

**NEW YORK STATE
MEDICAID PROGRAM**

**TRANSPORTATION MANUAL
POLICY GUIDELINES**

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Section I - Requirements for Participation in Medicaid

To participate in the Medicaid Program, a provider must meet all applicable State, County and Municipal requirements for legal operation.

Department regulation at Title 18 of the New York Code of Rules and Regulations (NYCRR) Section 505.10, which applies to transportation services, can be found at:

<http://www.health.state.ny.us/nysdoh/phforum/nycrr18.htm>.

Qualifications of Ambulance Providers

Only lawfully authorized ambulance services may receive reimbursement for the provision of ambulance transportation.

An ambulance service must meet all requirements of the New York State Department of Health (NYSDOH).

An ambulance service may provide ambulette in addition to ambulance services; however, each ambulance must meet staffing and equipment regulations of a certified ambulance at all times, including occasions when an ambulance vehicle is used as an ambulette.

Qualifications of Ambulette Providers

Only lawfully authorized ambulette services may receive reimbursement for the provision of ambulette transportation.

Ambulettes need to be in compliance with any and all New York State Department of Transportation licensing requirements.

Ambulette drivers must be qualified under Article 19A of the New York State Department of Motor Vehicles' **Vehicle and Traffic Law**.

Some local departments of social services (LDSS) require local certification of new ambulette services prior to new ambulette companies enrolling into the Medicaid Program.

New vendors should contact the LDSS in the area(s) in which they intend to operate to inquire about local certification requirements.

Qualifications of Taxi/Livery Providers

To participate in the Medicaid Program, a taxi/livery provider must meet all applicable State, County and Municipal requirements for legal operation.

Taxi/livery companies must also receive support from the appropriate LDSS in the area in which the taxi/livery intends to operate in order to enroll into the Medicaid Program unless they fall under purview of a local taxi and limousine commission.

Enrollment Requirements of Multiple Operating Locations

To receive reimbursement from the Medicaid Program, transportation providers must be enrolled in the Medicaid Program **and** have a separate provider identification number for each location furnishing supplies, care or services.

When a provider fails to disclose all operating locations to the Department, it is considered an improper practice under Department regulations and could result in administrative action that would affect the provider's participation in the Program.

This could also result in disallowances or penalties being assessed against the provider.

Enrollment must be approved by the Department prior to being eligible to receive Medicaid reimbursement.

Ambulance providers must obtain **Medicare** approval prior to submitting their application for enrollment.

Section II - Transportation Services

Medicaid reimbursement is available to lawfully authorized transportation providers for transportation furnished to recipients whenever necessary to obtain medical care.

Transportation services are limited to the provision of passenger-occupied transportation to or from Medicaid covered services.

The Medicaid Program must assure that necessary transportation is available to recipients. The requirement is based on the recognition that unless needy individuals can actually get to and from providers of services, the entire goal of the Medicaid Program is inhibited at the start.

This assurance requirement means that Medicaid will consider assisting with the costs of transportation when the costs of transportation become a barrier to accessing necessary medical care and services covered under the Medicaid Program. The decision to assist with the costs of transportation is called the prior authorization process.

The Medicaid Program will cover the costs of all modes of transportation, when necessary, as well as the necessary transportation expenses incurred by the Medicaid recipient who must travel an extraordinary distance.

The costs of emergency ambulance transportation do not require prior authorization. All other modes of transportation, while available to a recipient, need to be prior authorized by the appropriate prior authorization official prior to payment by the Medicaid Program.

Approved requests for prior authorization are communicated to the transportation provider via a [roster](#), which lists the information necessary to submit a valid claim to the Medicaid Program.

The information on the claim must match the information on the prior authorization as one condition for the claim to be paid.

Transportation services are distinguished by three separate modes of transportation:

- Ambulance (ground and air),
- Ambulette (wheelchair van) and
- Taxi/Livery.

The mode of transportation used by a recipient may involve a medical practitioner, who is best able to determine the most appropriate mode. Each of these categories of

providers may provide single, episodic transports. Ambulette and taxi/livery providers may also provide group ride transports to and from a daily program.

