



INDIANA HEALTH COVERAGE PROGRAMS

PROVIDER REFERENCE MODULE

Transportation Services

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Revision History

Version	Date	Reason for Revisions	Completed By
1.0	Policies and procedures as of October 1, 2015 Published: February 25, 2016	New document	FSSA and HPE
1.1	Policies and procedures as of April 1, 2016 Published: September 13, 2016	Scheduled update	FSSA and HPE
1.2	Policies and procedures as of April 1, 2016 (<i>CoreMMIS</i> updates as of February 13, 2017) Published: April 11, 2017	<i>CoreMMIS</i> update	FSSA and HPE
2.0	Policies and procedures as of October 1, 2017 Published: February 15, 2018	Scheduled update	FSSA and DXC
3.0	Policies and procedures as of October 1, 2018 Published: April 30, 2019	Scheduled update: <ul style="list-style-type: none"> • Edited and reorganized text for clarity • Incorporated relevant information from the <i>Medical Policy Manual</i> • Updated the initial note with standard language • Updated the links to the new IHCP website • Removed information specific to managed care programs, including the <i>Package C Ambulance Transportation</i> section • In the Introduction section, added information about IHCP transportation requirements, including new brokerage requirements for FFS NEMT • Added the Brokered Nonemergency Medical Transportation section and subsections • Added the Emergency Transports in Response to 9-1-1 Dispatches section • Updated the “other emergency procedures” in the Basic Life Support (BLS) Ambulance Service section • Updated the Prior Authorization for Transportation Services section: <ul style="list-style-type: none"> – Removed family member transportation from requiring PA – Added note regarding NEMT PA – Removed information about DFR approval for train or bus services 	FSSA and DXC

Version	Date	Reason for Revisions	Completed By
		<ul style="list-style-type: none"> • Updated the General Billing and Reimbursement Guidelines section to include billing information for FFS transportation services and a cross-reference for brokered NEMT billing information • Added the Hospital-to-Hospital Transports section • Added the Pharmacy-Only Transportation section • In the Noncovered Transportation Services section, removed text about transporting a member to or from the pharmacy to pick up a prescription • Added reference for NEMT documentation in the Documentation Requirements for Transportation Service section • Clarified in the Ambulance Transportation (Provider Specialty 260) section that NAS and CAS are also covered services rendered by ambulance providers • Clarified in the Air Ambulance Transportation (Provider Specialty 261) section that IHCP policy applies to both fixed-wing and rotary-wing aircraft • Updated the Patient Expiration section • Added the Common Carrier – Ambulatory Transportation (Provider Specialty 264) and Common Carrier – Nonambulatory Transportation (Provider Specialty 265) sections • Updated the Family Member Transportation (Provider Specialty 266) section, including adding information about brokered NEMT 	

Table of Contents

Introduction	1
Brokered Nonemergency Medical Transportation	2
Exempted NEMT Services	2
Scheduling Procedures for Brokered NEMT Services	3
Prior Authorization and Benefit Limits for Brokered NEMT Services	4
Billing and Reimbursement for Brokered NEMT Services	4
Scheduling and Billing NEMT Services for Dually Eligible Members	4
Emergency Transports in Response to 9-1-1 Dispatches	5
Level of Service Rendered versus Level of Response	5
Advanced Life Support (ALS) Ambulance Service	5
Basic Life Support (BLS) Ambulance Service	6
Commercial or Common Ambulatory Service (CAS) Transportation	6
Nonambulatory Service (NAS) Transportation (Wheelchair Van)	7
Member Copayments	7
Exemptions to Copayments for Transportation Services	7
Federal Guidelines Regarding Inability to Afford Copayment	8
Retroactive Eligibility	8
Prior Authorization for Transportation Services	8
Twenty One-Way Trip Limitation and Exemptions	9
Emergency Transportation Services	9
Return Trip from the Emergency Room	9
Inpatient Hospital Admission or Discharge	10
Members on Renal Dialysis or in Nursing Homes	10
Accompanying Parent or Attendant	10
Additional Attendant	10
General Billing and Reimbursement Guidelines	11
Transportation Diagnosis Coding	11
Definition of a Trip	11
Transportation Origin and Destination Modifiers	12
Mileage	12
Multiple Passengers	14
Accompanying Parent or Attendant	15
Additional Attendant	15
Waiting Time	16
Hospital-to-Hospital Transports	16
Pharmacy-Only Transportation	17
Noncovered Transportation Services	17
Documentation Requirements for Transportation Services	18
Ambulance Transportation (Provider Specialty 260)	19
Ambulance Mileage	20
Neonatal Ambulance Transportation	20
Pediatric and Neonatal Critical Care during Interfacility Transportation	20
Oxygen and Oxygen Supplies	20
Air Ambulance Transportation (Provider Specialty 261)	21
Prior Authorization for Air Ambulance Transportation	21
Medical Necessity for Air Ambulance Transportation	21
Special Circumstances Related to Air Ambulance Transportation	22
Base Rate and Mileage for Air Ambulance Transportation	23
Taxi Transportation (Provider Specialty 263)	23
Common Carrier – Ambulatory Transportation (Provider Specialty 264)	24
Common Carrier – Nonambulatory Transportation (Provider Specialty 265)	24
Family Member Transportation (Provider Specialty 266)	24

