
# Transportation Services Provider Handbook

**Illinois Department of Healthcare and Family Services**
**Issued August 25, 2021**

**Revision History**

| Date | Reason for Revisions |
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| Policies and procedures as of December 21, 2018 Published: December 21, 2018 | Updated information since last Transportation Handbook issued – 2008. |
| August 25, 2021 | Medicaid Long Term Services and Supports (MLTSS); Physician Certification Statement (PCS); and Program Integrity topics added; Post-Authorization Request information revised to require receipt within 30 calendar days post-service instead of 20 business days; reference added regarding secure safety car coverage by managed care plans; clarified base rate reimbursement is determined by the county in which the provider(s) are registered with the Department; clarified elective or non-medically necessary transportation services from long-term care facility to long-term care facility is non-covered; clarified prior authorization for non-emergency hospital to hospital transport to a higher level of care is not required; clarified new provider IMPACT enrollment is needed in the buyout/change in ownership process; general cleanup of text and formatting. |

# Transportation Services
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# Foreword

The Department of Healthcare and Family Services (HFS) or "Department" is the agency that administers Illinois' Medical Assistance (Medicaid) Program, as well as other public healthcare programs. This handbook, along with recent provider notices and Chapter 100, Handbook for Providers of Medical Services, General Policy and Procedures, will act as effective guides to participation in the Department's Medical Programs. It is important that both the provider of services and the provider's billing personnel read all materials prior to initiating services to ensure a thorough understanding of the Department's Medical Programs policy and billing procedures. Revisions and supplements to the handbook are released as necessary based on operational need and State or federal laws requiring policy and procedural changes and are posted on the Provider Handbooks webpage. The Department encourages providers to utilize the All Providers Handbook Supplement for guidance in claim submittal.

Providers are held responsible for compliance with all policy and procedures contained herein. Providers should register to receive e-mail notification when new provider information has been posted by the Department.

Charges for covered non-emergency services provided to participants enrolled in a HealthChoice Illinois managed care organization (MCO) must be billed to the MCO. Providers should always verify eligibility before providing services, both to determine eligibility for the current date and to discover any limitations to the participant's coverage. It is imperative that providers check HFS electronic eligibility systems regularly to determine eligibility. The Recipient Eligibility Verification (REV) System, the Automated Voice Response System (AVRS) at 1-800-842-1461, and the Medical Electronic Data Interchange (MEDI) systems are available.

Providers submitting X12 electronic transactions must refer to the Handbook for Electronic Processing. This handbook identifies information specific to conducting Electronic Data Interchange (EDI) with the Illinois Medical Assistance Program and other health care programs funded or administered by the Illinois Department of Healthcare and Family Services.

Transportation provider services are classified as "emergency" or "non-emergency". Both emergency and non-emergency (NEMT) services can include the use of ambulances and fixed wing transports. Non-emergency services also include medicar, taxicab, service car, private automobile, bus, train, and commercial airplane transports.

Non-emergent behavioral health transport services via "secure safety cars" are services that MCOs may render to eligible members. This service is currently not a covered service under Medicaid fee-for-service.

Inquiries regarding fee-for-service coverage of a service or billing issues may be directed to the Bureau of Professional and Ancillary Services at 1-877-782-5565.

# 201 Provider Enrollment

The web-based provider enrollment system is known as Illinois Medicaid Program Advanced Cloud Technology (IMPACT). Both MCO and FFS transportation providers must be enrolled in IMPACT. When enrolling in IMPACT, all required information must be included. Provider Type Specialty must be selected. A Provider Type Subspecialty may or may not be required. The table of IMPACT Provider Types, Specialties and Subspecialties is a reference guide that provides important information for providers enrolling via IMPACT. All information for each transportation vehicle must be included in IMPACT.

## 201.1 Enrollment Requirements

Transportation providers eligible to be considered for participation are those who own or lease, and operate any of the following:

- Ambulances licensed by the Illinois Secretary of State and inspected annually by the Illinois Department of Public Health (Vehicle Registration Type Ambulance).
- All air ambulances possessing a special EMS license and an FAA Air Carrier Certificate issued by the United States Department of Transportation.
- Medicars licensed by the Illinois Secretary of State and the Illinois Department of Public Health if the provider provides and bills for a stretcher.
- Taxis licensed by the Illinois Secretary of State and, where applicable, by local regulatory agencies.
- Service cars licensed by the Illinois Secretary of State as livery or public transportation.
- Private automobiles licensed by the Illinois Secretary of State.
- Other specialized modes of transportation, such as buses, trains and commercial airplanes.

Drivers and vehicles must meet the Illinois Secretary of State licensing requirements, as well as applicable insurance requirements and adhere to any other municipal regulations.

Ambulance providers who provide services within Illinois must be in compliance with the EMS Systems Act (210 ILCS 50). Other transportation provider types based outside of Illinois must provide a valid license, permit or certification from the state where the business is headquartered.

Providers billing for stretcher services must meet the Illinois Department of Public Health licensing requirements found at 77 Ill. Admin. Code Section 515.835.

**Safety Training Certification Requirement** - As required under Public Act 095-0501 and 89 Ill. Admin. Code Section 140.490(f), all providers of non-emergency Medicar, taxi, and service car transportation must certify that all drivers and employee attendants have completed a safety program approved by the Department, prior to transporting participants of the Department's Medical Programs.

