



Handbook for Providers of Transportation Services

Chapter T-200 Policy and Procedures for Transportation Services

Illinois Department of Healthcare and Family Services

CHAPTER T-200

Medical Transportation Services

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FOREWORD

PURPOSE

This handbook has been prepared for the information and guidance of transportation providers who provide services to participants in the department's Medical Programs. Contained in this handbook are both policy and procedures for emergency and non-emergency transportation services. This handbook provides information on how to access the department's authorized agent for the transportation prior approval process. This handbook provides information regarding specific policies and procedures relating to transportation services.

This handbook can be viewed on the department's Web site at

<http://www.illinois.gov/hfs/MedicalProviders/Handbooks/Pages/Chapter200.aspx>

It is important that both the provider of service 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 in and supplements to the handbook will be released from time to time as operating experience and state or federal regulations require policy and procedure changes in the department's Medical Programs. The updates will be posted to the department's Web site at

<http://www.illinois.gov/hfs/MedicalProviders/notices/Pages/default.aspx>

Providers will be held responsible for compliance with all policy and procedures contained herein.

Inquiries regarding coverage of a particular service or billing issues may be directed to the Bureau of Comprehensive Health Services at 1-877-782-5565.

CHAPTER T-200

TRANSPORTATION SERVICES

T-200 BASIC PROVISIONS

For consideration for payment by the department for transportation services, a provider enrolled for participation in the department's Medical Programs must provide such services. Services provided must be in full compliance with both the general provisions contained in the Chapter 100, Handbook for Providers of Medical Services, General Policy and Procedures <http://www.illinois.gov/hfs/MedicalProviders/Handbooks/Pages/Chapter100.aspx> and the policy and procedures contained in this handbook. Exclusions and limitations are identified in specific topics contained herein.

The billing instructions contained within this handbook are specific to the department's paper forms. Providers wishing to submit 837P electronic transactions must refer to Chapter 300, Handbook for Electronic Processing <http://www.illinois.gov/hfs/MedicalProviders/Handbooks/Pages/5010.aspx>. Chapter 300 identifies information that is 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.

An approved provider is responsible for the safety and wellbeing of patients during the transport.

All non-emergency transportation requires approval except as specified in Topic T-211.

T-201 PROVIDER PARTICIPATION

T-201.1 PARTICIPATION 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).
- Helicopters 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.
- Taxicabs 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.

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.

Safety Training Certification Requirement- As required under *Public Act 095-0501*, all providers of non-emergency medi-car 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. It is the provider's responsibility to re-certify. Medicar 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 or 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.

Providers of transportation services are classified as emergency or non-emergency. Emergency transportation includes ambulance and helicopter providers. Non-emergency transportation includes medicar, taxicab, service car, private automobile, bus, train, and commercial airplane providers.

The provider must be enrolled for the specific category of service(s) (COS) for which charges are to be made. The categories of service for which a transportation provider may enroll are:

COS	SERVICE DEFINITION
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- | | |
|----|---|
| 50 | Emergency Ambulance- Transportation of a patient whose medical condition requires immediate treatment of an illness or injury.

The destination of an emergency ambulance is a hospital or another source of medical care when a hospital is not immediately accessible.
<div style="text-align: center;">Or</div> Emergency Helicopter- Transportation of a patient when the responsible physician determines such mode to be a medical necessity. Such determination must be documented in writing by the physician. |
| 51 | Non-emergency Ambulance- Transportation of a patient whose medical condition requires transfer by stretcher and medical supervision. The patient's condition may also require medical equipment or the administration of drugs or oxygen, etc., during the transport. |
| 52 | Medicar- Transportation of a patient whose medical condition requires the use of a hydraulic or electric lift or ramp, wheelchair lockdowns, or transportation by stretcher when the patient's condition does not require medical supervision, medical equipment, the administration of drugs or the administration of oxygen, etc. |
| 53 | Taxicab- Transportation by passenger vehicle of a patient whose medical condition does not require a specialized mode. |
| 54 | Service Car- Transportation by passenger vehicle of a patient whose medical condition does not require a specialized mode. |
| 55 | Private Automobile- Transportation by passenger vehicle of a patient whose medical condition does not require a specialized mode. |
| 56 | Other Transportation- Transportation by common carrier, e.g., bus, train or commercial airplane. |

To participate, a transportation provider is required to enroll and file a provider agreement with the department.