The Medicaid Program intends to authorize transports using the *least costly, medically-appropriate* mode of transport.

If a Medicaid-eligible client uses the public transit system for the events of daily living, then transportation for the client should be requested at a mode of transportation no higher than that of the public transit system.

Amounts for reimbursement of transportation services are established by the county of recipient fiscal responsibility, usually the LDSS in the county of recipient residence.

Record Keeping Requirements

Payment to ambulette, taxi/livery/van and day treatment transportation providers who transport Medicaid recipients Medicaid-covered services will only be made for services documented in contemporaneous records.

Documentation shall include the following:

- The recipient's name and Medicaid identification number;
- The origination of the trip;
- The destination of the trip;
- The date and time of service; and,
- The name of the driver transporting the recipient.

For auditing purposes, Medicaid recipient records must be maintained and be available to authorized officials for six (6) years following the date of payment.

Ambulance Services

Non-emergency and emergency ambulance services are covered by the Medicaid Program.

In non-emergency situations, a determination must be made by the LDSS or State agency of fiscal responsibility whether the use of an ambulance, rather than a non-specialized mode such as ambulette service, taxi service, livery service or public transportation, is medically necessary.

The recipient's physician, physician's assistant, or nurse practitioner **must** order non-emergency ambulance services.

The only exception to this requirement may be made in the case of emergency ambulance service. In this instance, emergency medical services are provided without regard to the patient's ability to pay and no order is required.

Ambulance services are bound by the operating authority granted them by the NYSDOH.

Ambulance services whose operating authority has been revoked by the NYSDOH will be disenrolled from the Medicaid Program, thus precluding payment from the Medicaid fiscal agent.

Ambulance services must maintain the NYSDOH-required Patient Care Report as a condition of Medicaid reimbursement.

For auditing purposes, Medicaid recipient records must be maintained and be available to authorized officials for six years following the **date of payment**.

Billing for Advance Life Support Assist (ALS)/Fly-Car Service

Advanced Life Support Assist/Fly-Car Service, as defined in the definition section of this manual, is an emergency advanced life support response in conjunction with an emergency ambulance transport provided by another ambulance service.

This type of service should not be billed at the regular ALS reimbursement rate, which is established for those providers who deliver ALS and transport the patient in the provider's vehicle.

ALS-assist services can only be billed if the LDSS has established a unique reimbursement amount for this service.

Billing for Advanced Life Support services vs. Basic Life Support services

Ambulance companies may not bill Medicaid for both basic life support services (BLS) and advanced life support services when advanced life support service is provided. This type of billing is incorrect for those counties that have established separate rates for advanced life support and basic life support services.

*The provision of advanced life support services **includes** the delivery of basic life support services.*

When an ambulance is sent to the scene and it provides advanced life support services, only that service may be billed to the Medicaid Program.

Ambulance Transportation of Neonatal (Newborn) Infants to Regional Perinatal Centers

Neonatal (newborn) ambulance transportation services (surface only) of critically ill newborn infants between community hospitals and Regional Perinatal Centers (RPCs) are the responsibility of each RPC.

The RPC will arrange for necessary ambulance services and be reimbursed directly by Medicaid for the costs of that ambulance transportation service.

Regionalization of neonatal services into a single system of care was established by the NYSDOH to assure that each infant who requires intensive care receives it as expeditiously as possible in the appropriate facility. These facilities (RPC's) have affiliation agreements with community hospitals within their region.

The RPC is responsible for finding a RPC hospital bed and arranging for neonatal ambulance transportation of the critically ill infant to the RPC. At the time of discharge the RPC will arrange for the transfer of the infant back to the community hospital.

LDSS staff will not accept requests from hospitals for prior authorization of this ambulance transportation service. The service will be authorized by the RPC, and they will make payment to the ambulance company.

Please note that neither air transportation of neonatal infants nor maternal transportation is covered under the Regional Perinatal Center Program.

Air Ambulance Guidelines and Reimbursement

In determining whether air ambulance transportation reimbursement will be authorized the following critical guidelines can be used:

- The patient has a catastrophic, life-threatening illness;
- The patient is at a hospital that is unable to properly manage the medical condition;
- The patient needs to be transported to a uniquely qualified hospital facility;
- Ground transport to the uniquely qualified hospital facility is not appropriate for the patient;
- Rapid transport is necessary to minimize risk of death or deterioration of the patient's condition; and,
- Life-support equipment and advanced medical care is necessary during transport.