The safety training certification is required every three years for all transportation employees. It is the provider's responsibility to ensure their employees are recertified by a Department approved safety training program. Medicar, taxi, and service car providers must maintain documentation of their driver and employee attendant certifications. Failure to produce the documentation upon request from the Department shall result in recovery of all payments made by the Department for services rendered by a non-certified driver or attendant.

Medicar and service car providers receiving federal funding under 49 U.S.C. 5307 (pdf) or 49 U.S.C. 5311 are not subject to the safety training program certification requirement during the period of federal funding. Documentation of the federal funding period must be made available to the Department upon request.

A list of certified safety training providers is maintained on the Department's website.

**Enrollment approval is not transferable** - Change in ownership or corporate structure necessitating a new Federal Tax Identification Number terminates the participation of the enrolled provider. Claims submitted by the new owner using the prior owner's assigned provider number may result in recoupment of payments and other sanctions.

**Fingerprint-Based Criminal Background Checks** - As part of the enrollment process, non-emergency transportation providers, excluding vendors owned or operated by governmental agencies and private automobiles, must submit to a fingerprint-based criminal background check as set forth in 89 Ill. Admin. Code 140.498.

## 201.2 Enrollment Approval

When enrollment is approved, the provider will receive a computer-generated notification, the Provider Information Sheet, listing certain data as it appears on the Department's files. The provider is to review this information for accuracy immediately upon receipt. If all information is correct, the provider is to retain the Provider Information Sheet for subsequent use in completing billing statements to ensure that all identifying information required is an exact match to that in the Department file.

Enrollment of a provider is subject to a provisional period and shall be conditional for one year unless otherwise specified by the Department. During the period of conditional enrollment, the Department may terminate or disenroll the provider from the Medical Assistance Program without cause.

## 201.3 Enrollment Denial

When enrollment is denied, the provider will receive written notification of the reason for denial. Within ten calendar days after the date of this notice, the provider may request a hearing. The request must be in writing and must contain a brief statement of the basis upon which the Department's action is being challenged. If such a request is not received within ten calendar days, or is received, but later withdrawn, the Department's decision

shall be a final and binding administrative determination. Department rules concerning the basis for denial of enrollment are set out in 89 Ill. Admin. Code Section 140.14. Department rules concerning administrative hearing process are set out in 89 Ill. Admin. Code Section 104 Subpart C.

### 201.4 Provider File Maintenance

The information in the Department's files for participating providers must be maintained on a current basis. The provider and the Department share responsibility for keeping the file updated. The provider should ensure that all information in the IMPACT system is accurate and up to date at all times. Provider Enrollment Services (PES) is the section within the Department of Healthcare and Family Services that is responsible for reviewing and approving any modifications to provider enrollment records. All providers must be registered in the HFS IMPACT system.

#### Provider Responsibility

The information contained on the Provider Information Sheet is the same as in the Department's files. Each time the provider receives a Provider Information Sheet, it is to be reviewed carefully for accuracy. The Provider Information Sheet contains information to be used by the provider in the preparation of claims; any inaccuracies found must be corrected by submitting a modification in IMPACT.

Provider change information must be updated via the on-line application available on the IMPACT Provider Enrollment web page. The on-line modification function is available to notify the Department of updates to required enrollment information. Failure of a provider to properly update the IMPACT provider enrollment system with corrections or changes may cause an interruption in participation and payments.

#### Department Responsibility

When a provider submits a modification in IMPACT, the Department will review the request and either reject or approve the modification. The Department will generate an updated Provider Information Sheet reflecting the modification and the effective date of the modification, if appropriate. The updated sheet will be sent to the provider's office address and to all billing providers associated to the provider in IMPACT.

## 202 Provider Reimbursement

### 202.1 Charges

Transportation providers are to submit charges to the Department only after services have been rendered. Charges are to be the provider's usual and customary charges to the public for the services provided. To be eligible for reimbursement, all claims, including claims that are corrected and resubmitted, must be received within 180 days of the date of service, or within 24 months from the date of service when Medicare or its fiscal intermediary must first

adjudicate the claim unless one of the exceptions to the timely filing rule applies. Refer to the Timely Filing Override Submittal Instructions for a list of exceptions to the 180-day rule and billing instructions for each.

### 202.2 Claim Preparation and Submittal

For information on policy and procedures regarding claim submittal, including billing for Medicare covered services and submittal of claims for participants eligible for Medicare Part B, refer to HFS Chapter 100 Handbook for Providers of Medical Services General Policy and Procedures. For technical guidelines for claim preparation and submittal refer to the Handbook Supplement.

### 202.2.1 Paper Claim Submittal

The Department no longer accepts paper claims that do not require an attachment for processing. Paper claim forms received without a valid attachment will be returned to the billing provider address submitted on the paper claim form.

