INDIANA HEALTH COVERAGE PROGRAMS

PROVIDER REFERENCE MODULE

Transportation Services

Note: For updates to the information in this module, see the following Indiana Health Coverage Programs (IHCP) bulletin, accessible from the IHCP Bulletins webpage at in.gov/medicaid/providers:

- *BT2025119 – IHCP announces updates to transportation billing guidelines*

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6.0	Policies and procedures as of Sept. 1, 2023 Published: Dec. 5, 2024	Scheduled update: • Reorganized and edited text as needed for clarity • Changed Southeastrans references to Verida • Updated references to the IHCP PA contractor where needed • Updated the *Exempted NEMT Services* section and subsections • Updated the *Scheduling Procedures for Brokered NEMT* Services section • Updated the *Billing and Reimbursement for Brokered NEMT Services* section and subsections • Removed the *NEMT Services for Members Residing in Extended Care Facilities Other Than Nursing Facilities* section	FSSA and Gainwell

Version	Date	Reason for Revisions	Completed By
		• Added the *Meals and Lodging* section • Updated address in the *Verida Review and Appeals Process* section • Updated the *Member Copayments* section • Updated the *Prior Authorization for Transportation Services* section • Updated the *General Billing and Reimbursement Guidelines* section • Updated *Table 1 – Transportation Origin and Destination Modifiers* • Updated the *Covered Mileage* section • Updated the *Mileage Procedure Codes* section • Updated the *Hospital-to-Hospital Transports* section • Updated the *Pharmacy-Only Transportation* section • Updated the *Medical Review Team Transportation* section • Removed the *Nursing Home Transportation Provider (Specialty 268)* section • Updated the *Noncovered Transportation Services* section • Updated the *Ambulance Mileage* section • Updated the *EMS Naloxone Billing Procedures* section	
6.1	Policies and procedures as of Sept. 1, 2023 Published: TBD	Interim update: • Added note on title page pointing to *IHCP Bulletin BT2025119*	FSSA and Gainwell

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> *Note: The information in this module applies to Indiana Health Coverage Programs (IHCP) services provided under the **fee-for-service (FFS)** delivery system. For information about services provided through the **managed care** delivery system – including Healthy Indiana Plan (HIP), Hoosier Care Connect or Hoosier Healthwise member services – providers must contact the member's managed care entity (MCE) or refer to the MCE provider manual. 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 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, with the exception of treat-no-transport services. 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.

Most nonemergency medical transportation (NEMT) services for IHCP members served through the fee-for-service (FFS) delivery system are brokered by Verida. Providers rendering transportation services brokered through Verida submit claims for reimbursement to Verida. See the *Brokered Nonemergency Medical Transportation* section for details.

> *Note: Not all members enrolled under the FFS delivery system are eligible for NEMT services. Some FFS benefit plans do not offer coverage for NEMT services, including the following:*
>
> - *Package E – Emergency Services Only*
> - *Package B – Emergency Services Only with Pregnancy Coverage*
> - *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)*

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

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 (excluding hospital-to-hospital ambulance transports) are also considered NEMT services.

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

Figure 1 – IHCP Portal Eligibility Verification for a Member With Nonemergency Medical Transportation Brokered through Verida

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**
05/05/2023	05/05/2023	VERIDA, INC	

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

Verida operates a call center with a toll-free, statewide telephone number for scheduling NEMT services and answering related member and provider inquiries: **855-325-7586**. Information about contracting with Verida and other guidance for transportation providers can be found on the *Indiana Transportation Providers* page at verida.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 Verida. However, some NEMT services are exempt from the requirement to broker the transportation through Verida. The following NEMT services are scheduled directly with the transportation provider and, unless otherwise stated, follow standard FFS billing and reimbursement procedures:

- Transportation for members requiring **basic life support (BLS)** or **advanced life support (ALS)** services during transport or requiring transport via a **stretcher** (See the *NEMT Brokerage Exemption for Advanced Life Support and Basic Life Support Services* section.)
- All **hospital-to-hospital** transports (See the *NEMT Brokerage Exemption for Hospital-to-Hospital Transports* section.)
- Transportation for members residing in **nursing facilities** arranged by designated types of facilities for their residents. (See the *NEMT Brokerage Exemption for Nursing Facility Residents* section for details.)
- 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 Verida.*

- Transportation services provided by **school corporations**
- Transportation for **Medical Review Team** (MRT) services

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.

> *Note: On July 1, 2024, the IHCP added the Indiana PathWays for Aging (PathWays) managed care program. NEMT for PathWays members is also provided through the members' MCE.*

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.