Procedure: The provider must complete and submit:

- \$ Form HFS 2243 (Provider Enrollment/Application)
- \$ Form HFS 1413T (Agreement for Participation)
- \$ W9 (Request for Taxpayer Identification Number)

The following documentation must be provided with the application, if appropriate.

- Medicare Method of Payment- ambulance only
- Copy of Secretary of State Vehicle Identification card.
- Copy of approved rate of reimbursement as established by local government authority.
- Copy of FAA Air Carrier Certificate.

The above HFS forms and the W9 may be obtained from the Provider Participation Unit. E-mail requests for enrollment forms should be addressed to:

HFS.PPU@illinois.gov

Providers may also call the unit at 217-782-0538 or mail a request to:

Healthcare and Family Services

Provider Participation Unit

Post Office Box 19114

Springfield, Illinois 62794-9114

<http://www.illinois.gov/hfs/impact/Pages/default.aspx>

The forms must be completed (printed in ink or typewritten), signed and dated in ink by the provider, and returned to the above address. The provider should retain a copy of the forms.

Participation approval is not transferable - When there is a change in ownership of an enrolled transportation company, or a change in the Federal Employer's Identification Number or the Social Security number of an enrolled transportation provider, a new application for participation must be completed. Claims submitted by the new owner, using the prior owner's provider information, 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. Adm. Code 140.498.

T-201.2 PARTICIPATION APPROVAL

When participation is approved, the provider will receive a computer-generated notification, the Provider Information Sheet, listing all data on the department's computer files. The provider is to review this information for accuracy immediately upon receipt. For an explanation of the entries on the form, see Appendix T-3 and T-3a.

If all information is correct, the provider is to retain the Provider Information Sheet for subsequent use in completing claims to ensure that all identifying information required is an exact match to that in the department files. If any of the information is incorrect, refer to Topic T-201.4.

The Provider Participation Unit will assign the enrollment date.

Non-emergency transportation providers are subject to a 180-day probationary enrollment period as set out in 89 Ill Adm. Code 140.11.

T-201.3 PARTICIPATION DENIAL

When participation 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 participation are set out in 89 Ill. Adm. Code 140.14. Department rules concerning the administrative hearing process are set out in 89 Ill. Adm. Code 104 Subpart C.

T-201.4 PROVIDER FILE MAINTENANCE

The information carried 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.

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 are to be corrected and the department notified immediately.

Any time the provider effects a change that causes information on the Provider Information Sheet to become invalid the department is to be notified. When possible, notification should be made in advance of a change.

Procedure: The provider is to line out the incorrect or changed data, enter the correct data, sign and date the Provider Information Sheet with an original signature on the line provided. Forward the corrected Provider Information Sheet to:

Healthcare and Family Services
Provider Participation Unit
Post Office Box 19114
Springfield, Illinois 62794-9114

Failure of a provider to properly notify the department of corrections or changes may cause an interruption in participation and payments. In addition, the prior approval process may be interrupted if the department's prior approval agent does not have correct information.

Department Responsibility

When there is a change in a provider's enrollment status or the provider submits a change the department will generate an updated Provider Information Sheet reflecting the change and the effective date of the change. The updated sheet will be sent to the provider and to all payees listed if the payee address is different from the provider address.

T-202 TRANSPORTATION REIMBURSEMENT

T-202.1 CHARGES

Charges billed to the department must be the provider's usual and customary charge billed to the general public for the same service or item. Providers may only bill the department after the service has been provided.

T-202.2 ELECTRONIC CLAIMS SUBMITTAL

Any services that do not require attachments or accompanying documentation may be billed electronically. Further information concerning electronic claims submittal can be found in Chapter 100, Topic 112.3.

Providers billing electronically should take special note of the requirement that Form HFS 194-M-C, Billing Certification Form, must be signed and retained by the provider for a period of three years from the date of the 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. Refer to Chapter 100, Topic 130.5 for further details.