The Department uses a claim imaging system for scanning paper claims. The imaging system allows efficient processing of paper claims and also allows attachments to be scanned. The Department offers a claim scannability/imaging evaluation. Turnaround on a claim scannability/imaging evaluation is approximately seven to ten working days, and providers are notified of the evaluation results in writing. Please send sample claims with a request for evaluation to the following address:

Healthcare and Family Services
201 South Grand Avenue East 2nd Fl - Data Preparation Unit
Springfield, Illinois 62763-0001
Attention: Vendor/Scanner Liaison

For a non-routine claim submittal, use HFS 2248, Special Approval Envelope. A non-routine claim is any claim to which any other document is attached. Non-routine claims may not be electronically submitted.

If envelopes are unavailable, the claims can be mailed to:

Non-Routine Claims:
Illinois Department of Healthcare and Family Services
Attn: Transportation Consultant
P.O. Box 19115
Springfield, IL 62794-9115

HFS 2209 Transportation Invoice:
Illinois Department of Healthcare and Family Services
Post Office Box 19126
Springfield, IL 62794-9126

HFS 3797 (Medicare Crossover Invoice) with attachments:
Illinois Department of Healthcare and Family Services
Post Office Box 19109
Springfield, IL 62794-9109

Providers must use the Department's original claim forms. Carbon copies, photocopies, facsimiles, or downloaded forms are not acceptable. Forms and envelopes should be requested on the Department's Paper Medical Forms Request page.

### 202.2.2 Electronic Claim Submittal

Any services that do not require attachments or accompanying documentation must be billed electronically. Further information concerning electronic claims submittal can be found in Chapter 100, Handbook for Providers of Medical Services General Policy and Procedures, the 5010 Companion Guide, and the MEDI webpage.

Providers billing electronically should take special note that Form HFS 194-M-C, Billing Certification Form, must be signed and retained by the provider for a period of three (3) years from the date of the remittance advice (voucher). Failure to do so may result in revocation of the provider's right to bill electronically, recovery of monies or other adverse actions. Form HFS 194-M-C can be found on the last page of each Remittance Advice that reports the disposition of any electronic claims.

### 202.3 Payment

Payment made by the Department for allowable services will be made at the lower of the provider's usual and customary charge or the maximum rate as established by the Department. Base rate reimbursement is determined by the County in which the provider(s) are registered with the Department.

All claims processed by the Department are assigned a 12-digit Document Control Number (DCN). The DCN format is YDDDLLSSSSSS:

Y - Last digit of year claim was received
DDD - Julian date claim was received
LL - Document Control Line Number
SSSSSS - Sequential Number

Adjudicated claims are identified on the HFS 194-M-2, Remittance Advice. The Remittance Advice is sent to the provider's payee address on file with the Department. Refer to Appendix 3 of the General Policy and Procedures handbook for payment procedures utilized by the Department and explanations of Remittance Advice detail provided to providers.

### 202.3.1 Helicopter and Fixed Wing Transports

Providers of emergency helicopter and fixed wing services must maintain the air flight record, a physician's written statement that indicates the patient's diagnosis and medical need for each service. A general statement such as "transport ordered by an M.D." or "transport to a higher level of care," is not sufficient. Non-emergency fixed wing transports require prior authorization.

Emergency helicopter trips will be reimbursed using an all-inclusive rate depending upon whether the services are for transport team only, helicopter only, or transport team and helicopter services.

Helicopter transportation providers, who own the helicopter and provide their own transport team, will be reimbursed at the Department's maximum rate per trip or the provider's usual and customary charges, whichever is less. To be reimbursed for a team and helicopter, a U3 modifier must be used in addition to the procedure code.

If a hospital provides the transport team but does not own the helicopter, the Department will equally divide the established reimbursement rate or the usual and customary charges of the providers, whichever is less, between the hospital and the helicopter provider.

Hospitals that own their own helicopter and report its costs on their cost reports will not be paid for helicopter transportation services. The Department will not cover the services of helicopter transportation providers that have entered into payment agreements with receiving facilities.

The Department does not pay for international transports.

### 202.3.2 Ambulance Transports

Ambulance trips will be reimbursed a base rate, oxygen rate, and a loaded mileage rate, pursuant to 89 Ill. Admin. Code 140.492 for Basic Life Support (BLS) and Advanced Life Support (ALS) trips. As of April 1, 2021, all emergency ambulance (COS 050) claims should be billed to HFS as fee-for-service claims, even when the participant is in an MCO. This change affects Medicare-Medicaid Alignment Initiative (MMAI), YouthCare for DCFS youth in care, and Medicaid Managed Care Plan (HealthChoice Illinois) billing.

In August, 2019, the Department introduced a supplemental payment methodology that would allow publicly owned transportation providers that deliver ambulance services in the Medical Assistance program to receive supplemental payments for ground emergency medical transportation (GEMT) above the fee schedule rates they currently receive, if their cost to provide the services exceeds the reimbursement the providers currently receive based on the HFS fee schedule. Questions regarding the program should be directed to HFS.GEMT@illinois.gov.

### 202.3.3 Critical Care Transports

Critical Care Transport (CCT) often referred to as Specialty Care Transport (SCT) trips will be reimbursed a base rate, a loaded mileage rate, and oxygen rate when medically necessary. Ancillary charges are included in the base rate established by the Department pursuant to 89 Ill. Admin. Code 140.492. Payment for CCT/SCT is only made to providers who are certified for the service by the Illinois Department of Public Health.