A case-by-case prepayment review, by the local district's Medical Director of the ambulance provider's *Pre-hospital Care Report*, will enable the LDSS to determine if these guidelines were met.

Transportation of a Hospital Inpatient

When a Medicaid recipient is admitted to a hospital (under Article 28 of the Public Health Law), the hospital is reimbursed their inpatient rate, Diagnostic Related Group (DRG) and per diem, which **includes all transportation services for the patient.**

If the admitting hospital sends a Medicaid inpatient (round trip) to another hospital for purposes of obtaining a diagnostic or therapeutic service, **the original admitting hospital is responsible for the provision of the transportation services.**

The admitting hospital is responsible for the reimbursement of the ambulance or other transportation service for the transport of the patient.

For example: An admitting hospital arranges for the round trip transport of a Medicaid inpatient to another hospital for a diagnostic test. The admitting hospital should reimburse the transportation provider for the transport of the patient.

Fixed-Wing Air Ambulance

The following fixed-wing air ambulance services are reimbursable:

- Base Rate (Lift-off/call-out amount);
- Patient Loaded Mileage;
- Physician (when ordered by hospital);
- Respiratory Therapist
(When ordered by the hospital, and only when the hospital is unable to supply);
- Destination Ground Ambulance Charge
(To be charged only when the destination is out of state)

The District of fiscal responsibility, or the Department, should be contacted for the current rates.

The established rates assume the following:

- The provider will be responsible for advanced life support services, inclusive of all services and necessary equipment, except as noted above;

- The provider will be responsible for paying the charges of ground ambulance at the destination end of the trip only when the destination is out-of-state.

When the destination is within New York State, the Destination Ground Ambulance charge can be billed to the Medicaid Program by the provider. Ground ambulance charges for trips within New York State will be submitted at the established basic life support rate on a fee-for-service basis by the ground ambulance company providing transportation between the airport and the hospital;

- These amounts will be applied regardless of time or date of transport, i.e., day, night, weekend and holiday;
- The provider will not seek or accept additional reimbursement from the Medicaid recipient (under any circumstances when billing the Medicaid Program), other individuals, or a facility, except when a third party insurance is billed, in which case the provider will be reimbursed as follows:
 - a) For patients covered by Medicare, Medicaid will pay the coinsurance and deductible amount.
 - b) For patients covered by other third parties, Medicaid will pay the coinsurance and deductible amount up to the Medicaid rate. If the insurance company pays more than the Medicaid rate, Medicaid will not make any additional reimbursement.
 - c) When an air ambulance bill is rejected by a third party insurance with the determination that the trip was medically **unnecessary**, the provider will not bill the Medicaid Program. If the third party insurance pays at the ground ambulance rate, Medicaid will reimburse as described in a) or b).
- The mileage rate will be applied only to patient **loaded** miles, i.e., those miles during which the patient is on the aircraft.

Unloaded mileage, i.e., those miles covered while the aircraft is in transit to receive the patient or while the aircraft is returning to base, will not be charged.

Helicopter Air Ambulance

The following helicopter air ambulance services are reimbursable:

- Lift-off from base and
- Patient Occupied Flight Time.

The District of fiscal responsibility, or the Department, should be contacted for the current rates.

Transport from an Emergency Room to a Psychiatric Center

An ambulance service may be requested to transfer a Medicaid recipient, undergoing an acute episode of mental illness, from an emergency room to a psychiatric hospital.

Hospital and law enforcement officials, when dealing with such a person, must use an ambulance vehicle in transporting that person to acute psychiatric care; they do **not** use non-emergency modes of transportation such as ambulette or taxi.

A transport of a mentally ill individual under the above conditions is an emergency ambulance transport as defined in this Manual.

This transportation ordered by hospital or law enforcement staff qualifies as an emergency ambulance transport; i.e., the patient is in immediate need of acute psychiatric care that is to be provided at the psychiatric hospital.