Please note that the specifications for electronic claims billing are not the same as those for paper claims. Please follow the instructions for the medium being used. If a problem occurs with electronic billing, providers should contact the department in the same manner as would be applicable to a paper claim. It may be necessary for providers to contact their software vendor if the department determines that the service rejections are being caused by the submission of incorrect or invalid data. For information regarding electronic billing please refer to Chapter 300, Handbook for Electronic Processing <<http://www.illinois.gov/hfs/MedicalProviders/Handbooks/Pages/5010.aspx>>

T-202.3 CLAIM PREPARATION AND SUBMITTAL

Refer to Chapter 100, Topic 112, for general policy and procedures regarding claim submittal. For general information on billing for Medicare covered services and submittal of claims for participants eligible for Medicare Part B, refer to Chapter 100, Topics 112.5 and 120.1. For specific instructions for preparing claims for Medicare covered services refer to Appendix T-2.

Form HFS 2209, Transportation Invoice, is to be used to submit charges for transportation services. All services for which charges are made must be coded with specific procedure codes. Procedure codes and reimbursement rates for each transportation provider are listed on the Provider Information Sheet.

The department uses a claim imaging system for scanning paper claims. The imaging system allows more efficient processing of paper claims and also allows attachments to be scanned. Refer to Appendix T-1 for technical guidelines to assist in preparing paper claims for processing. The department offers a claim scannability/imaging evaluation. Please send sample claims with a request for evaluation to the following address:

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

All routine paper claims are to be submitted in a pre-addressed mailing envelope provided by the department for this purpose, HFS 2244. Use of the pre-addressed envelope should ensure that billing statements arrive in their original condition and are properly routed for processing.

For a non-routine claim submittal, use HFS 2248, Special Approval Envelope. A non-routine claim is:

Any claim to which Form HFS 1411, Temporary MediPlan Card, is attached.

Any claim to which any other document is attached.

Should envelopes be unavailable, the HFS 2209, Transportation Invoice can be mailed to:

Healthcare and Family Services
Post Office Box 19105
Springfield, IL 62794-9105

For electronic claims submittal, refer to Topic T-202.2 above. Non-routine claims may not be electronically submitted.

T-202.31 Submittal of Emergency Helicopter Services

Providers of emergency helicopter services, including hospitals, should follow the instructions for claim preparation and submittal set out in Section T-202.3. In addition, the provider's record for each service must contain the air flight record and a physician's written statement that indicates the patient's diagnosis and medical need. A general statement such as "transport ordered by an M.D." or "transport to a higher level of care," is not sufficient.

T-202.4 PAYMENT

Payment made by the department for allowable medical transportation services provided to patients who are not eligible for Medicare will be made at the lower of the provider's usual and customary charge or the maximum rate as established by the department, pursuant to 89 Il. Adm. Code 140.492 and 140.493. Refer to Chapter 100, Topics 130 and 132, for payment procedures utilized by the department and General Appendix 8 for explanations of Remittance Advice detail provided to providers.

Payment made by the department for ambulance or helicopter transportation services provided to patients who are eligible for both Medicare and Medicaid will be at the lower of the provider's usual and customary charge or the maximum rate as established by the department, pursuant to 89 Il. Adm. Code 140.492 and 140.493, or the Medicare allowable rate.

Procedure codes and reimbursement rates for each transportation provider are listed on the Provider Information Sheet.

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 a maximum rate per trip or the usual and customary charges, whichever is less.

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 shall not cover the services of helicopter transportation providers that have entered into payment agreements with receiving facilities.

Emergency helicopter transportation claims that are denied because the patient's condition does not meet medically necessary criteria will be reimbursed by the department at the appropriate ground rate.

Ambulance trips will be reimbursed using a base rate and a loaded mileage rate. When Basic Life Support (**BLS**) is provided, claims made for the administration of oxygen when medically necessary, will be paid at a maximum rate established by the department, pursuant to 89 Il. Adm. Code 140.492.