### 202.3.4 Medicar Transports

Medicar trips will be reimbursed a base rate and a loaded mileage rate, pursuant to 89 Ill. Admin. Code 140.492. Refer to Topic 206.1 for the Department's policy on billing mileage for additional passengers. Payment for an attendant, who is a person other than the driver, and non-emergency stretcher, will be made at a maximum rate established by the Department, pursuant to 89 Ill. Admin. Code 140.492. Refer to Topic 206.6 for the Department's policy regarding attendants. If a stretcher is billed, the provider must meet the licensing requirements as established at 77 Ill. Admin. Code 515.835 and 515.840, regarding the Illinois Department of Public Health's rules for Stretcher Van Provider Licensing Requirements, as well as 210 ILCS 50/3.86.

### 202.3.5 Service Car Transports

Service Car trips will be reimbursed at a base rate and a loaded mileage rate pursuant to 89 Ill. Admin. Code 140.492. Refer to Topic 206.6 for the Department's policy on billing mileage for additional passengers. Payment for an attendant, who is a person other than the driver, will be made at a maximum rate established by the Department, pursuant to 89 Ill. Admin. Code 140.492. Refer to Topic 206.6 for the Department's policy regarding attendants.

### 202.3.6 Taxi Transports

Taxis will be reimbursed at the community rate, as set by local government or if no regulated local government rates exist, at a maximum rate established by the Department, pursuant to 89 Ill. Admin. Code 140.492. Payment for an attendant, who is a person other than the driver, will be made at a maximum rate established by the Department, pursuant to 89 Ill. Admin. Code 140.492. Refer to Topic 206.6 for the Department's policy regarding attendants.

### 202.3.7 Private Auto Transports

Private Auto trips will be reimbursed at a loaded mileage rate as set by the Department, pursuant to 89 Ill. Admin. Code 140.492.

### 202.4 Fee Schedule

The fee schedule of allowable procedure codes and special billing information is available on the Department's website.

### 202.5 Managed Long-Term Services and Supports (MLTSS) Claims

The information below provides transportation reimbursement policy clarification for participants who are eligible under Managed Long-Term Services and Supports (MLTSS).

The MCO MLTSS covers the non-emergency transportation categories of service listed below:

- 051 Non-Emergency Ambulance
- 052 Medicar
- 053 Taxi
- 054 Service Car
- 055 Private Auto
- 056 Other Transportation

If a **non-emergency** transportation service is allowed by Medicare and Medicare makes a payment, reimbursement of the Medicare cost-sharing is the responsibility of the HealthChoice Illinois managed care plan.

Cost sharing for MLTSS **emergency** transportation after Medicare adjudication should be billed to the Department.

## 203 Covered Services

A covered service is a service for which payment can be made by the Department in accordance with 89 Ill. Admin. Code 140.3. The services covered in the Medical Assistance Program are limited and include only those reasonably necessary medical and remedial services that are recognized as standard medical care required for immediate health and well-being because of illness, disability, infirmity, or impairment.

If the transportation is subject to prior approval or post-approval authorization by the Department, payment will be made only if approved.

Transportation of a patient to or from a covered source of medically necessary care to the nearest, appropriate, available medical provider is covered and payment can be made only if a cost-free mode of transportation is not available or is not appropriate. It is the responsibility of the referring medical provider to validate that the participant is being referred to the closest appropriate Medicaid provider.

Oxygen usage is a covered service when medically necessary and administered in the transport of a patient by ambulance.

The use of an attendant in the transport of a patient by a medicar, service car, or a taxi is a covered service when medically indicated. The use of an attendant for transport is subject to the Department's transportation prior authorization process.

The use of a stretcher in a medicar is a covered service for non-emergency transport when the medical need of the patient does not require a higher level of special medical services, i.e., paramedics, emergency medical technicians; medical equipment and supplies; or the administration of drugs or oxygen. The requirements for operation of a stretcher van are provided in 77 Ill. Admin. Code 515.860 and 210 ILCS 50/3.86

Basic Life Support (BLS) services, as defined in 77 Ill. Admin. Code 215.100, are covered when the patient's medical condition requires a BLS level of service. A BLS ambulance provides transportation plus the equipment and staff for basic services such as giving first aid, controlling bleeding, administering oxygen, treatment of shock, taking vital signs or administering cardiac pulmonary resuscitation (CPR).

Advanced Life Support (ALS) services, as defined in 77 Ill. Admin. Code 215.100, are covered when the patient's medical condition requires an ALS level of service. An ALS ambulance provides all basic ambulance services and typically has complex life-sustaining equipment and radio or telephone contact with a physician or hospital. An ALS ambulance will have equipment and staff to provide services such as administration of appropriate drugs, intravenous therapy, airway intubation, or defibrillation of the heart.

Critical Care Transport (CCT), often referred to as Specialty Care Transport (SCT), may be provided by: Department-approved critical care transport providers, not owned or operated by a hospital, utilizing EMT-Paramedics with additional training, nurses, or other qualified health professionals as defined by the Illinois Department of Public Health at 77 Ill. Admin. Code 515.860.

Ambulance services must be billed at the appropriate level of service (BLS, ALS, or CCT/SCT).

