Handbook for Providers of Transportation Services

Illinois Department of Healthcare and Family Services
Issued March 2024

Revision History

Date	Reason for Revisions
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.
March 11, 2024	Reorganized some sections; changed First Transit name to Transdev; clarified in-house safety training; clarified billing instructions on rotary and fixed wing transports; noted category of service 051 – non-emergency ambulance claims must be billed to HFS; added oxygen billing clarification for ambulance transports; added Advanced Life Support 2 guidance/information; removed reference to All Kids Premium Level 2 coverage exclusion for NET services; added acceptable types of Physician Certification Statement (PCS) attempt proof; noted additional medical staff allowed to sign PCS form; Certificate of Transportation Services (CTS) info/guidance added; hospital-to-hospital transport to higher level of care only billing clarification; Relay Line information added; added Transdev as HIPAA-approved vendor for HFS; added ambulance appeal process information; added billing guidance for BLS, ALS, ALS2, SCT; added amended stairs/lifting policy for non-emergency ambulance.

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 customers 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 customer'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 medical transportation (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 (FFS).

Inquiries regarding FFS 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 (ISOS) and inspected annually by the Illinois Department of Public Health (IDPH)(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 ISOS and the IDPH if the provider provides and bills for a stretcher.
- Taxis licensed by the ISOS and, where applicable, by local regulatory agencies.
- Service cars licensed by the ISOS as livery or public transportation.
- Private automobiles licensed by the ISOS.
- Other specialized modes of transportation, such as buses, trains and commercial airplanes.

Drivers and vehicles must meet the ISOS licensing requirements, as well as applicable insurance requirements and adhere to any and all 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 businessis headquartered.

Providers billing for stretcher services must meet the IDPH 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 customers 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. A list of certified safety training providers is maintained on the Department's website. 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 will 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.

Effective January 1, 2022, (pursuant to Public Act 102-0364), contingent upon review and approval by HFS of a transportation provider's safety training curriculum, in-house safety training will be allowed by medicar and service car transportation providers licensed by the IDPH. Providers interested in conducting in-house safety training can submit their safety training curriculum for Department review via email to HFS.Transportation@illinois.gov.

Enrollment approval is not transferable - Change in ownership or corporate structure necessitating a new Federal Tax Identification Number (TIN) 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, NEMT 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.

On-Sites – As part of the enrollment process, NEMT providers are subject to on-site visits by the Office of the Inspector General (OIG).

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 the 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 that is responsible for reviewing and approving any modifications to provider enrollment records. All providers must be enrolled 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 webpage. 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 Billing and 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 customers eligible for Medicare Part B, refer to Chapter 100.

202.2.1 Electronic Claim Submittal

All services must be billed electronically. For claims requiring attachments, providers must use the Attachment Upload Portal. Further information concerning electronic claims submittal can be found in Chapter 300, 5010 Companion Guide.

Providers 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 (3) 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 for further details.

If a problem occurs with electronic billing, providers should contact the Department. 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.

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. Transportation provider fee schedules are posted on the Department's website.

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 the Chapter 100 handbook appendices for payment procedures utilized by the Department and explanations of Remittance Advice detail provided to providers.

202.4 Billing Categories of Service

202.4.1 Helicopter and Fixed Wing Transports

Providers of rotary 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 and rotary wing transports require prior authorization (PA). When a non-emergency rotary wing transport is billed to the Department, the provider must bill using the U3 modifier and the modifier must follow directly after the Origin/Destination codes specified and approved in the PA for the trip.

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.

202.4.2 Ambulance Transports

Ambulance trips may 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 FFS claims, even when the customer is in an MCO.This change affects Medicare-Medicaid Alignment Initiative (MMAI), YouthCare for DCFS Youth In Care (YIC), and Medicaid Managed Care Plan (HealthChoice Illinois) billing.

Effective January 1, 2022, **non-emergency** ambulance (COS 051) claims for MCO HCI customers should be billed to HFS. This change affects HCI Medicaid MCO Plans (HealthChoice Illinois and YouthCare for DCFS YIC).

HCI MCO customers with exclusion code 3 or 6 (see eligibility status listed in MEDI) should request PA from Transdev for non-emergency ambulance services not covered by Medicare and the ambulance company will bill the Department for these services.

MMAI customers (identified in MEDI with exclusion code 8) will go through the appropriate MCO/Broker process for PA and the ambulance company will bill their respective MMAI MCO plan for services covered by Medicare. Non-emergency ambulance services not covered by Medicare require PA from Transdev and will be billed to the Department.

In August 2019, the Department introduced a supplemental payment methodology. This methodology allows publicly owned transportation providers, delivering ambulance services in the Medical Assistance Program, to receive supplemental payments for ground emergency medical transportation (GEMT) above the fee schedule rates, 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.