Other Transportation Services.....24
Medical Review Team Transportation.....25

Transportation Services

Note: The information in this module applies to services provided under the fee-for-service delivery system. Within the managed care delivery system, individual managed care entities (MCEs) establish their own coverage criteria, prior authorization requirements, billing procedures, and reimbursement methodologies. For services covered under the managed care delivery system, providers must contact the Healthy Indiana Plan (HIP), Hoosier Care Connect, or Hoosier Healthwise member's MCE or refer to the MCE provider manual for specific policies and procedures. MCE contact information is included in the [IHCP Quick Reference Guide](#) available at in.gov/medicaid/providers.

For updates to the information in this module, see [IHCP Banner Pages and Bulletins](#) at in.gov/medicaid/providers.

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 module. The member being transported must be present in the vehicle for IHCP reimbursement to be available. The transportation provided must be the least expensive type of transportation that meets the medical needs of the member. Additionally, providers are expected to transport members along the shortest, most efficient route to and from a destination.

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.

Beginning June 1, 2018, most nonemergency medical transportation (NEMT) services for IHCP members served through the fee-for-service (FFS) delivery system are brokered by Southeastrans. Providers rendering transportation services brokered through Southeastrans submit claims for reimbursement to Southeastrans. See the [Brokered Nonemergency Medical Transportation](#) section for details.

Emergency transportation, as well as NEMT services that are exempt from the brokerage requirement, continue to be reimbursed through DXC Technology for FFS members. For these services, providers should follow normal guidelines for submitting the professional claim (CMS-1500 claim form, IHCP Provider Healthcare Portal [Portal] professional claim, or 837P electronic transaction), as described in this module and the [Claim Submission and Processing](#) module.

Brokered Nonemergency Medical Transportation

NEMT services occur when needs are not immediate, such as scheduled appointments, dialysis, chemotherapy, physical therapy, and picking up prescriptions. Hospital discharges to home and nonemergency interfacility transports are also considered NEMT services.

Southeastrans is responsible for brokering NEMT services for IHCP members served through the FFS delivery system. Members who receive brokered NEMT services through Southeastrans are identified as **Fee for Service + NEMT** on the *Managed Care Assignment Details* panel during the IHCP Provider Healthcare Portal (Portal) eligibility verification process (see Figure 1).

Figure 1 – Portal Eligibility Verification for a Member with Nonemergency Medical Transportation Brokered through Southeastrans

Managed Care Assignment Details			
Managed Care Program		Primary Medical Provider	Provider Phone
Fee for Service + NEMT			
Effective Date	End Date	MCO / CMO Name	MCO / CMO Phone
06/21/2018	06/21/2018	SOUTHEASTRANS, INC	

For reimbursement of brokered NEMT services, providers – including common carriers (ambulatory and nonambulatory), taxis, buses, and ambulances – must be enrolled as IHCP providers and must contract with Southeastrans to be a part of its statewide NEMT network.

Southeastrans operates a call center with a toll-free, statewide telephone number for scheduling NEMT services and answering related member and provider inquiries: **1-855-325-7586**. Information about contracting with Southeastrans and other guidance for transportation providers can be found on the [Southeastrans website](http://southeastrans.com) at southeastrans.com.