Advanced Life Support (ALS) trips will be reimbursed using a base rate, loaded mileage rate, oxygen when medically necessary, and all ancillary charges at an all-

inclusive maximum rate established by the department, pursuant to 89 Il. Adm. Code 140.492. Payment for ALS is only made to providers who are certified for the service by the Illinois Department of Public Health.

Medicar trips will be reimbursed using a base rate and a loaded mileage rate, pursuant to 89 Il. Adm. Code 140.492. Refer to T-210.1 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 Il. Adm. Code 140.492. Refer to T-210.6 for the department's policy regarding attendants.

Service Car trips will be reimbursed at a base rate and a loaded mileage rate pursuant to 89 Il. Adm. Code 140.492. Refer to T-210.1 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 Il. Adm. Code 140.492. Refer to T-210.6 for the department's policy regarding attendants.

Taxicab trips will be reimbursed at the community rate, as set by local government or if no regulated local government rates exists, at a maximum rate established by the department, pursuant to 89 Il. Adm. 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 Il. Adm. Code 140.492. Refer to T-210.6 for the department's policy regarding attendants.

Private Auto trips will be reimbursed at a loaded mileage rate as set by the department, pursuant to 89 Il. Adm. Code 140.492.

Unique or Exceptional Modes of Transportation may be reimbursed at a negotiated rate, which is determined prior to transport by the department's prior approval agent.

Billing of excess mileage is not allowed. In performing audits, the department verifies mileage with a travel route software package.

T-202.5 ALLOWABLE PROCEDURE CODES

Procedure codes and reimbursement rates for each transportation provider are listed on the Provider Information Sheet. Anytime a change in procedure codes or rates is made, the provider will receive an updated Provider Information Sheet.

T-203 COVERED SERVICES

A covered service is a service for which payment can be made by the department. Refer to Chapter 100, Topic 103. If the transportation is subject to prior approval by the department, payment will be made only if prior approval has been given. Refer to Topic T-211.

Transportation of a patient to or from a covered source of medically necessary care is covered and payment can be made only if a cost-free mode of transportation is not available or is not appropriate.

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 taxicab is a covered service when medically indicated. The use of an attendant for transport is subject to the department's transportation prior approval process in most instances. Refer to Topic T-210.6 for the department's policy regarding the use of an attendant.

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.

Basic Life Support (BLS) services, as defined in the rules and regulations of the Illinois Department of Public Health, 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 the rules and regulations of the Illinois Department of Public Health, 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.

Ambulance services must be billed at the level of service (ALS or BLS) appropriate for the patient's medical condition.

Emergency helicopter 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.

T-204 NON-COVERED SERVICES

Certain medical services are not covered in the scope of the department's Medical Programs and payment cannot be made for transportation to and from such services. Refer to Chapter 100, Topic 104 for a general list of non-covered services.

The department does not reimburse for transportation provided in connection with any services 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 is required but has not been obtained.
- Services medically inappropriate for the patient's condition (e.g., a taxicab 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 or ALS rates.
- Transportation of a person having no medical need, other than an approved attendant. Refer to Topic 210.6 for the policy regarding the use of an attendant.
- "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.
- Charges for waiting time, meals, lodging, parking, tolls.
- Transportation provided in vehicles other than those owned or leased and operated by the provider.
- 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 in-patient hospital setting. In this instance, the transportation provider must seek payment from the in-patient hospital.
- Transportation to receive services when a patient is a current member of a Managed Care Organization (MCO). Refer to Topic 210.4 for prior authorization information.
- Medical transportation provided for patients who reside in State Operated Facilities. 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.

T-205 RECORD REQUIREMENTS

Refer to Chapter 100, Topic 110.1 for information regarding the maintenance of records and Topic 110.2 regarding the retention of records. The transportation provider's basic record must, at a minimum, contain a dispatcher's log and individual trip ticket that documents the following:

- Identification of the participant (name, address and recipient identification number (RIN).
- Name and address of person requesting the service. Anyone may make this request, including, but limited to, the patient, the transportation provider or the provider of medical care.
- Copy of the Transportation Invoice.
- Identification of the type of vehicle used, (i.e., ambulance, medicar, service car, etc.) and the vehicle's license plate number.
- Name of the driver and attendant, if applicable.
- Medical necessity must be documented for the following circumstances:
 - Non-emergency transportation which does not require prior approval,
 - Use of an ambulance,
 - Administration of oxygen by an ambulance provider,
 - Use of an attendant by a medicar, service car or a taxicab provider, and,
 - Use of a stretcher by a medicar provider.

