INDIANA MEDICAID UPDATE

February 9, 1998

TO: All Indiana Medical Assistance Program Providers

SUBJECT: Changes in Transportation

In response to concerns expressed by transportation providers regarding current prior authorization (PA) procedures, the Office of Medicaid Policy and Planning (OMPP) has effected several changes which should reduce or eliminate the difficulties in this area. An outline of these changes, which are effective March 27, 1998, are presented in this bulletin.

I. Signature Stamps

The use of signature stamps on prior authorization requests is allowable. PA processing staff have been advised that either a written or stamped signature is now acceptable for all prior authorization requests.

II. Removal of Prior Authorization for Dialysis and/or Nursing Home Patients

Because of the ongoing medical need associated with patients on dialysis or those residing in nursing homes, OMPP has removed claims for these populations from the twenty-trip limit and from prior authorization. To avoid the PA requirement, claims must be filed with one of the diagnosis codes listed below. The diagnosis code should be inserted in field 21 of the HCFA 1500 form, and a 1 should be inserted in field 24E to indicate the first diagnosis code applies. Note that transportation providers have not previously completed this information on the claim form and are only required to complete this now **for claims being submitted for dialysis or nursing home patients. Failure to complete this field correctly could result in the claim being denied for prior authorization once the twenty-trip limit has been reached.**

For Dialysis Patients, use codes:	V56.0, V56.1 or 56.8
For Nursing Home Patients, use code	V70.5

III. Prior Authorization for Base Code or Multiple Passenger Code

Providers may obtain prior approval for a base code and find on the day of the actual transport that, instead, a multiple passenger code is needed (or vice versa). This is due to last-minute changes in scheduling by the recipient which are unavoidable by the provider. To resolve this problem, PA staff will approve both a base code and a multiple passenger code that corresponds to the approved base code will

be given PA. For example, if the base code of X3032 is approved (taxi 6-10 miles), the corresponding multiple passenger code of X3037 (taxi 6-10 miles, multiple passenger) would also be approved.

NOTE: Total units should not exceed the amount used for the trip. Providers should use either the base code or the multiple passenger code, whichever is appropriate. Both codes should not be billed for the same trip. This will be subject to post-payment audit.

IV. Removal of Recipient Attendant Codes from the 20 trip limit

The codes used for accompanying parent and recipient attendant will be excluded from the twenty-trip limit. The base code is counted, but the accompanying parent/attendant code with a base code would not constitute an additional trip.

V. Return Trip from the Emergency Room

Currently, if an ambulance (code A0222) is needed for a return trip from the emergency room, it is subject to PA. If an ambulance is used for a return trip from the emergency room **and is medically necessary for the transport, this code may be billed and will no longer require PA. Note that if an ambulance is not needed and a less expensive mode of transportation is suitable for the return trip, an ambulance trip should not be billed. This provision will also be subject to post-payment audit.**

VI. Obtaining Medical Information or the Physician's Signature for the Prior Authorization Request Form

Transportation providers sometimes are not able to gain the physician's cooperation in obtaining a signature or medical information for the PA Request Form. Transportation providers who have attempted to obtain the physician's signature or medical information for the PA form, but were unsuccessful, may complete and sign the PA Request Form themselves, **after discussing the medical information and need for transportation with the recipient.** In the patient's record, the provider should denote that he was unable to obtain the needed information or signature from the physician. EDS will closely monitor utilization of transportation. In the event of over utilization, this policy change may be retracted.

Note to Physicians: Physicians who are asked to complete and sign the prior authorization form are being asked to either supply medical information or to verify the recipient has made a medical appointment or has a medical need. The physician is not expected to render an opinion as to whether or not the recipient needs transportation from a Medicaid provider, nor are physicians held accountable for this.

VII. Additional Attendant for Loading Recipients

Transportation providers sometimes need an additional attendant to help load a recipient. This is in unusual circumstances when the driver cannot do this without help, such as in the case when a wheelchair recipient lives upstairs, and his residence has no wheelchair ramp. Local code Z5023 has been assigned

for billing the additional attendant charge. This code will be reimbursed at a rate of $5.00 and will not be subject to prior authorization or the twenty-trip limit. The additional attendant that assists in loading must be an employee of the provider that is billing and is not required to remain for the trip. Providers will need to document the need for this service in their records, and this would be subject to post-payment audit. The additional attendant is limited to a maximum of two extra units, although usually one attendant is sufficient. This code applies only to ambulance or nonambulatory transportation vehicles.

If there are any questions about changes, please contact EDS Provider Assistance at 1-800-577-1278.