NEMT Brokerage Exemption for Advanced Life Support and Basic Life Support Services

For dates of service on or after July 1, 2023, if a fee-for-service member requires ALS or BLS services during transport, or requires transport via a stretcher, the NEMT service should be scheduled directly with an IHCP-enrolled ambulance provider and **not** arranged through the FFS NEMT broker, Verida. (For prior dates of service, this policy applied only to dually eligible members.)

Ambulance providers should bill the appropriate procedure codes for nonemergency ALS and BLS ambulance services based on the types of services provided according to medical necessity criteria during the transport. For applicable codes, see *Transportation Services Codes*, accessible from the *Code Sets* page at in.gov/medicaid/providers. Claims for these transports must be submitted to Gainwell for adjudication.

This exemption applies only to NEMT services that meet the definition of ALS or BLS. All other NEMT services, including wheelchair van transports provided by ambulance providers, must be scheduled and billed through Verida, unless exempted from brokerage for some other reason (for example, because the member resides in a nursing facility).

See the *Advanced Life Support (ALS) Ambulance Service* and *Basic Life Support (BLS) Ambulance Service* sections for more information, including definitions of ALS and BLS.

NEMT Brokerage Exemption for Hospital-to-Hospital Transports

All hospital-to-hospital transports, including nonemergency wheelchair transports, are nonbrokered services for FFS members. These transports should be scheduled directly with transportation providers and not arranged through Verida. Claims for these transports must be submitted to Gainwell for adjudication, and must have the HH modifier appended to the procedure code, as described in the *Hospital-to-Hospital Transports* section.

NEMT Brokerage Exemption for Nursing Facility Residents

Effective for dates of service on or after July 1, 2023, nursing facilities are responsible for coordinating and reimbursing transportation providers for non-ALS/BLS NEMT services for their IHCP residents. Additionally, with the exception of ALS and BLS transports, IHCP reimbursement for NEMT services provided to nursing facility residents will be considered included in the nursing facility per diem rate and cannot be billed separately to the IHCP.

For nonemergency ambulance transports that meet medical necessity for ALS or BLS services, the nursing facilities must coordinate the ALS or BLS transportation directly with an IHCP-enrolled ambulance provider, and the ambulance provider will submit claims to Gainwell for the appropriate procedure codes based on the types of services provided during the transport.

Nursing facilities are enrolled as provider type 03 – *Extended Care Facility* with one of the following specialties:

- 030 – *Nursing Facility*
- 032 – *Pediatric Nursing Facility*

Scheduling Procedures for Brokered NEMT Services

Verida provides scheduling for brokered NEMT services as follows:

- For nonurgent rides, members contact Verida at least two business days in advance to arrange for transportation. Members must book the trip through the Verida reservation line at **855-325-7586** or the Verida Member Portal at member.verida.com, rather than contacting transportation providers 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) Verida, and the provider's level of transportation is suitable for the member.

  Trips scheduled with fewer than two business days of advance notice need to be confirmed by the member's healthcare provider. Either the member or the healthcare provider can contact Verida to schedule the trip. If the call is made by the member, the provider will also need to contact Verida to confirm the appointment before scheduling the trip.

- For hospital discharges to home, the hospital should call the Verida Facility Dispatch Line at 888-822-6104. Verida 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 transports of members who reside in an extended care facility other than a nursing facility, the facility may call the Verida Facility Assistance Line at 855-325-7588.

> *Note: Verida handles interfacility transports (such as between a hospital and an extended care facility) as **urgent** transports. Urgent transports are required to be serviced within three hours of notice; Verida will make arrangements accordingly.*

The preceding options do not apply to NEMT services that are *excluded* from the brokerage requirement, such as ALS or BLS services, hospital-to-hospital transports, or transportation for members who reside in a nursing facility. Verida does not provide scheduling for such services. See the *Exempted NEMT Services* section for more information.

Emergency transports are not included as NEMT services and instead should be managed via standard 9-1-1 protocols. Emergency transportation occurs when a member's 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 for Brokered NEMT Services

Verida is responsible for obtaining prior authorization (PA) through the IHCP FFS prior authorization and utilization management (PA-UM) contractor, as needed, for brokered NEMT services. Transportation providers are not required to submit PA requests when the service is brokered through Verida.

PA requirements for NEMT mirror the IHCP requirements for nonbrokered transportation services. See the *Prior Authorization for Transportation Services* section for detailed PA information.

Billing and Reimbursement for Brokered NEMT Services

IHCP-enrolled transportation providers must sign a provider agreement with Verida and go through the credentialing process to render NEMT services for FFS members. Interested providers should fill out the *Request for Qualifications and Vehicle List Form*, accessible from the *Indiana Transportation Providers* page at verida.com.

New providers will be required to complete the credentialing process within 60 days of signing a provider agreement. Verida provides training and technical assistance regarding online claim submission for providers participating in its network.