Emergency air transport service is a covered service when the patient's medical condition is such that immediate and rapid transportation cannot be provided by ground ambulance. An emergency may include, but is not limited to:

- Life threatening medical conditions;
- Severe burns requiring treatment in a burn center;
- Multiple trauma;
- Cardiogenic shock; and
- High-risk neonates.

## 204 Non-Covered Services

Services for which medical necessity is not clearly established are not covered by the Department's Medical Programs. Refer to 89 Ill. Admin. Code 140.6 for a general list of non-covered services.

The Department does not reimburse for transportation provided in connection with any service not reimbursed by the Department's Medical Programs, such as Early Intervention services, sheltered workshops, day care programs, social rehabilitation programs or day training services. In these instances, transportation providers must verify reimbursement sources prior to delivery of services with the entity requesting the service.

Additionally, payment will not be made by the Department for the following:

- Non-emergency transportation where Department prior approval or post-approval authorization is required but has not been obtained.
- Non-emergency transportation beyond the nearest, appropriate, available, medical provider.
- Services medically inappropriate for the patient's condition (e.g., a taxi when public transportation is available and medically appropriate or a Medicar when a service car is warranted).
- Services of a paramedic, emergency medical technician, or nurse in addition to the BLS, ALS, or CCT/SCT rates.
- "No Show" trips (i.e. patient not transported).
- Trips for filling a prescription or obtaining medical supplies, equipment or any other pharmacy-related item.
- Charges for mileage other than loaded miles.
- Transportation of a person who has been pronounced dead by a physician or where death is obvious before transport transpires.
- Charges for waiting time, meals, lodging, parking, tolls.
- Transportation provided in vehicles other than those owned or leased and operated by the provider.
- Elective or non-medically necessary transportation services from Long-Term Care Facility to Long-Term Care Facility.
- Transportation services provided for a hospital inpatient that is transported to another medical facility for outpatient services not available at the hospital of origin and the return trip to the inpatient hospital setting. In this instance, the transportation provider must seek payment from the inpatient hospital. Emergency Services provided in an Emergency Department are not considered outpatient services under this section.
- Transportation to receive services when a patient is a current member of a Managed Care Organization (MCO). The provider must work with the appropriate plan and/or third-party administrator. **Exceptions:** Emergency ground ambulance services for HealthChoice Illinois managed care plan members are covered by the Department

and MLTSS crossover payments for emergency transportation services are also covered by the Department.

- Medical transportation provided for patients who reside in State Operated Facilities (i.e. State Operated Developmental or Mental Health Center). In this instance, the transportation provider must seek payment from the State Operated Facility.
- Services provided by a hospital owned and operated transportation provider where the transportation costs are reported in the hospital's cost report for the following:
    - Transportation services provided on the date of admission and the date of discharge.
    - Transportation services provided on the date that an Ambulatory Procedures Listing (APL) service is performed, or an emergency room visit is made.
- Non-emergency transportation rendered to All Kids Premium Level 2 participants (except for SASS-eligible youth, whose services are covered even with All Kids Premium Level 2).
- Non-emergency transportation rendered to Veterans Care participants without any other form of medical coverage.
- Ambulance trips when the participant was not transported. For example, the ambulance is dispatched but the participant does not require transport.
- Transportation of family members to visit a hospitalized patient.

Out-of-state transportation requests must be submitted to First Transit for prior approval authorization and will require review by the Department.

## 205 Record Requirements

Record requirements for medical transportation services are provided in 89 Ill. Admin. Code 140.494. Refer to the Chapter 100 Handbook for information regarding the maintenance of records and the retention of records.

When appropriate, records must also contain the following documents:

- FAA Air Carrier Certificate issued by the U.S. Department of Transportation.
- A physician's statement indicating the patient's diagnosis and medical necessity.
- The air flight record for air transport services.

Ambulance providers must document medical necessity for the transport on the patient care report. Providers of Advanced Life Support and Critical Care Transport/Specialty Care Transport must include a copy of the Emergency Medical Services Patient Care Report (PCR) or other form as required by the Illinois Department of Public Health.

The Department and its professional advisors regard the preparation and maintenance of adequate records as essential for the delivery of quality medical care. In the absence of proper and complete records, no payment will be made, and payments previously made will be recouped. Lack of records or falsification of records may also be cause for a referral to the appropriate law enforcement agency for further action.

## 205.1 Physician Certification Statement

For all non-emergency transports originating at a hospital or long term care facility (LTC), a HFS 2270 Physician Certification Statement (PCS) form must be completed by the LTC or hospital. A PCS form is not required for non-emergency hospital to hospital transport to a higher level of care.

The PCS form is considered the standardized medical necessity form for non-emergency ground Ambulance, Medicar/Wheelchair Van and Service Car transports. The form must be submitted, or the provider's documented attempt to obtain the requested certification must be submitted in order to receive prior or post approval of transportation.

Completion of the form is required prior to each transport and must be submitted to First Transit for approval. A copy of this form must also be provided to the transportation provider at the time of transport.

This PCS form certifies that the appropriate level of transportation is being requested and is necessary for payment and/or verification of the level of service. This applies to participants covered under fee-for-service programs as well as HealthChoice Illinois Managed Care Organization plans.