Exempted NEMT Services

In most cases, for the transportation provider to receive IHCP reimbursement, IHCP members who receive benefits through the FFS delivery system are required to have their NEMT services brokered through Southeastrans. However, some NEMT services are exempt from the requirement to broker the transportation through Southeastrans. Services in these instances are arranged directly with the transportation provider and follow standard billing and reimbursement procedures:

- Transportation for **waiver services** provided through a 1915(c) home and community-based services (HCBS) waiver program

*Note: Nonemergency transportation provided to HCBS waiver members for **nonwaiver services** is **not** exempt and must be brokered through Southeastrans.*

- Transportation services provided by school corporations
- Transportation for Medical Review Team (MRT) services
- Transportation for dually eligible members requiring basic life support (BLS) or advanced life support (ALS) services during transport (see the [Scheduling and Billing NEMT Services for Dually Eligible Members](#) section)
- All hospital-to-hospital transports (see the [Hospital-to-Hospital Transports](#) section)

Some FFS benefit plans do not offer coverage for NEMT services, including the following:

- Package E – Emergency Services Only
- Family Planning Eligibility Program
- Qualified Individual (QI)
- Qualified Disabled Working Individual (QDWI)
- Qualified Medicare Beneficiary-Only (QMB-Only)
- Specified Low-Income Medicare Beneficiary-Only (SLMB-Only)

Managed care members who are eligible for NEMT coverage through the HIP, Hoosier Care Connect, Hoosier Healthwise, or Program of All-Inclusive Care for the Elderly (PACE) programs continue to obtain transportation services through the MCE (or PACE entity) with which the member is enrolled.

If a member has access to transportation that does *not* require IHCP reimbursement (such as from a nonenrolled friend, family member, or nonprofit organization), those options should be used instead. Members should arrange for IHCP-reimbursed NEMT only if no other means of transportation is available to them.

Scheduling Procedures for Brokered NEMT Services

Southeastrans provides scheduling for brokered NEMT services as follows:

- For nonurgent rides, members contact Southeastrans at least 2 business days in advance to arrange for transportation. Members must book the trip through the Southeastrans reservation line at **1-855-325-7586** or the [Southeastrans member website](http://member.southeastrans.com) at member.southeastrans.com, rather than contact the provider directly. Members may request that rides be arranged with their preferred provider as long as that provider is enrolled with the IHCP and is contracted by (or in the process of being credentialed with) Southeastrans, and the provider's level of transportation is suitable for the member.
- Trips scheduled with fewer than 2 business days of advance notice need to be confirmed by the member's healthcare provider.
- For hospital discharges to home, the hospital should call the Southeastrans reservation line. Southeastrans will work closely with the hospital to find the closest, most appropriate provider to provide the transport and will respect current preferred-provider relationships.
- For nonemergency interfacility transports between a hospital and a long-term care facility, facilities should call the Southeastrans reservation line. Southeastrans handles interfacility transports as **urgent** transports. Urgent transports are required to be serviced within 3 hours of notice; Southeastrans will make arrangements accordingly. Southeastrans can arrange rides with the preferred provider; however, Southeastrans still must ensure that the provider is IHCP-enrolled and meets member requirements.

Note: For temporary exceptions and transitional procedures currently in place for extended care facilities, see IHCP Bulletin [BT201845](#) – IHCP revises process for scheduling NEMT services for FFS members residing in certain facilities.

Emergency transports are not included as NEMT services and instead should be managed via standard 9-1-1 protocols. Emergency transportation occurs when needs are immediate, such as heart attack, stroke, transplant, serious injury, or other life-threatening situations. Neonatal transports are considered emergency transports. See the [Emergency Transports in Response to 9-1-1 Dispatches](#) and the [Neonatal Ambulance Transportation](#) sections for details.

Prior Authorization and Benefit Limits for Brokered NEMT Services

Southeastrans is responsible for obtaining prior authorization (PA) through Cooperative Managed Care Services (CMCS), as needed, for brokered NEMT services. Transportation providers will no longer be required to submit PA requests when the service is brokered through Southeastrans.

Current benefit limits and PA requirements for NEMT remain unchanged. Units for NEMT services will continue to be monitored. See the [Prior Authorization for Transportation Services](#) section for detailed PA and benefit limit information.