Clean claims submitted to Verida by Wednesday of each week will be paid within 14 days. Providers may arrange for payment by check or electronic funds transfer. Verida provides remittance advices (RAs) detailing claims processed during each payment cycle. The Verida 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 Verida rate agreement detailing these rates. Verida has the ability to negotiate higher and/or special rates with each provider individually.

For more information about Verida policy and procedures, see the *Indiana Transportation Providers* page at verida.com.

Services Originally Arranged as Emergency Transportation but Downgraded to NEMT

Transports initially arranged as Emergency Medical Services (EMS) transports that are ultimately determined to be nonemergencies are reimbursed as follows for FFS members:

- If the ambulance provider provided medically necessary ALS or BLS services, the claim should be submitted to Gainwell for reimbursement.
- If the ambulance trip did not meet medical necessity requirements for ALS or BLS, and the member does not reside in a nursing facility, the ambulance provider should submit the claim to Verida for reimbursement. The claim must be submitted on a *CMS-1500* claim form following current billing guidelines, with "**911 Downgrade. Non-ALS/BLS Trip**" entered in field 23. The claim form can be submitted online via the ZenDesk, which may be accessed through the Verida Provider Portal at provider.verida.com, or it can be submitted by mail to:

  Claim Processing
  Verida
  4751 Best Rd., Suite 300
  Atlanta, GA 30337

- If the ambulance trip does not meet medical necessity requirements for ALS or BLS and the member is a nursing facility resident, the ambulance provider should bill the trip to the nursing facility. IHCP reimbursement for these terms is included in the nursing facility per diem.

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). The following billing requirements apply:

- If the NEMT service is **exempt from brokerage** (see the *Exempted NEMT Services* section), providers should submit the claim 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 **Gainwell** on a *CMS-1500* claim form with the Medicare explanation of benefits (EOB) attached for reimbursement consideration.

  Exception: If the member resides in a nursing facility, and the NEMT service is not an ALS or BLS service, then the transportation provider should bill the nursing facility for reimbursement. As

explained in the *NEMT Brokerage Exemption for Nursing Facility Residents* section, IHCP reimbursement for all NEMT services other than medically necessary ALS and BLS services are included in the nursing facility per diem and are not separately reimbursable.

- If the NEMT service is **not exempt from brokerage**, providers should **not** submit the claim to Medicare; instead, the claim should be submitted directly to **Verida** with a Trip Leg ID (obtained from Verida when scheduling the service).

Meals and Lodging

In certain situations, meals and lodging may be provided for a member and one escort for extended treatment that requires at least one overnight stay. All requests for meals and lodging must be evaluated and preapproved by the Indiana Family and Social Services Administration (FSSA). Should a member require meals and lodging, the transportation broker may employ expense restrictions for overnight travel that aligns with the Indiana State Travel Policy and Procedures. The transportation broker shall incur the cost of meals and lodging as part of the capitation payments it receives. The broker shall use discounted lodging and meal services that might be offered through the medical provider.

Brokered NEMT and Retroactive Eligibility

Occasionally, IHCP transportation providers may receive requests for services from individuals who have filed applications for IHCP coverage, but for whom eligibility has not yet been determined. Transportation providers may choose independently to render transportation services before eligibility has been determined; however, there is no guarantee of IHCP reimbursement for those services.

If NEMT services are rendered and IHCP eligibility for that individual is ultimately established, the provider can receive IHCP reimbursement for those services as long as the member's retroactive eligibility date is on or before the date of service. To receive payment, the provider must follow established IHCP guidance, including refunding any payments collected from the member for the service. If the IHCP requires prior authorization for the service rendered, such authorization may be requested retroactively. The applicable policies and procedures that must be followed are outlined in the *Member Eligibility and Benefit Coverage* module.

If the member's retroactive coverage is under a qualifying eligibility category within the fee-for-service delivery system, the provider must contact Verida for instructions for submitting claims.

Verida Review and Appeals Process

Transportation providers with issues about claims adjudicated by Verida must follow the established review and appeal process through Verida. This process applies regardless of whether or not the transportation provider has a contract with Verida.

When a claim issue arises, providers should first contact Verida via the Verida Provider Portal at provider.verida.com. After logging in, select the ZenDesk option to request an administrative review. An administrative review covers claim questions and is used to report underpayment and overpayment issues. In the event the administrative review process does not resolve the issue, providers may file a formal claim appeal with Verida by sending notice in writing to the following address:

Claim Appeals
Verida Claims
843 Dallas Highway
Villa Rica, GA 30180

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.