LTC and hospitals are required to:

- Develop a policy requiring a physician or their designee to complete the PCS;
- Maintain a copy of the PCS in the patient's medical record; and
- At the request of the transportation provider, assist in completing the PCS if it is incomplete.

In cases when a PCS is not completed prior to or at the time of transport, the PCS must be provided at no charge within 10 calendar days of the request of the transportation provider.

The PCS form is required for repetitive trips. One PCS form may be valid for recurring ground ambulance transports for up to 60 days, while one PCS form may be valid for recurring medi-car/wheelchair van and service car transports for up to 180 days. However, if medical necessity or the level of transportation changes, a new PCS form will be required.

The licensed medical professional who signs the PCS must check the appropriate box indicating their certification. Licensed medical professionals include the Physician (MD/DO), Physician Assistant, Clinical Nurse Specialist (CNS), Registered Nurse (RN), Nurse Practitioner (NP), Discharge Planner, Licensed Clinical Social Workers (LCSW) and Licensed Practical Nurses (LPN).

The PCS is not required prior to transport if a delay in transport can be expected to negatively affect the patient outcome. In these cases, the form must be provided at no charge within 10 calendar days of the request of the transportation provider.

# 206 General Limitations and Considerations

Transportation approval will be given for the nearest available appropriate provider, by the least expensive mode that is adequate to meet the individual's need. When public transportation is available and is a practical form of transportation, payment will not be made for a more expensive mode of transportation, pursuant to 89 Ill. Admin Code 140.491 (a).

## 206.1 Additional Passengers

Anytime more than one passenger is transported in the same vehicle for any portion of a trip, the transportation provider may only charge mileage for the first passenger. The base rate and attendants, if provided, may be charged for each passenger.

Procedure:

- A separate claim must be filed for each passenger.
- Base rate and attendants, if provided, may be charged for each passenger.
- Mileage may only be charged for the first passenger picked up. The mileage charge is limited to the most direct (shortest) route between the origination address and the destination address for the first passenger, no matter how far the first passenger travels.

## 206.2 Car Seats

It is the transportation provider's responsibility to confirm with the child's parent or guardian that they will supply an appropriate car seat for the transport. Providers may choose to provide a car seat; however, it is ultimately the parent/guardian's responsibility and should be discussed when the trip is being arranged.

## 206.3 Residents of Long-Term Care (LTC) Facilities

Prior approval or post approval authorization is required for non-emergency transportation of participants who reside in a Long-Term Care (LTC) Facility.

The Department may not be billed when a participant who is a resident of a LTC facility is transported for a service other than a covered medical service. Examples of non-covered services include, but are not limited to, transportation to a sheltered workshop, day training center, or transport from one LTC facility to another LTC facility. The transportation provider must verify reimbursement source (i.e., the day training center, sheltered workshop or LTC facility) prior to transport.

## 206.4 Hospital-Based (Owned) Transportation Services

Hospitals that own and operate medical transportation vehicles as a corporation separate from the hospital entity must enroll in IMPACT as a Transportation

Facility/Agency/Organizations (FAO), Ambulance – Non-Hospital Based and select the applicable sub-specialty(s). All policies and procedures contained in this handbook apply.

Hospitals that own and operate medical transportation vehicles included as a cost center of the hospital entity must enroll in IMPACT as a Transportation (FAO), Ambulance – Hospital Based and select the applicable sub-specialty(s).

## 206.5 Screening Assessment and Support Services (SASS)

Participants receiving SASS services are eligible for non-emergency transportation services. These services require prior authorization. The provider delivering these services is responsible for assisting in arranging prior authorization in the event the participant or their family cannot safely transport the participant both at times of crisis and non-crisis. The prior approval process for non-emergency transportation is separate from the Crisis and Referral Entry Service (CARES) process.

**Hospital Admits -** Providers of SASS services are responsible for providing a copy of the Illinois Medicaid Crisis Assessment Tool (IM-CAT) form and any other documentation needed to verify the medical necessity and level of transport is to the nearest appropriate available medical provider. In the event a participant is experiencing a mental health crisis and requires transportation to a psychiatric inpatient facility, the provider of SASS services should work with the transportation provider to determine the most appropriate level of transportation and emergency/non-emergency status of the transport. Non-emergent transports at the point of crisis will be handled as an "urgent request" by the transportation approval agent. Additional information regarding transportation for participants receiving SASS services can be found in the SASS Handbook.

**Hospital Discharges** - When a SASS participant is being discharged from a hospital and requires transportation services, prior authorization is required regardless of the level of transportation needed. Due to the uncertainty of discharge timelines, participants or a provider working on behalf of a participant may request transportation approval within 24 to 48 hours prior to discharge. It is important to remember that time to process a non-emergency transportation request is required. Additional medical documentation from the discharging hospital provider is required to justify the level of transportation requested.

Transportation from inpatient psychiatric facilities must utilize the lowest level of transport as supported by the participant's medical necessity.

## 206.6 Coverage of an Employee Attendant and a Non-Employee Attendant

An employee attendant is defined as a person, other than the driver, who is an employee of a Medicar, service car, or taxi company. A non-employee attendant is defined as a family member or other individual who may accompany the participant when there is a medical need for an attendant.