A sample uniform trip ticket can be found in Appendix T-4. The department does not issue this form or require that providers use it for documentation.

When appropriate, the 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 emergency helicopter services.

In addition, ambulance providers must document the medical necessity for the transport on the trip ticket. Providers of Advanced Life Support transportation must include a copy of the Emergency Medical Services Run Sheet or other form as required by the Illinois Department of Public Health.

The department regards the maintenance of adequate records essential for the delivery of quality medical care. In addition, providers should be aware that medical records are key documents for post-payment audits. Refer to Chapter 100, Topic 110 for record requirements applicable to all providers.

In the absence of proper and complete medical 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.

T-210 GENERAL LIMITATIONS AND CONSIDERATIONS ON COVERED SERVICES

Transportation approval will be given for the least expensive mode of transportation available that is appropriate for the participant. When public transport is available and there is no medical condition to prevent the participant from using public transport, the patient may obtain public transportation passes from the Illinois Department of Human Services (DHS) Family Community Resource Centers (FCRCs).

T-210.1 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. Allowable ancillaries, such as attendants, if provided, may be charged for each passenger.

Procedure:

- A separate HFS 2209 provider invoice must be filed for each passenger.
- Allowable ancillaries, if provided, and the base rate 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.
- Mileage may not be charged for another passenger until the vehicle is empty. (See example below)

Example:

Person	Pick-Up Location	Drop-Off Location	Claim Submittal
1	A	C	Charge base rate and direct mileage from A to C (the additional mileage to pick-up persons 2 and 3 should not be included in the mileage submitted on the claim)
2	B	C	Charge base rate
3	B	D	Charge base rate
4	D	E	Charge base rate and direct mileage from D to E
Note: When Person 3 is dropped off the vehicle is empty. Therefore, the provider may charge mileage for Person 4. Allowable ancillaries, if provided, may be charged for each person.			

T-210.2 RESIDENTS OF LONG TERM CARE FACILITIES (LTC)

Reimbursed by the Department- Prior approval is required for non-emergency transportation of participants who reside in a LTC facility. Refer to Topic T-211.

Not Reimbursed by the Department- The department may not be billed when a participant who is a resident of a LTC Facility is transported for services other than covered medical services. This includes, but is not limited to, transportation to a sheltered workshop or a day training center. The transportation provider should look to the training center or workshop for compensation. Refer to Topic T-204.

T-210.3 HOSPITAL-BASED (OWNED) AMBULANCE

Hospitals that own and operate medical transportation vehicles as a corporation separate from the hospital entity must enroll as a medical transportation provider under the appropriate provider type. All policies and procedures contained in this handbook apply.

Hospitals that own and operate medical transportation vehicles that are included as a cost center of the hospital are required to enroll as a medical transportation provider under provider type 74, Hospital-Based Transportation. Refer to Topic T-204 for non-covered services. Transportation services may be billable in the following instances:

- The origin or destination of the trip is outpatient hospital for primary care physician services.
- The origin or destination of the trip is a source of medical care other than the hospital that owns the transportation service.

T-210.4 PARTICIPANTS ENROLLED WITH A MANAGED CARE ORGANIZATION (MCO)

All non-emergency transportation services for participants enrolled in a MCO must be prior approved by the MCO when transport is needed for medical services covered by the MCO. To obtain prior approval for non-emergency transportation for participants enrolled with an MCO, the MCO must be contacted. The phone number for the MCO is printed on the participant's Medical Program card. MCOs have medical personnel available 24 hours a day to provide prior approval.

Prior approval from the MCO is not required in the following circumstances:

- Emergency services do not require prior approval.
- Participants are not limited to in-network providers for family planning services. If the participant seeks family planning services outside of the MCO network, then the department's transportation approval agent must be contacted for approval of the transport rather than the MCO. Refer to Topic 211.