These ambulance transports should be treated as an emergency transport. Prior authorization from the LDSS is not required.

Transport from an Emergency Room to a Trauma, Cardiac Care or Burn Center

An ambulance service may be requested to transfer a Medicaid recipient from an emergency room to a regional trauma, cardiac or burn center.

These ambulance transports should be treated as an emergency transport. Prior authorization from the LDSS is not required.

Ambulance Transportation by Voluntary Ambulance Services

Voluntary ambulance services may bill the Medicaid Program for the transportation of a Medicaid recipient when the following conditions are met:

- The Voluntary Ambulance Service has been authorized by the LDSS to bill Medicaid at a rate established for this transportation; and,
- The Voluntary Ambulance Service first bills all other third party insurance companies.

Rules for Ordering Non-emergency Ambulance Transportation

A request for prior authorization for non-emergency ambulance transportation must be supported by the order of an ordering practitioner who is the Medicaid recipient's attending physician, physician's assistant or nurse practitioner.

A diagnostic and treatment clinic, hospital, nursing home, intermediate care facility, long term home health care program, home and community based services waiver program, or managed care program may order non-emergency ambulance transportation services on behalf of the ordering practitioner.

Non-emergency ambulance transportation may be ordered when the recipient is in need of services that can only be administered by an ambulance service. The ordering practitioner must note in the recipient's patient record the recipient's condition that qualifies the use of non-emergency ambulance services.

An ordering practitioner, or facilities and programs ordering on the practitioner's behalf, which do not meet the above rules, may be sanctioned according to the regulations established by the DOH.

Medicare Involvement (18 NYCRR Section 360-7.3)

Medicare, in many instances, is obligated to pay for ambulance transportation for patients with Medicare Part B coverage.

Medicare guidelines require that the patient be suffering from an illness or injury which contraindicates transportation by any other means. This requirement is presumed to be met in the following instances when the patient:

- Was transported in an emergency situation, e.g.; as a result of accident, injury, or acute illness;
- Needed to be restrained;
- Was unconscious or in shock;
- Required oxygen or other emergency treatment on the way to the destination;
- Had to remain immobile because of a fracture that had not been set or the possibility of a fracture;
- Sustained an acute stroke or myocardial infarction;
- Was experiencing severe hemorrhage;
- Was bed confined before and after the ambulance trip; or
- Could be moved only by stretcher.

Ambulance services shall submit a claim to the Medicare carrier when transportation has been provided to a Medicare eligible person.

Upon approval by Medicare of the claim, a claim may be submitted to Medicaid.

Claims for ambulance services will be reviewed by the Medicaid Program to determine if the recipient has Medicare and if the provider billed Medicare prior to submission to Medicaid.

When an ambulance service has been instructed by the Medicare carrier **not** to submit a claim to the carrier for the ambulance transportation of a person covered under Medicare Part B because Medicare does not cover that particular service (for example, the transport of a person to a physician's office), the ambulance service must submit evidence of such instructions to the Prior Authorization Official.

The Prior Authorization Official will then determine if Medicaid reimbursement will be authorized.

Ambulance services are covered under Medicare Part A when a hospital inpatient is transported to and from another hospital or freestanding facility to receive specialized treatment not available at the first hospital.

The ambulance service is included in the hospital's Medicare Part A payment.

In such situations when an ambulance service transports a hospital inpatient covered under Medicare to medical care not available at the hospital, the ambulance service shall seek reimbursement from the hospital.

The provider shall **not** seek authorization from the Prior Authorization Official nor shall the provider submit a claim to Medicaid for reimbursement.

Reimbursement for ambulance transportation of a hospital inpatient covered only under Medicaid to and from another hospital or freestanding facility to receive specialized treatment not available at the first hospital may be included in the hospital's reimbursement or may be available as a separately billed service.

The provider shall contact the Prior Authorization Official to determine whether reimbursement should be sought from the hospital or claimed through the eMedNY.

In general, when an original admitting hospital sends a Medicaid inpatient to another hospital for purposes of obtaining a diagnostic or therapeutic service not available in the admitting hospital, the original hospital is responsible for the costs of transportation. Neither hospital may bill the Medicaid Program separately for the transportation services.