An attendant is covered by the Department in the following circumstances:

- To accompany a patient to a medical provider when needed, such as parent going with a child to the doctor or when an attendant is needed to assist the patient
- To participate in the patient's treatment when medically necessary upon review by the Department

The use of an employee or a non-employee attendant is subject to prior authorization in all situations and is determined on a case-by-case basis.

# 207 Authorization for Non-Emergency Transportation

The Department has contracted with a prior authorization agent to operate a centralized transportation prior and post authorization process.

Prior authorization is required for non-emergency transportation services to and from a source of medical care covered by the Department's Medical Programs. Prior authorization for non-emergency hospital to hospital transport to a higher level of care is not required.

## 207.1 Prior Authorization for Non-Emergency Transportation

The Department contracts with First Transit Inc. to adjudicate prior authorization requests and post authorization requests as provided in 89 Ill. Admin. Code 140.491 for non-emergency transportation services. First Transit assists participants to connect with transportation providers in their area, utilizing a random selection process.

To request a prior authorization, a participant or their designated representative, transportation provider, or medical provider should contact First Transit. Requests for authorizations must be made at least seven (7) business days prior to the date the transportation service is needed. "Business days" means Monday through Friday and does not include Saturdays, Sundays or major holidays.

Prior authorization requests must contain enough information to show medical necessity. First Transit reviews submitted documentation from the medical providers to support the requested categories of service, appropriate level of transport, and assures that the medical service requested by the provider is to the nearest, appropriate, available medical provider. Some transportation requests will require additional information before the request can be processed.

**PassPORT -** First Transit uses its PassPORT system to maintain prior authorization information. PassPORT is a free web portal developed by First Transit for use by providers to process non-emergency transportation prior approval requests. PassPORT enables providers to submit Single Trip and Standing Prior Authorizations requests, view the status of requests, and is available 24 hours a day, 7 days a week, 365 days a year. Information on how to access PassPORT is available at First Transit's NETSPAP site.

## 207.2 Prior Authorization for First Transit, Inc.

Trips may be requested as a single trip or a standing prior authorization. Single trip and standing prior authorization forms are available at First Transit's NETSPAP site.

First Transit's regular business hours are Monday through Friday, 8 AM to 5 PM, excluding major holidays. First Transit can be reached by calling the Provider Line at 866-503-9040 or the Participant Line at 877-725-0569. The TTY Line is 630-873-1449.

### 207.2.1 Single Trip Requests

Single trip requests can be submitted over the phone, by fax, or providers may also submit through PassPORT. When submitting a single trip request, First Transit will ask:

- Recipient identification number (RIN)
- Participant name;
- The participant's authorization to speak with the person calling for them, if that is the situation;
- Pick up address and phone number;
- The appointment date and time;
- The doctor's name and general reason for the doctor visit;
- The name of the office/clinic/hospital destination;
- The address and phone number of the destination;
- If there is a medical or non-medical reason why the participant cannot use public or other transportation;
- If the participant uses a walker, wheelchair, or cane;
- If the participant can travel alone or needs an attendant.

### 207.2.2 Standing Orders

A standing order or a standing prior authorization (SPA) may be obtained when subsequent trips to the same medical source are required based on standing orders for specific medical services at the same location more than three times a month. Please note:

- Standing prior authorization requests are not accepted by telephone.
- Standing prior authorizations requests may be faxed to 630-873-1450 or transportation providers may also submit requests via PassPORT.
- Standing prior authorization requests should be submitted to First Transit at least seven (7) business days in advance of the begin date of the medical services. All medical documentation justifying the level of transportation required by the participant must be submitted with the standing prior authorization request in order for validation to occur.

When requesting a standing prior authorization, the patient's physician or other health professional may be contacted by First Transit to validate the following:

- The participant's name, address, and telephone number;
- Participant's RIN;
- The name and address of the medical provider;
- The date, time and purpose for the appointment;
- Information to determine the level of transportation;
- Transportation provider name and provider number;
- The necessity for ongoing visits;
- Already established appointment dates; and
- The number and expected duration of the required ongoing visits.

First Transit will review the request and take one of the following actions:

1. If the request is approved, First Transit will issue a Request Tracking Number (RTN), (a unique number assigned to each request for non-emergency transportation at the time the request is initially recorded in First Transit's system). First Transit will submit the authorization to the Department's prior authorization system for posting. A Notice of Approval letter or the PassPORT system will contain information necessary to bill the Department for the service. To ensure accurate billing, the transportation provider must wait for the authorization notice before submitting a bill to the Department. The transportation provider should review and verify the authorization information is correct. Providers must contact First Transit to correct errors or make changes to transportation requests.

2. If the request is denied, First Transit will issue an RTN. First Transit will submit the denial, along with the general reason for the denial, to the Department's prior authorization system for posting. A denial letter will be generated to the participant. Denial information will also be mailed to the NET provider or posted on First Transit's PassPORT system.

   The status of the approved or denied request by First Transit is displayed in PassPORT the business morning after the request is adjudicated.

   When a claim is submitted to the Department, the information on the claim must match the prior authorization information or the claim will reject.