> *Note: In accordance with Indiana Code IC 16-31-3-1, vehicles and staff that provide emergency services must be certified by the Emergency Medical Services Commission (EMSC) to be eligible for reimbursement for transports involving either ALS or BLS services.*

Advanced Life Support (ALS) Ambulance Service

IC 16-18-2-7 and the Indiana 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 (AEMT)
- More advanced than the care usually provided by a basic emergency medical technician (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 waiting time are reimbursable for ALS ambulance services. Codes for the ALS base rate include reimbursement for supplies and oxygen; therefore, those items are ***not*** separately reimbursed for ALS ambulance 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

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 and oxygen supplies 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.

Base rate, mileage and waiting time are separately reimbursable for CAS transportation.

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.

Base rate, mileage and waiting time are separately reimbursable for NAS transportation.

Member Copayments

All IHCP copayment requirements were suspended effective April 1, 2020, due to the coronavirus disease 2019 (COVID-19) public health emergency.

In accordance with *House Enrolled Act* (HEA) 1513 (2023), copayments will not be reinstated for most IHCP programs. When the IHCP cost-sharing pause ends, effective July 1, 2024, only Package C – Children's Health Insurance Program (CHIP) will resume its previous copayment requirements. See the *Member Eligibility and Benefit Coverage* module for information about CHIP copayments.

> **Note:* *At the time of this module's publication, cost-sharing for the Healthy Indiana Plan (HIP), including copayments, remains paused. Providers and members are advised to watch for future announcements regarding changes to the HIP program, including possible resumption of cost-sharing obligations.*

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 Package C copayments) rendered on or after the eligibility effective date.

For information specific to retroactive eligibility for Verida brokered NEMT services, see the *Brokered NEMT and Retroactive Eligibility* section.

Prior Authorization for Transportation Services

The IHCP requires PA for the following transportation services:

- Airline or air ambulance services
- Bus services for trips of 50 miles or more one-way
- Train services
- Interstate transportation or transportation services rendered by a provider located out-of-state in a nondesignated area
- All out-of-state pickup and destination locations, except in designated sister cities

For brokered nonemergency transportation services, Verida (not the individual provider) is responsible for securing any required PA for FFS members. See the *Prior Authorization for Brokered NEMT Services* section for more information.

For FFS transportation services that require PA and that are exempt from brokerage, providers must submit the PA request to the IHCP FFS PA-UM contractor via their provider portal or by fax or mail using the *Indiana Health Coverage Programs Prior Authorization Request Form,* available on the *Forms* page at in.gov/medicaid/providers. See the *IHCP Quick Reference Guide* for contact information. For more information on submitting PA requests, see the *Prior Authorization* module.

The following information should be included in the request:

- 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)

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

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 Verida-brokered transportation services, providers must follow the instructions in the *Billing and Reimbursement for Brokered NEMT Services* section. For all other FFS transportation services, providers must bill the service on the professional claim (*CMS-1500* claim form or electronic equivalent) as described in the *Claim Submission and Processing* module.

Providers must bill all transportation services provided to the same member on the same date of service together on one claim. The only exception is when both brokered and nonbrokered services are provided on the same date – in which case, the services must be billed on two separate claims, each submitted to the appropriate entity.

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.

> *Note: Table 3 includes information about the policy for multiple passengers.*

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.

See the *Multiple Passengers* section for billing guidance when the same member is transported on the same date of service, once as a single-passenger trip and the other as a multi-passenger trip.

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.

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 1 lists the individual, single-character transportation modifiers. For a list of all the two-character (origin and destination) modifiers used when billing a trip, see the *Origin and Destination Modifiers for Transportation Services* table in *Procedure Code Modifiers for Professional Claims,* accessible from the *Code Sets* page at in.gov/medicaid/providers.

Note that origin and destination modifiers are not used in prior authorization requests.

Table 1 – Transportation Origin and Destination Modifiers

Modifier	Description
D	Diagnostic or therapeutic site other than P [physician's office] or H [hospital] when these are used as origin codes
E	Residential, domiciliary or custodial facility (other than 1819 facility)
G	Hospital-based ESRD facility
H	Hospital
I	Site of transfer (e.g., airport or helicopter pad) between modes of ambulance transport

Modifier	Description
J	Freestanding ESRD facility
N	Skilled nursing facility
P	Physician's office
R	Residence
S	Scene of accident or acute event
X	Intermediate stop at physician's office on way to hospital (This is a destination code only[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.
- Providers must bill all transportation services provided to the same member on the same date of service together on one claim. The only exception is when both brokered and nonbrokered services are provided on the same date – in which case, the services must be billed on two separate claims, each submitted to the appropriate entity.

Mileage Procedure Codes

To report ground transportation mileage, providers must use procedure code A0425 – *Ground mileage, per statute mile*. For CAS and NAS transports, the appropriate U modifier (U3 and U5, respectively) must be included with the procedure code. Effective for dates of service on or after July 1, 2023, modifiers U1 and U2 are not required when billing A0425 for ALS or BLS transports. Ground mileage for ALS and BLS transports will be reimbursed at the same rate, regardless of whether A0425 is billed with modifier U1 or U2 or with no modifier.