202.4.3 Critical Care Transports

Critical Care Transport (CCT) often referred to as Specialty Care Transport (SCT) trips may be either non-emergent or emergent. They 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 IDPH.

202.4.4 Medicar Transports

Medicar transport is defined as transportation provided to a customer who is confined to a wheelchair and requires the use of a hydraulic or electric lift or ramp

and wheelchair lockdown when the patient's condition does not require medical observation, medical supervision, medical equipment, the administration of medications, or the administration of oxygen. Medicar trips are non-emergent only and cannot be billed as emergent. 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 206.2 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 IDPH rules for Stretcher Van Provider Licensing Requirements, as well as 210 ILCS 50/3.86.

202.4.5 Service Car Transports

Service Car transport is defined as transportation provided to a customer by a passenger vehicle when that customer does not require ambulance or medicar services. Service Car transports are non-emergent only and cannot be billed emergent. 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 206.1 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 Ill. Admin. Code 140.492. Refer to Topic 206.2 for the Department's policy regarding attendants.

202.4.6 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 206.2 for the Department's policy regarding attendants.

202.4.7 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.

202.5 Fee Schedule

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

202.6 Managed Long-Term Services and Supports (MLTSS) Claims

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

The MCO MLTSS covers the NEMT categories of service listed below:

- 052 Medicar
- 053 Taxi
- 054 Service Car
- 055 Private Auto
- 056 Other Transportation

If a NEMT service is allowed by Medicare and Medicare makes a payment, reimbursement of the Medicare cost-sharing is the responsibility of the HealthChoice Illinois MCO.

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 PA 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 customer is being referred to the closest appropriate Medicaid provider.

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

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 PA process.

The use of a stretcher in a medicar is a covered service for NEMT when the medical need of the patient does not require a higher level of special 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 cardiopulmonary 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.

Advanced Life Support Level 2 (ALS2), as defined is the transportation via ground ambulance vehicle with the provision of medically necessary supplies and services including (1) at least three separate administrations of one or more medications by intravenous push/bolus or by continuous infusion (excluding crystalloid fluids) or (2) ground ambulance transport, medically necessary supplies and services, and the provision of at least one of the following ALS2 procedures:

- Manual defibrillation/cardioversion
- Endotracheal intubation
- Central venous line
- Cardiac pacing
- Chest decompression
- Surgical airway
- Intraosseous line.

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 IDPH 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 and does not require PA 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.
- High-risk neonates.

Non-emergent air transport **does** require PA.

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. Non-reimbursable services may include 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:

- NEMT where Department PA or post-approval authorization is required but has not been obtained.
- NEMT 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 who 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 an MCO. The provider must work with the appropriate plan and/or third-party administrator. **Exceptions:** Emergency and non-emergency ground ambulance services for HCI MCO plan members are covered by the Department, as well as MLTSS crossover payments for emergency and non-emergency transportation services, and MMAI non-emergency ambulance services not covered by Medicare 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 a hospital outpatient or emergency room service is performed.
- NEMT rendered to Veterans Care customers without any other form of medical coverage.
- Ambulance trips when the customer was not transported. For example, the ambulance is dispatched but the customer does not require transport.
- Transportation of family members to visit a hospitalized patient.

Out-of-state transportation requests must be submitted to Transdev for PA and will require review by the Department.

205 Record Requirements

Record requirements for medical transportation services are provided in 89 Ill. Admin. Code140.494. Refer to Chapter 100 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 IDPH.

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 (PCS)

For all non-emergency transports originating at a hospital or long term care facility (LTC), an 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. Private auto transports do not require a PCS form be completed. The form must be submitted, or the provider's documented attempt to obtain the requested certification, must be submitted to receive PA or post approval of transportation. Acceptable documentation includes a signed return receipt from the U.S. Postal Service, facsimile receipt, email receipt, or other similar evidence that the provider attempted to obtain the required PCS from the patient's attending physician or other approved medical professional.

Completion of the form is required prior to each transport and must be submitted to Transdev 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 customers covered under the FFS program, as well as HCI MCOs.

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.
- 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 medicar/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. When a PCS is used for a hospital discharge, that PCS is only valid for that date.

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 (PA), Clinical Nurse Specialist (CNS), Registered Nurse (RN), Nurse Practitioner (NP), Discharge Planner, LTC Medical Director, Licensed Practical Nurse (LPN), Licensed Vocational Nurse (LVN), Social Worker, and Caseworker.

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.

205.2 Certificate of Transportation Services (CTS)

For non-emergency ground ambulance, medicar/wheelchair van or service car transports originating from a home residence, an HFS 2271 Certificate of Transportation Services (CTS) form should be completed by a medical professional on behalf of the customer requesting these levels of transportation assistance. Private auto transports do not require a CTS form be submitted.