Prior authorization to provide services does not include any determination of the patient's eligibility and does not guarantee payment. It is the provider's responsibility to verify the patient's eligibility on the day of the trip in MEDI or 800-842-1461 (AVRS) prior to each transport.

The Department reserves the right for its transportation authorization agent to determine the appropriate mode of transportation and if requested, provide the participant with a random selection of transportation providers enrolled with the Department in the participant's geographic area.

On behalf of the Department, First Transit randomly samples trips to verify the validity of transportation requests.

### 207.3 Prior Authorization Changes

When a change or correction to a prior authorization is necessary, First Transit must be contacted via telephone.

First Transit generates a unique tracking number for all requests.

All dates of service that were billed and paid using the original prior authorization number should not be rebilled. All remaining trips that have not been billed and reimbursed should be billed using the new prior authorization number.

Providers should take caution to not rebill claims that were paid using the original prior authorization number. For billing assistance, please call 877-782-5565 and select the options to speak with a transportation billing representative, options 1, 2, 4, and 4.

If a scheduled appointment is cancelled by the doctor or clinic and the participant is not informed and finds out after reaching the destination, the transportation provider can bill for the trip to and from the appointment. If the participant learns of an appointment cancellation prior to the trip, every effort should be made to contact First Transit and cancel the request.

### 207.4 Post Authorizations

In the event it is not possible to obtain prior authorization for non-emergency transportation, post authorization must be requested as provided in 89 Ill. Admin. Code 140.491(h).

#### 207.4.1 Post Authorization Requests within 30 Calendar Days

First Transit processes post authorization requests made within 30 calendar days of the date of service. Requests must include the same information as required for a prior authorization. Requests submitted to First Transit for transports beyond 30 calendar days of the date of service will be denied.

Requests for post authorization are subject to the same criteria as those for prior authorizations.

#### 207.4.2 Post Authorization Requests after 30 Calendar Days

The Department processes post authorization requests submitted beyond 30 calendar days from the date of service. Providers must submit the post authorization requests to the Department on either the single trip or standing prior authorization form available at First Transit's NETSPAP site. A letter from the provider must accompany the completed form to indicate which exception applies to the request:

a) The Department or the Department of Human Services (DHS) Family Community Resource Center (FCRC) received the patient's application for one of the Department's Medical Programs, but approval of the application had not been issued as of the date of service. In such a case, the post authorization request must be received by the Department no later than ninety (90) calendar days following the date of the Agency's Notice of Decision approving the application.

b) The participant did not inform the provider of his or her eligibility for one of the Department's Medical Programs. In such a case, the post authorization request must be received by HFS no later than six (6) months following the date of service. The request will be considered for prior authorization only if the provider's dated, private pay bill or collection correspondence, that was addressed and mailed to the participant each month following the date of service, is attached to the request.

Requests for exceptions to the post approval deadline are to be submitted to the Department by fax at 217-524-6948 or may be mailed to the following address:

Illinois Department of Healthcare and Family Services
Bureau of Professional and Ancillary Services
Post Approval Requests Exceptions
607 East Adams Street, 4th floor
Springfield, Illinois 62701

### 207.5 Prior Approval Notification

If the requested transportation service is approved, the transportation provider will receive a notice of approval letter for transportation services, listing the approved service(s), if the provider is not signed up in PassPORT. If the provider is signed up in PassPORT, they can check status on the PassPORT site.

## 208 Buy-Out/Change in Ownership Procedures

When a company acquires another transportation company, HFS considers it a buy-out. Effective with the date of the company's purchase, the new provider will need to enroll in IMPACT with a new NPI/Provider Number. The provider must bill for transportation services with its 10-digit NPI number or provider number if an atypical provider.

The company that was sold cannot bill or be reimbursed for any dates of service after the end date of enrollment. The new company cannot bill for transportation services with the purchased company's NPI; therefore, all the prior approvals with the purchased company's NPI and Provider Number that extend beyond the company's end date must be changed.

New companies must request new prior approvals for all new non-emergent transports. HFS allows 90 calendar days from the date of provider enrollment to request revisions to

current approvals and 180 calendar days from the date of the post-approvals to submit claims.

Providers should contact a transportation billing representative for further information at 877-782-5565, options 1, 2, 4 and 4.

## 209 Program Integrity

Providers are expected to obey all laws, civil and criminal, state and federal regulations, and Department policies pertaining to delivery of and payment for health care. The Department monitors all claims to identify suspicious activities and providers suspected of fraud will be criminally investigated and, when appropriate, prosecuted in state or federal court.

Title XIX of the Social Security Act, under which the Medical Assistance Program is administered, provides federal penalties for fraudulent acts and false reporting. In addition to administrative and civil remedies, providers are subject to State and federal laws pertaining to penalties for provider fraud and kickbacks (305 ILCS 5/8A-3). Program members, providers or other individuals who have information regarding possible fraud or abuse should call the Medicaid/Welfare Fraud Hotline, at (844) 453-7283/(844)-ILFRAUD.

Providers suspected of fraud, waste, or abuse shall be subject to the Department's sanction authority, including but not limited to payment suspension, payment denial, monetary penalties, and termination or exclusion from participation in the program. See Illinois Public Aid Code at 305 ILCS 5/12-4.25 and 89 Ill. Admin. Code 140 Subpart B.