Billing and Reimbursement for Brokered NEMT Services

*Note: NEMT services for FFS members for dates of service **before** June 1, 2018, are processed and reimbursed by DXC Technology. Claims for nonexempt FFS NEMT services submitted to DXC with dates of service on or after June 1, 2018, will be denied with explanation of benefits (EOB) code 2065 – The member has been identified as being enrolled in the Non-Emergency Medical Transportation assignment plan. The claim should be billed to the NEMT broker.*

Contracted, in-network providers submit claims electronically through an online solution provided by Southeastrans. Southeastrans provides training and technical assistance regarding online claim submission for providers participating in their network.

Emergency medical services (EMS) providers submit claims on a paper *CMS-1500* claim form by mail to:

Southeastrans
Attn: Claim Processing
4751 Best Rd., Suite 300
Atlanta, GA 30337

Southeastrans processes and pays claims on a weekly basis. Providers may arrange for payment by check or electronic funds transfer. Southeastrans provides Remittance Advices (RAs) detailing claims processed during each payment cycle. The Southeastrans NEMT rate schedule is based on the IHCP Professional Fee Schedule, accessible from the [IHCP Fee Schedules](#) page at in.gov/medicaid/providers. Each NEMT provider must sign a Southeastrans rate agreement detailing these rates.

For more information about Southeastrans policy and procedures, see the Southeastrans [Indiana Policy and Procedures Manual](#) at southeastrans.com.

Scheduling and Billing NEMT Services for Dually Eligible Members

The IHCP provides NEMT coverage for dually eligible members who have Traditional Medicaid in addition to Medicare (SLMB-Also and QMB-Also members).

If the dually eligible member requires basic life support (BLS) or advanced life support (ALS) services during transport, or that require transport via a stretcher, the NEMT service should be scheduled directly with an ambulance provider as follows:

- The transport should be scheduled directly with the emergency medical services (EMS) transportation provider. Advance reporting to Southeastrans to secure a Trip Leg ID is not necessary.
- Providers should submit claims for these NEMT services to Medicare as the primary payer.
- If the Medicare claim is denied, or if it is paid but a balance remains for the member's coinsurance or deductible amount, the provider may submit the claim to Southeastrans on a *CMS-1500* claim form with the Medicare explanation of benefits (EOB) attached for reimbursement consideration.

Dually eligible Traditional Medicaid members that do **not** require BLS or ALS services during transport should schedule the NEMT through Southeastrans following normal procedures. Providers **should not** submit these claims to Medicare; instead, the claims should be submitted directly to Southeastrans with a Trip Leg ID.

Emergency Transports in Response to 9-1-1 Dispatches

The IHCP considers all transports to an emergency room in response to 9-1-1 dispatches to be emergency transports. For 9-1-1 dispatched trips to an emergency room, ambulance providers should bill the appropriate procedure codes for emergency advanced life support (ALS) or basic life support (BLS) services, based on the type of services provided during the transport. If an ambulance dispatched by 9-1-1 transports a member to a destination other than the emergency room, the transport is considered nonemergency, and reimbursement is subject to the billing rules of the transportation broker associated with the member's benefit plan and/or managed care entity (MCE) assignment.

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), in *Indiana Administrative Code IAC 836 1-1-1*, define advanced life support (ALS) as care that is:

- Given in one of the following settings:
 - At the scene of an accident, act of terrorism, or illness
 - During transport
 - At a hospital
- Provided by a paramedic or an advanced emergency medical technician (EMT)
- More advanced than the care usually provided by an EMT

ALS may include any of the following acts of care:

- Defibrillation
- Endotracheal intubation
- Parenteral injection of appropriate medications
- Electrocardiogram (ECG) 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
- Administration of epinephrine through an auto-injector
- Blood glucose monitoring that is not more invasive than a capillary sampling using a lancet
- Other procedures authorized by the Indiana EMSC, including procedures contained in the revised national EMT-basic training curriculum guide
 - The EMSC has provided, in *Indiana Administrative Code 836 IAC 1-1-1(12)(I)*, that BLS includes the following:
 - Use of an automatic or a semiautomatic defibrillator if used in accordance with training procedures established by the commission
 - The EMSC has provided in *836 IAC 1-1-1(12)(K)* that BLS for an EMT-basic advanced includes the following:
 - Electrocardiogram (ECG) interpretation
 - Manual external defibrillation
 - Intravenous (IV) 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 not 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, as described in this section and in *405 IAC 5-30-2* and *IC 12-15-6*. The provider collects the copayment from the member at the time the service is rendered. IHCP reimbursement to the provider is adjusted to reflect the copayment amount for which the recipient is liable.