The CTS form is considered the Department's standardized medical necessity form for non-emergency ground ambulance, medicar/wheelchair van and service car transports originating from a **home residence**. Completion of the form should occur prior to each transport and be submitted to Transdev for approval. A copy of this form should also be provided to the transportation provider at the time of transport.

The CTS 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 customers covered under the FFS program, as well as HCI MCOs.

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

The licensed medical professional who signs the CTS must also include their title, indicating their certification. Examples of licensed medical personnel who can complete this form include the following: Physician (MD/DO),Physician Assistant (PA), Clinical Nurse Specialist (CNS), Registered Nurse (RN), Nurse Practitioner (NP), Discharge Planner, Licensed Clinical Social Worker (LCSW) and Licensed Practical Nurse (LPN).

A completed PCS or CTS must support medical necessity for the appropriate level of transport being requested. A customer is only eligible for ambulance transportation

if, at the time of transport, he or she is **unable** to travel **safely** in a personal vehicle, taxi, or wheelchair van.

Ambulance transport requests that are for the patient or requestor's preference or convenience, or because another provider with the appropriate type of service is not immediately available, **do not meet criteria** and **will not be eligible for reimbursement**. Service must be to the nearest available appropriate provider/facility.

A customer who requires assistance with stairs or lifting and otherwise meets the criteria for non-emergency ambulance transportation, will be considered as meeting medical necessity for non-emergency ambulance transport purposes. This change applies to PA requests and claims for customers covered under the FFS program, as well as HCI MCOs and the MMAI plans.

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

Additional passengers are allowed to travel with customers that are being transported to medically necessary appointments via medicar, service car or taxi. A passenger is **not** the same as an attendant. A **passenger** is simply an individual who is traveling with the Medicaid customer. This passenger may be a family member (mother, father, grandparent, sibling, etc.) or another non-related individual. Additional passenger(s) who may or may not be Medicaid-eligible have the ability to travel along with a Medicaid-eligible member **if** the transportation provider is aware of the additional passenger(s) and all safety measures are in place, i.e., enough room, seatbelts, car seats, etc.

The transportation provider may **not** charge extra for the additional passenger(s) as this is a courtesy to our customers.

206.2 Coverage of an Employee Attendant and a Non-Employee Attendant

There are two types of attendants, 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 customer when there is a medical need for an attendant.

The use of an employee or a non-employee attendant is subject to PA, determined on a case-by-case basis, and may be covered by the Department in the following circumstances:

- To accompany a customer 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 customer.
- To participate in the customer's treatment when medically necessary upon review by the Department.
- To learn to care for the customer after discharge from the hospital.

The Department does **not** pay for transportation of family members to visit a hospitalized patient.

In cases with more than one customer in the vehicle, a separate claim must be completed for each customer. For example, a mother and son both are Medicaid customers, and both have appointments with medical providers. The transportation provider must fill out a separate claim for each customer. Base rate and attendants, if provided, may also be charged for each customer. However, mileage may only be charged for the first customer picked up. The mileage is limited to the most direct (shortest) route between the original address and the destination address for the first customer, no matter how far the first passenger travels.

A medicar may bill for the services of both an employee and a non-employee attendant. Billings for the services of an employee attendant and a non-employee attendant are allowable when the services are rendered during a single trip. However, a service car and taxi may receive payment only for a non-employee attendant.

206.3 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.

206.4 Residents of Long-Term Care (LTC) Facilities

PA or post approval authorization is required for non-emergency transportation of customers who reside in a LTC facility.

The Department may not be billed when a customer who is a resident of an 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 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.

206.5 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).

206.5.1 Screening Assessment and Support Services (SASS)

Customers receiving SASS services are eligible for non-emergency transportation services. These services require PA. The provider delivering these services is responsible for assisting in arranging PA in the event the customer or their family cannot safely transport the customer both at times of crisis and non-crisis.

The PA process for NEMT 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 customer 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 customers receiving SASS services can be found in the SASS Handbook.

Hospital Discharges – When a SASS customer is being discharged from a hospital and requires transportation services, PA is required regardless of the level of transportation needed. Due to the uncertainty of discharge timelines, customers or a provider working on behalf of a customer 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 customer's medical necessity.

207 Authorization for Non-Emergency Transportation

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

PA is required for NEMT services to and from a source of medical care covered by the Department's Medical Programs.

PA for non-emergency ground ambulance hospital to hospital transport to a higher level of care (services not available at the originating facility) is not required and can be billed directly to the Department. Hospital to hospital transports for a higher level of care utilizing lower categories of services (i.e., medicar or service car) would require PA and should request PA through Transdev. **Please note**: The only hospital to hospital transports covered by the Department are those for a higher level of care. Hospital to hospital transports for other reasons, such as patient preference, outpatient services, or downgraded level of care, are not covered by the Department.

