nonemergency vehicles, one-half (1/2) hour increments; \$4.50*
- A0425 SE – *Ground mileage, per statute mile; \$1.25*