Providers must not fragment mileage. Providers must submit mileage for round trips on one detail line using the A0425 procedure code (and applicable U modifier, if needed), as listed in Table 2.

Procedure code S0215 – *Nonemergency transportation; mileage, per mile* is nonreimbursable and should not be included on the claim.

Table 2 – Ground Transportation Mileage Procedure Code and Modifiers

Code	Description
A0425*	Ground mileage, per statute mile
A0425 U3	Ground mileage, per statute mile; CAS
A0425 U5	Ground mileage, per statute mile; NAS

** A0425 without a U modifier should only be used for ALS or BLS transports. Optionally, modifier U1 or U2 may be included as informational only to denote ALS or BLS level of service, respectively.*

The IHCP does not apply the medically unlikely edit (MUE) for procedure 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 (such as different buildings on the same medical campus) 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, for each additional member transported in the same CAS trip, providers should bill using T2004 – *Nonemergency transport; commercial carrier, multipass provided to more than one patient in the same setting*, instead of the full base code of T2003, and no mileage or waiting time should be billed in conjunction with T2004.

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 3 shows the correct coding methods for multiple passengers.

Table 3 – 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)

Type of Transportation	First Member	Second and Subsequent Members
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)

If the same member is transported on the same date of services, once as a single-passenger trip (T2003) and once as a multiple-passenger trip (T2004), the multiple-passenger trip must be billed with modifier XE – *Separate encounter, a service that is distinct because it occurred during a separate encounter*. Modifier 59 – *Distinct procedural service* is not appropriate for this circumstance.

> *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 Adult or Attendant

Members younger than 16 years of age must have an adult (such as a parent) accompany them to a medical service. In some cases, adult members may also require an attendant to travel or stay with them due to medical necessity. In either situation, the provider should bill the appropriate accompanying adult or attendant code.

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

- Bill the procedure code for the base rate and the accompanying adult or attendant under the IHCP Member ID.
- The IHCP does not provide additional reimbursement for accompanying adult 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 adult or attendant was transported with the IHCP member. This documentation must include the name, signature and relation of the accompanying adult or attendant.

Table 4 lists the base codes and the applicable accompanying adult or attendant code. The provider must bill the base code and the accompanying adult or attendant code using the member's information.

Table 4 – Procedure Codes for Accompanying Adult or Attendant

Type of Transportation	Base Code	Accompanying Adult/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.

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 5 – 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 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.

Hospital-to-Hospital Transports

Ambulance providers should bill the appropriate procedure codes for emergency or nonemergency ALS, BLS or wheelchair transport 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 the *Procedure Code/Modifier Combinations for Billing Hospital-to-Hospital Transports* table of *Transportation Services Codes* on the *Code Sets* page at in.gov/medicaid/providers.

Pharmacy-Only Transportation

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 as well as durable medical equipment and supplies.

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.

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.*

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. All MRT transports must be approved before arranging the service with an approved transportation provider.

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

- T2003 SE – *Nonemergency transportation, encounter/trip*
- T2007 SE – *Transportation waiting time, air ambulance and nonemergency vehicles, one-half (1/2) hour increments*
- A0425 SE – *Ground mileage, per statute mile*

For reimbursement rates, see the Professional Fee Schedule, accessible from the *IHCP Fee Schedules* page at in.gov/medicaid/providers. For more information on MRT billing, see the *Claim Submission and Processing* module.

Noncovered Transportation Services

The IHCP does not reimburse for the following transportation services:

- First 30 minutes of waiting time for any type of conveyance, including ambulance
- Ancillary nonemergency transportation charges, including but not limited to the following:
  - Parking fees
  - Tolls
- 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 without the member present

IHCP Transportation Provider Specialties

The following sections provide basic information about the IHCP provider specialties under which transportation providers (provider type 26) can enroll. See the *Provider Enrollment* module for detailed information about IHCP enrollment and certification requirements and responsibilities for transportation providers.

For a complete list of procedure codes billable by each specialty, see *Transportation Services Codes*, accessible from the *Code Sets* page at in.gov/medicaid/providers.

Ambulance Transportation Providers (Specialty 260)

Providers that transport members by ambulance can enroll in the IHCP as a provider specialty 260 – *Ambulance*. Ambulance providers can be reimbursed for emergency and nonemergency ALS and BLS ambulance services, as well as for CAS and NAS transportation rendered via ambulance. See the *Ambulance Transportation and Related Services* section for billing and reimbursement details specific to this provider specialty.