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 from IHCP members equal to the amounts listed in Table 1.

Table 1 – Fee-for-Service Member Transportation Copayments

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

No copayment is required for an accompanying parent or attendant.

Note: Contact the appropriate MCE for information about transportation copayment amounts and exemptions for managed care members.

Exemptions to Copayments for Transportation Services

The IHCP exempts the following services from the copayment requirement:

- Emergency ambulance services
- Services furnished to the following:
 - Members younger than 18 years old
 - Pregnant women
 - Members who are patients in hospitals, nursing facilities, ICFs/IID, or other medical institutions (including instances where a provider transports a member for the purpose of admission or discharge)
 - Members of the Indiana Breast and Cervical Cancer Program (regulation *42 CFR 447.56*)
 - Members who are American Indian or Native Alaskan

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.

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
- Airline or air ambulance services

Note: For brokered nonemergency transportation services, Southeasterns (not the individual provider) is responsible for securing any required PA. See the [Prior Authorization and Benefit Limits for Brokered NEMT Services](#) section for more information.

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 in.gov/medicaid/providers) or a PA request submitted via the 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 3 months)
- Total mileage for each trip (such as 129 miles)
- Total waiting time for each trip (such as 2 hours)

The IHCP may grant PA up to 1 year following the date of service.

Twenty One-Way Trip Limitation and Exemptions

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

PA is required for services that exceed the 20 one-way trip limitation. PA may be approved in cases where it is determined that 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. PA may be granted up to 1 year following the date of service. 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.

For transportation services that are **exempt** from the 20 one-way trip limitation, see the following sections.

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:

- On the *CMS-1500* paper claim form – Enter **Y** in field 24C (EMG).
- On the 837P electronic transaction – Enter **Y** in the Emergency Services Indicator field (loop 2400, segment SV1, element SV109).
- On the Portal professional claim – Select the EMG checkbox.

In addition, the primary diagnosis code on the claim must reflect the emergency nature of the service.

Return Trip from the Emergency Room

A return trip from the emergency room in an ambulance is exempt from the 20 one-way trip limitation if the use of an ambulance is medically necessary for the transport.

Inpatient Hospital Admission or Discharge

Transportation of a member to a hospital for inpatient admission or from a hospital following discharge from an inpatient stay is 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.

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 2. 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 2 – 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/adjustment 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.

General Billing and Reimbursement Guidelines

The transportation provided 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.

The IHCP limits transportation providers to specific procedure codes based on the provider specialty listed on the provider enrollment file. For complete lists of the procedure codes allowed for each provider specialty under provider type 26 – *Transportation*, see *Transportation Services Codes*, accessible from the [Code Sets](#) page at in.gov/medicaid/providers.

When billing for Southeastern-brokered transportation services, providers must follow the instructions provided in the [Billing and Reimbursement for Brokered NEMT Services](#) section. For all other FFS transportation services, providers must bill the service on the *CMS-1500* claim form, Portal professional claim, or 837P transaction as described in the [Claim Submission and Processing](#) module.

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.

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.

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 5](#) 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 3 lists the modifiers used for transportation. These modifiers are not used in prior authorization (PA) requests.

Table 3 – 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 4.

Procedure code S0215 – *Nonemergency transportation; mileage, per mile* is nonreimbursable. Providers must bill the appropriate mileage code listed in Table 4. For proper reimbursement, providers must not report procedure code S0215 with the codes listed in Table 4.

Table 4 – 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

Note: The IHCP does not apply the medically unlikely edit (MUE) for HCPCS code A0425 billed in excess of 250 units per date of service. Regardless of national billing guidelines, IHCP providers may bill this procedure code for more than 250 units per date of service as appropriate.

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*. When billing T2004, providers need to include the modifier XE – *Separate encounter, a service that is distinct because it occurred during a separate encounter*.