207.1 Prior Authorization for Non-Emergency Medical Transportation

The Department contracts with Transdev Inc. to adjudicate PA requests and post authorization requests as provided in 89 Ill. Admin. Code 140.491 for NEMT services. Transdev assists customers to connect with transportation providers in their area, utilizing a random selection process.

To request a PA, a customer or their designated representative, transportation provider, or medical provider should contact Transdev. Requests for PAs 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.

PA requests must contain enough information to show medical necessity. Transdev 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 - Transdev uses its PassPORT system to maintain PA information. PassPORT is a free web portal developed by Transdev for use by providers to process NEMT PA requests. PassPORT enables providers to submit Single Trip and Standing PA 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 Transdev's NETSPAP site.

207.2 Prior Authorization for Transdev, Inc.

Trips may be requested as a single trip or a standing PA. Single trip and standing PA forms are available at Transdev's NETSPAP site.

Transdev's regular business hours are Monday through Friday, 8 AM to 5 PM, excluding major holidays. Transdev can be reached by calling the Provider Line at 866-503-9040 or the Participant Line at 877-725-0569. The Relay Line is 7-1-1. Please see Transdev's NETSPAP website for a list of all additional Illinois Relay access numbers.

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, Transdev will ask:

- Recipient identification number (RIN).
- Customer name.
- The customer'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 customer cannot use public or other transportation.
- If the customer uses a walker, wheelchair, or cane.
- If the customer can travel alone or needs an attendant.

As a HIPAA-approved PA Vendor for HFS, Transdev may need to speak to the referring physician to verify whether this is the closest appropriate provider for transportation purposes.

207.2.2 Standing Orders

A standing order or a standing PA 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 PA requests are not accepted by telephone.
- Standing PA requests may be faxed to 630-873-1450 or transportation providers may also submit requests via PassPORT.
- Standing PA requests should be submitted to Transdev 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 customer must be submitted with the standing PA request in order for validation to occur.

When requesting a standing PA, the patient's physician or other health professional may be contacted by Transdev to validate the following:

- Customer's name, address, and telephone number.
- Customer'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.
- The number and expected duration of the required ongoing visits.

Transdev will review the request and take one of the following actions:

1. If the request is approved, Transdev will issue a Request Tracking Number (RTN), (a unique number assigned to each request for NEMT at the time the request is initially recorded in Transdev's system). Transdev will submit the authorization to the Department's PA 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 Transdev to correct errors or make changes to transportation requests.

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

   The status of the approved or denied request by Transdev 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 PA information or the claim will reject.

PA 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 customer with a random selection of transportation providers enrolled with the Department in the customer's geographic area.

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

207.3 Prior Authorization Changes

When a change or correction to a PA is necessary, Transdev must be contacted via telephone.

Transdev generates a unique tracking number for all requests.

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

Providers should take caution to not rebill claims that were paid using the original PA 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 customer 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 customer learns of an appointment cancellation prior to the trip, every effort should be made to contact Transdev and cancel the request.

207.4 Post Authorizations

In the event it is not possible to obtain PA for NEMT, 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

Transdev processes post authorization requests made within 30 calendar days of the date of service. Requests must include the same information as required for a PA. Requests submitted to Transdev 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 PA.

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 PA form available at Transdev'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 customer 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 PA only if the provider's dated, private pay bill or collection correspondence, that was addressed and mailed to the customer 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.

207.6 Ambulance Informal Review/Appeal Process

In accordance with 89 Ill. Adm. Code 140.491(j), an ambulance provider may appeal any denial made by the Department or its vendor, Transdev.

An informal review is the first step an ambulance provider has toward appealing a denied decision. The purpose of the informal review is to determine whether the submitted documentation is sufficient to reverse the original denial.

In requesting an informal review, the ambulance provider must submit a written request within 90 calendar days from the date of service and include:

- A copy of the decision issued by Transdev.
- A brief statement of the issue
- Documentation supporting the appeal request.

Transdev will complete the informal review process and mail a written decision to ambulance provider within 60 days from the date received.

If Transdev does not overturn the denial after the informal review, the ambulance provider may request an administrative hearing through the Bureau of Administrative Hearings within 10 calendar days of the informal review determination. All documentation from the informal review, including the informal review decision, shall be emailed to HFS fair hearings at: HFS.FairHearings@illinois.gov or sent to:

Illinois Department of Healthcare and Family Services
Bureau of Administrative Hearings
69 W. Washington St., 4th Fl.
Chicago, IL 60602

The Bureau of Administrative Hearings will schedule the hearing and make the final determination as to whether the ambulance appeal should be upheld or overturned.

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 National Provider Identifier (NPI)/ Provider Number. The provider must bill for transportation services with its 10-digit NPI 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 PAs 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 PAs 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.