Air Ambulance Transportation Providers (Specialty 261)

Providers that transport members by rotary-wing or fixed-wing aircraft ambulance can enroll in the IHCP as a provider specialty 261 – *Air Ambulance*. Transportation by air ambulance is covered only for transport to a hospital. 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. For billing and reimbursement details specific to this provider specialty, see the *Air Ambulance Transportation* section.

Taxi Transportation Providers (Specialty 263)

Taxi providers (enrolled under specialty 263 – *Taxi*) 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.

Common Carrier – Ambulatory Transportation Providers (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)*.

Base rate, mileage and waiting time are separately reimbursable for CAS transportation.

Common Carrier – Nonambulatory Transportation Providers (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*).

Base rate, mileage and waiting time are separately reimbursable for NAS transportation.

Family Member Transportation Providers (Specialty 266)

Family members, close associates or able-bodied members may enroll in the IHCP as drivers for a member's nonemergency medical transportation.

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, but not less than the rate established by the Indiana legislature for state employees.

For reimbursement of mileage, after enrolling in the IHCP as transportation providers (with specialty 266 – *Family Member*), these individuals must then contract with Verida for Traditional Medicaid (FFS) members or with the MCE's NEMT broker for managed care members.

The local county office of the Division of Family Resources (DFR) in which the member resides must authorize all family member transportation.

Transportation Network Company (TNC) Provider (Specialty 267)

A transportation network company can enroll in the IHCP under specialty 267 – *Transportation Network Company (TNC)*.

For reimbursement, after enrolling in the IHCP, the TNC provider must then contract with Verida for Traditional Medicaid (FFS) members or with the MCE's NEMT broker for managed care members.

Other – Including Bus Transportation Providers (Specialty 262)

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 (under transportation provider specialty 262 – *Bus*).

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.

Documentation Requirements for Transportation Services

> *Note: For information about Verida documentation requirements for brokered NEMT services, see the Indiana Transportation Providers page at verida.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 5/30/23
- 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 waiting 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 adult or attendant to support the accompanying adult or attendant code billed, if applicable

> *Note: When providers bill an accompanying adult (such as a parent) or attendant as part of the transport, the adult 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. EMS providers must comply with *836 IAC 1-1-5* documentation requirements. 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 and Related Services

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.

Ambulance CAS and NAS Services

The procedure codes listed in Tables 6 and 7 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 6 and 7 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 6 – 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 7 – 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

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 – *Ground mileage, per statute mile* (along with the appropriate U modifier, if applicable) to bill ambulance mileage. Effective for dates of service on or after July 1, 2023, A0425 may be billed without a U modifier for ALS or BLS mileage. Modifiers U1 and U2 are no longer required when billing for ALS or BLS mileage, because the same mileage rate is used for both levels of service. Modifiers U3 and U5 continue to be required when billing mileage for NAS and CAS ambulance transports, respectively.

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.

Naloxone Administration

The IHCP reimburses EMS provider agencies for administering naloxone. This policy does not apply to responding law enforcement agencies. Naloxone administered by responding law enforcement agencies will not be reimbursed by the IHCP.

EMS provider agencies must be EMS-certified provider organizations and enrolled with the IHCP under provider specialty 260 – *Ambulance* to receive reimbursement. EMS provider agencies may bill for both the drug and its administration, in accordance with the billing procedures and documentation requirements described in the following sections.

A transporting EMS provider may bill the IHCP for naloxone administered by another authorized medical provider. In this circumstance, both the following conditions must be met:

- The naloxone was administered by an authorized medical provider *before* the EMS provider arrived on scene.
- A compensatory agreement between the two providers was previously arranged.

The EMS provider may subsequently reimburse the authorized medical provider for administering naloxone according to the established compensatory agreement. The reimbursement must be properly documented, and all information must be included in the patient case record as described in the *EMS Naloxone Documentation Requirements* section.

EMS Naloxone Documentation Requirements

EMS providers are responsible for recording the National Drug Code (NDC) on the patient case record. The NDC, which can be found on the packaging of the drug (see Figure 2), must be recorded exactly as it appears on the package. The NDC will be 10 or 11 digits long, separated by hyphens. **Providers must include the hyphens when recording the NDC in the patient case record.**

Figure 2 – NDC on nasal spray and liquid vial of naloxone

EMS providers must also record in the patient case record the total amount of naloxone administered, as follows:

- Each administered dose of the prefilled nasal spray is considered one unit. EMS providers should record the **total** number of units administered.
- When the liquid (vial) form of naloxone is administered (regardless of the method of administration, such as injection, intravenous or atomizer), the EMS provider needs to record a **total** number of milligrams of naloxone of each individual dose administered.

Note that if the EMS provider administers both the prefilled nasal spray and the liquid naloxone, both the NDC and total amounts should be recorded separately.