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 5 shows the correct coding methods for multiple passengers.

Table 5 – 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 XE 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 6 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 6 – 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 7 – 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 1 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.

Hospital-to-Hospital Transports

Effective September 4, 2018, all hospital-to-hospital transports, whether emergency or nonemergency, will be nonbrokered services for FFS members. These transports should be scheduled directly with transportation providers and not arranged through Southeastrans. Claims for these transports must be submitted to DXC Technology for adjudication.

Ambulance providers should bill the appropriate procedure codes for emergency or nonemergency ALS or BLS services, based on the types of services provided during the transport. Claims for hospital-to-hospital transports must have the HH modifier appended to the procedure code for the base rate and for mileage as shown in Table 8. Claims submitted without the HH modifier will deny.

Table 8 – Procedure Code/Modifier Combinations for Billing Hospital-to-Hospital Transports, Effective for Transports Scheduled on or after September 4, 2018

Procedure Code	Description
A0425 U1 HH	Ground mileage, per statute mile; ALS
A0425 U2 HH	Ground mileage, per statute mile; BLS
A0426 HH	Ambulance service, advanced life support, nonemergency transport, level 1 (ALS 1)
A0427 HH	Ambulance service, advanced life support, emergency, level 1 (ALS 1-emergency)
A0428 HH	Ambulance service, basic life support, nonemergency transport, (BLS)
A0429 HH	Ambulance service, basic life support, emergency transport, (BLS, emergency)

Pharmacy-Only Transportation

Effective June 1, 2018, the IHCP covers pharmacy-only transports for IHCP members served through the FFS delivery system, subject to limitations established for certain benefit packages. Pharmacy-only transports are allowed when transport is the only option available to obtain prescriptions. Pharmacy-only transports are counted toward a member's 20 one-way trip limitation.

Prescribers and providers are encouraged to help minimize the need for members to make pharmacy-only trips to obtain prescriptions in the following ways:

- Prescribe maintenance drugs with 100 days' supply.
- Encourage members to fill prescriptions at the outpatient pharmacy of the medical facility or office location of the prescriber, if available.
- Use mail-order pharmacy services for prescriptions, if available.
- Coordinate a member's prescriptions or prescription refills so they can be picked up in a single trip, if possible.
- Encourage members to fill prescriptions on return trips from medical appointments. (A stop at a pharmacy when returning home from a medical appointment will not count against a member's transportation service limits.)

Transport to a pharmacy for pickup of prescriptions may be unavoidable under the following urgent situations:

- A prescription must be filled immediately (for example, insulin or other medications that could have serious side effects if not administered).
- There was an error when the prescription was initially filled (for example, the client was given the wrong medication).
- The member's condition will deteriorate if the prescription is not filled within 12 hours.

Note: Under no circumstances should a transportation provider pick up or sign for prescription medication on behalf of a member.

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 medical necessity for additional trips is documented through the PA process (For exceptions, see the [Twenty One-Way-Trip Limitation and Exemptions](#) section.)
- Trips of 50 miles or more one way, unless PA is obtained
- 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

Documentation Requirements for Transportation Services

Note: For information about Southeastrans documentation requirements for brokered NEMT services, see the Southeastrans [Indiana Policy and Procedures Manual](#) at southeastrans.com.

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 9/30/17
- 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 must 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.

Ambulance Transportation (Provider Specialty 260)

The IHCP covers emergency and nonemergency ALS and BLS ambulance services, as well as CAS and NAS services rendered by ambulance providers. 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 9 and 10 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 9 and 10 if the level of service does not meet the EMSC definition of ALS or BLS services. For a complete list of transportation codes billable by ambulance providers (specialty 260), see *Transportation Services Codes*, accessible from the [Code Sets](#) page at in.gov/medicaid/providers.

Table 9 – 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 10 – 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 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, subject to limitations established for certain benefit packages. 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).

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. EMTs and paramedics must document the medical necessity for oxygen use in the medical record maintained by the provider.

Air Ambulance Transportation (Provider Specialty 261)

The IHCP policy regarding air ambulance transportation services applies to both rotary-wing aircraft and fixed-wing aircraft. 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 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 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 air ambulance is not reimbursable.