- Transport for services not covered by the MCO plan, such as, dental and vision services. Contact the department's transportation approval agent. Refer to Topic 211.

T-210.5 PARTICIPANTS RECEIVING SCREENING, SUPPORT AND ASSESSMENT SERVICES (SASS)

Participants receiving SASS services are eligible for transportation services, including an attendant. The SASS provider is responsible for assisting in arranging transportation prior approval for participants and families in the event that the family either cannot, or cannot safely transport the participant both at times of crisis and non-crisis. The prior approval process for non-emergency transportation services is separate from the Crisis and Referral Entry Service (CARES) process. Additional information regarding transportation to SASS services can be found in The Handbook of Providers of Screening, Support and Assessment Services on the HFS Web site at www.illinois.gov/hfs/MedicalProviders/Handbooks/Pages/CMH200.aspx

T-210.6 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 taxicab 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 **employee attendant** or a **non-employee attendant** is a covered service when the mode of transportation is a medicar, service car, or taxicab, and the circumstances constitute a medical necessity, as provided below.

The department will pay for an attendant to accompany an eligible patient to and from the source of a covered medical service in the following circumstances:

- To go with the 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; or
- To learn to care for the patient after getting out of the hospital. The department does not pay for transportation of family members to visit a hospitalized patient.

The use of an employee and a non-employee attendant is subject to prior approval in all situations except for those non-emergency trips described in Topic T-211. In the instances that prior approval is not required for an attendant, medical necessity must be documented in the record.

The department's authorized approval agent may request documentation of medical necessity.

The attendant procedure code(s) used to bill for employee and non-employee attendants is contained in Section 6 of the Provider Information Sheet. Refer to Appendix T-3a for a facsimile of the Provider Information Sheet.

T-211 APPROVAL FOR NON-EMERGENCY TRANSPORTATION

The department has contracted with a prior approval agent to operate a centralized transportation prior approval process.

Except as listed below, prior approval is required for all non-emergency transportation services to and from a source of medical care covered by the department's Medical Programs.

Prior approval is not required for ambulance service from one hospital for admission to a second hospital to receive inpatient services, which are not available at the sending hospital.

In situations when prior approval is not required, providers have the responsibility for verifying the appropriate mode of transportation, the participant's eligibility and the origin and destination prior to accepting the participant for transport.

T-211.1 PRIOR APPROVAL FOR NON-EMERGENCY TRANSPORTATION

Healthcare and Family Services (HFS) contracts with First Transit Inc., to provide prior approvals of requests for non-emergency transportation services. To request a prior approval, medical providers should contact First Transit Inc. Requests for approvals 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 and holidays. Providers may also enroll with First Transit Inc. to submit prior approvals on line at: www.NETSPAP.com

Prior approval requests must contain enough information for the prior approval administrator to make a well-informed decision on medical necessity, appropriateness and anticipated patient benefits of the service.

Prior Approval Process for First Transit

Healthcare and Family Services (HFS) contracts with First Transit Inc., to provide prior approvals of requests for non-emergency transportation services. Each request, single or standing prior approval, must contain enough information for the department's prior approval administrator to make a well-informed decision on medical necessity, appropriateness and anticipated patient benefits of the service.

1. The request for transportation must be made **by calling** First Transit toll-free at: **1-866-503-9040 (TTY: 1-630-873-1449 for the hearing impaired)**
8 a.m. to 5 p.m. - Monday through Friday (closed on State holidays)
2. The request must be made to First Transit at least seven (7) business days (excluding weekends and holidays) prior to the trip.
3. Trips may be requested as a single trip or a standing prior approval.

4. A standing prior approval with duration of up to six (6) months, may be obtained when subsequent trips to the same medical source are required based on standing orders for specific medical services.
 - Standing prior approvals may be submitted by anyone for all services.
 - Standing prior approvals will not be accepted by telephone but are accepted by fax at 312-327-3854.
 - Standing prior approval requests should be submitted to First Transit at least seven 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 approval request in order for validation to occur.
5. When calling for a prior approval, the following information must be provided to First Transit:
 - The participant's name, address and telephone number;
 - Recipient identification number;
 - The name and address of the medical provider;
 - The date, time and purpose for the appointment;
 - Information to determine the level of transportation; and
 - Transportation provider name and provider number

When requesting a standing prior approval, the following also applies:

- The patient's physician or other health professional will be contacted by First Transit to validate the following:
 - Medical appointment(s)
 - Medical need
 - The necessity for ongoing visits
 - Already established appointment dates
 - The number and expected duration of the required ongoing visits.