When reporting the patient encounter in the patient case record, the EMS provider should include:

- Whether transportation was provided and, if so, the destination
- The NDC of the drug (as written on the packaging, including hyphens and spaces)
- The amount of drug administered

EMS Naloxone Billing Procedures

Coverage applies to eligible members under both the managed care and fee-for-service (FFS) delivery systems. For FFS members, the IHCP reimburses EMS transportation providers (with provider specialty 260 – *Ambulance*) for naloxone and its administration as a **nonbrokered** service, meaning that FFS claims for this service must be submitted to Gainwell rather than to the FFS transportation broker.

Transportation resulting from a 9-1-1 call in which naloxone is administered is considered an emergency; therefore, the transportation is nonbrokered as well. If transportation occurs, both the drug and its administration **must** be billed together on the same claim to receive reimbursement (see Table 8). If transportation does not occur, see later instructions in the *Naloxone Administered With No Transportation* section.

Table 8 – Billing Procedure Codes for Naloxone Drug and Administration

Form	Drug	Administration
Prefilled nasal spray	J3490	96372 U1
Liquid vial	J2310	96372 U2

> *Note: Effective for dates of service on or after June 7, 2024, another naloxone drug code is covered for EMS providers: J2311 – Injection, naloxone hydrochloride (zimhi), 1 mg. Zimhi administration is billed using 96372 U2. All guidance given for J2310 in the following subsections will also apply to J2311.*

Billing for Administration Fee

The administration fee can be billed only **once** per drug form. If an EMS provider uses both the prefilled nasal spray administration and liquid vial for a patient, the EMS billing provider can bill for the administration fee twice, once for each of the drug forms.

Providers must use the appropriate modifier for the form of the drug used, along with the procedure code for the administration, which is 96372 – *Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); subcutaneous or intramuscular.* The administration fee codes and modifiers for the drug forms are:

- 96372 U1 for nasal (prefilled nasal spray)
- 96372 U2 for injection (liquid vial)

The provider billing agency must include the U1 or U2 modifier to distinguish the different types of administration.

> *Note: The use of an atomizer to administer the liquid form of naloxone nasally is considered "injection" for billing purposes.*

Billing for Naloxone Drug

EMS providers use the following procedure codes in billing naloxone:

- Prefilled nasal spray: J3490 – *Unclassified drugs*
- Liquid vial: J2310 – *Injection, naloxone HCl, per 1 mg*

For the **prefilled nasal spray (J3490)**, units for the drug are considered as 1 unit equaling one dose of the nasal form. Providers may bill multiple doses of prefilled nasal spray on one line of the claim. For example, if the EMS provider administered three doses (units) of the prefilled nasal spray, the provider bills 1 unit of procedure code J3490 with an NDC quantity of 3 units.

For the **liquid (vial) form (J2310)**, procedure code billing units are measured in milligrams (mg). The provider billing agency will bill the total number of milligrams administered. Fractions of a milligram should be rounded up to the next whole milligram.

Example for 0.4 mg/mL doses from vial:

- One dose = 0.4 mg = 1 unit
- Two doses = 0.8 mg = 1 unit
- Three doses = 1.2 mg = 2 units

For procedure code J2310, the NDC quantity is the total number of milliliters administered.

Example: If the EMS provider administered three doses of 0.4mg/1mL fluid from the vial, the provider bills 2 units of procedure code J2310 with an NDC quantity of 3 milliliters.

Use separate lines for each form of naloxone used but combine all administrations of the same drug form on one line. For example, providers would enter the 3 units of the prefilled nasal form on one line and 1.2 mg/mL of the liquid vial form on the next line.

Entering NDC Information on Claims

For billing purposes, the NDC must be configured as 11 digits, using what is referred to as a "5-4-2" format:

- The first segment must include five digits.
- The second segment must include four digits.
- The third segment must include two digits.

If the product label displays an NDC with fewer than 11 digits, a zero must be added at the beginning of the appropriate segment to achieve the 5-4-2 format. **Hyphens and spaces are omitted when submitting the NDC number on a claim.** For example, if a package displays an NDC as 12345-1234-1, a zero must be added to the beginning of the third segment to create an 11-digit NDC as follows: 12345123401. For more information, see the *Injections, Vaccines and other Physician-Administered Drugs* provider reference module or contact your Provider Relations consultant.