Prior Authorization for Air Ambulance Transportation

Prior authorization (PA) is required for airline or air ambulance services. The IHCP acknowledges that PA for 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 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 Air Ambulance Transportation

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 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 he or she was 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 Related to Air Ambulance Transportation

Additional information concerning 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, if 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 expires **before takeoff** to the point of member pickup, the IHCP will not reimburse for the trip. It is expected that the flight would be aborted. This policy 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 expires **after takeoff** to the point of member pickup, **but before the member is loaded** on the aircraft, the IHCP will reimburse for the base rate, but will not reimburse for mileage. The provider should bill the appropriate base rate code for either rotary-wing or fixed-wing aircraft, along with the QL modifier:
 - A0430 QL – *Ambulance service, conventional air services, transport, one way (fixed wing); patient pronounced dead after takeoff to point of pickup, but before the patient is loaded*
 - A0431 QL – *Ambulance service, conventional air services, transport, one way (rotary wing); patient pronounced dead after takeoff to point of pickup, but before the patient is loaded*

Note: The mileage code should not be billed. 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.

- If the member expires **after the member has been loaded** on the aircraft, the IHCP will reimburse for the appropriate base rate and for mileage.

Severe 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 member is loaded onboard (either 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 or other circumstance beyond the pilot's control **after** the member is loaded, the appropriate base and mileage codes may be reimbursed.

Base Rate and Mileage for Air Ambulance Transportation

The IHCP provides reimbursement for a base rate and mileage for 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 11 shows Healthcare Common Procedure Coding System (HCPCS) codes for air ambulances services.

Table 11 – Air Ambulance Codes

Procedure Code	Description
A0430	Ambulance service, conventional air services, transport, one way (fixed wing)
A0431	Ambulance service, conventional air services, transport, one way (rotary wing)
A0435	Fixed wing air mileage, per statute mile
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 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.

Additional reimbursement is not available for multiple passengers in an air ambulance, nor is separate reimbursement available for an accompanying parent or attendant in an air ambulance.

For a complete list of transportation codes billable by air ambulance providers (specialty 261), see *Transportation Services Codes*, accessible from the [Code Sets](http://in.gov/medicaid/providers) page at in.gov/medicaid/providers.

Taxi Transportation (Provider Specialty 263)

Taxi providers transport ambulatory members to or from an IHCP-covered service via taxi. Taxi providers 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.

For a complete list of transportation codes billable by taxi providers (specialty 263), see *Transportation Services Codes*, accessible from the [Code Sets](#) page at in.gov/medicaid/providers.

Common Carrier – Ambulatory Transportation (Provider Specialty 264)

Commercial transportation providers that transport ambulatory (walking) members to or from IHCP-covered services can enroll in the IHCP as provider specialty 264 – *Common Carrier (Ambulatory)*.

For CAS transportation, providers can bill separately for base rate, waiting time, and mileage, and receive reimbursement. For a complete list of transportation codes billable by this provider specialty, see *Transportation Services Codes*, accessible from the [Code Sets](#) page at in.gov/medicaid/providers.

Common Carrier – Nonambulatory Transportation (Provider Specialty 265)

Commercial transportation providers that transport members who must travel in a wheelchair to or from IHCP-covered services can enroll in the IHCP as a provider specialty 265 – *Common Carrier (Nonambulatory)*.

For NAS transportation, providers can bill separately for base rate, waiting time, and mileage, and receive reimbursement. For a complete list of transportation codes billable by this provider specialty, see *Transportation Services Codes*, accessible from the [Code Sets](#) page at in.gov/medicaid/providers.

Family Member Transportation (Provider Specialty 266)

Family members or close associates 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.

Family members or close associates may enroll in the IHCP as drivers for a member's nonemergency medical transportation. For reimbursement of mileage, they must then contract with Southeastrans for Traditional Medicaid (FFS) members, or with the MCE's NEMT broker for managed care members.

For the transportation code billable by family member transportation providers (specialty 266), see *Transportation Services Codes*, accessible from the [Code Sets](#) page at in.gov/medicaid/providers.

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.

For a complete list of transportation codes billable by bus transportation providers (specialty 262), see *Transportation Services Codes*, accessible from the [Code Sets](#) page at in.gov/medicaid/providers.

Medical Review Team 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*