6. First Transit will review the request and take one of the following actions:
 - A. If the request is approved, First Transit will issue a **Request Tracking Number, (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 approval to HFS' prior approval system for posting. A Notice of Approval letter that contains information necessary to bill HFS for the service will be mailed to the transportation provider. **To ensure accurate billing, the transportation provider must wait for the approval notice before submitting a bill to HFS.** The transportation provider should bring errors on the Notice of Approval to the attention of First Transit.

- B. If the request is denied, First Transit will issue a Request Tracking Number. First Transit will submit the denial, along with the reason for the denial, to HFS's prior approval system for posting. A denial letter will be sent to the participant and the transportation provider.
7. Once the transportation has been provided and the Notice of Approval has been received and reviewed, the transportation provider may bill HFS following established procedures.
8. Upon receipt of the bill (claim) by HFS, prior approval of the transportation will be verified. If the transportation claim is not identical to the transportation approved on the Notice of Approval, the claim will be rejected.

An approval does not guarantee payment. The participant for whom transportation is approved must be eligible at the time each service is provided.

Approval will be given for the least expensive mode of transportation, which is adequate to meet the participants' medical needs. The department reserves the right for its authorized transportation approval agent to determine the appropriate mode of transportation and if necessary, provide the participant with a random selection of transportation providers in the participant's geographic area.

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

T- 211.2 POST APPROVAL FOR NON-EMERGENCY TRANSPORTATION

In the event it is not possible to obtain prior approval for non-emergency transportation, post approval must be requested.

Post approvals will be made only in urgent situations, such as hospital discharges after hours or on a weekend, or medical appointments scheduled for the same day.

Post Approval Requests Within 20 Business Days of the Date of Service

First Transit processes post approval requests made within 20 business days of the date of service, and must include the information required for a prior approval. All criteria for prior approval must be met for post approvals.

Requests for post approvals are subject to the same criteria as those for prior approvals as stated in Topic-211.1.

Post Approval Requests After 20 Business Days of the Date of Service

The department processes post approval requests submitted beyond 20 business days from the date of service. Providers must submit the post approval requests to

the department on either the single trip or standing prior approval form available at www.NETSPAP.com. Additionally, a letter from the provider must accompany the

completed form, and must indicate which of the following exceptions (T-211.2(a) or T-211.2(b)), the post approval is being submitted under:

T-211.2(a) - The department or the DHS FCRC has received the patient's application for one of the department's Medical Programs, but approval of the application has not been issued as of the date of service. In such a case, the post approval request must be received by HFS no later than ninety (90) calendar days following the date of the Agency's Notice of Decision approving the application.

T-211.2(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 approval request must be received by HFS no later than six (6) months following the date of service, but will be considered for payment only if there is attached to the request a copy of the provider's dated, private pay bill or collection correspondence, which was addressed and mailed to the participant each month following the date of service.

Requests for exceptions to the post approval deadline are to be submitted to HFS by fax at 217-524-7120, or may be mailed to the following address:

Bureau of Comprehensive Health Services
Transportation Billing Unit- Post Approval Requests Exceptions
607 East Adams St.
Springfield, Illinois 62701

T-211.3 PRIOR APPROVAL NOTIFICATION

If the requested transportation service is approved, the transportation provider will receive a computer-generated letter, form HFS 3076F, Notice of Approval for Transportation Services, listing the approved service(s). The transportation provider must review the Notice of Approval for Transportation Services for accuracy. If there are errors on the Notice, such as incorrect Origin and Destination Codes, First Transit must be contacted to correct the posted approval.

The transportation claim submitted must match the services that appear on the form HFS 3076F, Notice of Approval for Transportation Services, or the claim will be rejected.