When submitting the claim for naloxone and its administration, enter the following NDC information in the *NDC for Service Detail* panel for each applicable service detail in the IHCP Provider Healthcare Portal; in the shaded, top-half portion of each applicable service detail (fields 24A–H) on the *CMS-1500* paper claim form; or in equivalent fields in the 837P electronic transaction:

- NDC qualifier of N4 (or select National Drug Code in 5-4-2 Format from the Code Type drop-down list on the IHCP Portal)
- Eleven-digit NDC (*Note: Do not include spaces or hyphens.*)
- Drug description (autofills based on the NDC entered, if using the IHCP Portal)
- NDC unit of measure
  - UN – Unit (for J3490 claims)
  - ML – Milliliter (for J2310 claims)
- NDC total quantity administered

Naloxone Administered With No Transportation

Transportation is **not** required for EMS providers to be reimbursed for naloxone and its administration. In the event that transportation does not occur, EMS providers may bill the IHCP for the drug (J2310 and/or J3490) and for A0998 – *Ambulance response and treatment, no transport* ("treat-no-transport"). The IHCP considers A0998 inclusive of the drug administration if no transportation occurs and will deny the detail for the administration of naloxone (96372 U1/U2) if submitted on the same claim with the same date of service as treat-no-transport (A0998). Administration and treat-no-transport submitted on different claims for the same date of service and by the same provider will pay the first claim processed and deny the second claim, unless modifier XE or 59 is included on the claim, indicating that a separate and distinct service was provided. See the *Treat-No-Transport* section for more information.

Vaccine Administration

The IHCP reimburses EMS provider agencies for administering vaccines. To receive reimbursement, the EMS provider agencies must be EMS-certified provider organizations and enrolled with the IHCP under provider specialty 260 – *Ambulance*. EMS provider agencies will be reimbursed only for the administration of the vaccine and only when provided by a paramedic, an advanced emergency medical technician (AEMT) or (in the case of coronavirus disease 2019 [COVID-19] vaccination only) a basic emergency medical technician (EMT).

For vaccine administration, EMS provider agencies should bill using diagnosis code Z23 – *Encounter for immunization* and applicable procedure codes for ambulance providers (specialty 260) in *Transportation Services Codes*, accessible from the *Code Sets* page at in.gov/medicaid/providers.

For members age 18 or younger, the IHCP reimburses for vaccine administration only if the vaccine was supplied through the Vaccines for Children (VFC) program. When billed for members age 18 or younger, the procedure codes must include the SL modifier to indicate that the vaccine was supplied through the VFC program. If an EMS provider agency is administering a VFC vaccine, the vaccine must be obtained from a VFC-enrolled provider and a representative from the VFC provider must be present during the administration.

EMS provider agencies may establish relationships with VFC-enrolled providers or may become a VFC provider. Providers can direct questions concerning VFC provider enrollment, patient eligibility for VFC, and vaccine orders and distribution to the Indiana Department of Health (IDOH) at immunize@isdh.in.gov. For more information about the VFC program, see the *Injections, Vaccines and other Physician-Administered Drugs* module.

Treat-No-Transport

The IHCP will reimburse EMS providers for appropriate and medically necessary care billed under procedure code A0998 – *Ambulance response and treatment, no transport*. Previously, the IHCP reimbursed EMS providers for treatment rendered only when the patient was transported to the hospital emergency department.

Procedure code A0998 ("treat-no-transport") is billed when care is provided in response to an emergency call to a member's home or on a scene, when an ambulance is dispatched and treatment is provided to the patient without the patient being transported to another site.

Providers should submit A0998 only when all the following requirements are met:

- The response must originate through a 9-1-1 call.
- The member consents to evaluation and treatment.
- After the evaluation, the paramedic or emergency medical technician (EMT) and the patient agree there is not a medical emergency.
- The member does not desire transport to an emergency department for evaluation.
- The member is stable for referral to the patient's physician or other community resource.
- The member has the ability (mental capacity, transportation resources) to obtain assistance and medically indicated follow-up.

If treat-no-transport is provided to the same member multiple times per day, or if treat-no-transport and a separate transportation event occur on the same day, one of the following modifiers must be included on the claim detail to indicate that separate and distinct services were provided:

- Modifier XE – *Separate encounter, a service that is distinct because it occurred during a separate encounter*
- Modifier 59 – *Distinct procedural service*

The IHCP will systematically deny details for procedure code A0998 that are submitted on the same claim and with the same date of service as emergency transportation (procedure code A0427 or A0429) unless modifier XE or 59 is used. The detail will deny with explanation of benefits (EOB) 6539 – *Treat/no transport (A0998) is not payable with transportation (A0427/A0429) or drug administration (96372 U1/U2) on the same date of service*. Treat-no-transport (A0998) and emergency transportation (A0427 or A0429) submitted for the same date of service and on different claims, and without the use of modifier XE or 59, will pay the first claim processed and deny the second claim with EOB 6539.

Air Ambulance Transportation

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 severe weather or other circumstance.

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 or Other Circumstance

Providers should note that if the flight is aborted due to severe 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 severe 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 9 shows procedure codes for air ambulances services.

Table 9 – 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 adult (such as a 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* page at in.gov/medicaid/providers.