The hospital should reimburse the ambulance or other transportation service for the transport of the patient, as the Medicaid inpatient rate is inclusive of all services provided to the Medicaid patient.

The transport will not be authorized by the LDSS nor paid fee-for-service.

When a patient covered under Medicare is discharged from one hospital and is transported from that hospital to a second hospital for purposes of admission as an inpatient to the second hospital, the ambulance service is paid for under Medicare Part B. The provider shall submit a claim to the Medicare carrier as instructed above.

Medicaid will not reimburse claims that are not approved by Medicare or other insurance when a determination has been made that the transportation by ambulance was not medically necessary.

Regulation 18 NYCRR Section 360-7.3 applicable to this policy can be found at:

<http://www.health.state.ny.us/nysdoh/phforum/nycrr18.htm>

Ambulette Services

Medicaid reimbursement is available to lawfully authorized ambulette providers for ambulette transportation furnished to recipients whenever necessary to obtain medical care. Transportation services are limited to the provision of passenger occupied transportation to or from Medicaid covered services.

The LDSS or State agency of fiscal responsibility must make a determination whether the use of an ambulette, rather than a non-specialized mode such as taxi service, livery service or public transportation, is medically necessary.

Ambulette services are bound by the operating authority granted them by the New York State Department of Transportation (NYSDOT). In accordance with NYSDOT procedures, each service is given the authority to operate within a certain geographic area. Within the prescribed geographic area, transportation is to be "open to the public."

Service is not to be withheld between any points within the boundaries of the service's operating authority when the ambulette service is open for business.

Thus, an ambulette service participating in the NYSDOH's Medicaid Program at the current Medicaid rate may not refuse Medicaid transportation within the ambulette service's area of operation.

Furthermore, refusal to provide transportation within your operating authority constitutes a violation of New York State Transportation Law Section 146 which reads "*...It shall be the duty of every motor carrier to provide adequate service, equipment and facilities under such rules and regulations as the Commissioner may prescribe.*"

Ambulette services found guilty of violating Section 146 of the New York State Transportation Law will face fines up to \$5,000 and possible revocation of operation authority, as determined by NYSDOT.

Ambulette services whose operating authority has been revoked by the NYSDOT will be removed from the NYSDOH's Medicaid Program, thus precluding Medicaid payment.

An ambulette may not be used as an ambulance to provide emergency medical services.

An ambulette may transport a person who requires oxygen, as long as the passenger *self-administers* the oxygen.

Ambulette service personnel *may not* administer oxygen.

An ambulette is allowed to provide stretcher services when the vehicle is appropriately configured.

An ambulette may also provide taxi service (curb-to-curb service). The only requirement that ambulettes need to meet for this service is the proper authority and license to operate as an ambulette.

We do not require the ambulette to be licensed as a taxi service; it operates as an ambulette providing taxi service.

Group Rides and Mileage Reimbursement

All ambulette or van providers who transport more than one Medicaid recipient at the same time in the ambulette or van and who are reimbursed for vehicular mileage should claim only for the actual number of miles from the first pick-up of a Medicaid recipient to the final destination and drop-off of all recipients.

For example, Ace Company's reimbursement has been established at \$20 per one-way pickup rate plus \$1.00 per loaded mile.

On Monday, Ace is authorized to transport Mrs. Jones to her Friday morning clinic appointment, a one-way mileage of 13 miles.

On Tuesday, Ace is authorized to transport Mr. Frank to the same clinic at the same time, a one-way mileage of 7 miles.

Due to living on the same route, Ace will pick up both recipients in the same vehicle.

Ace should claim the base rate and the mileage rate of 13 miles for Mrs. Jones, who is the first one picked up. Ace should only claim the base rate for Mr. Frank. Even though Ace has been authorized 7 miles for Mr. Frank, since these 7 miles duplicate concurrent miles already paid for under Mrs. Jones claim, Ace should not claim for these 7 miles.

If you are reimbursed on a one-way pickup rate only (no mileage reimbursement), regardless of the number of miles transported, this policy does **NOT** apply to your transportation.

Some NYC recipients reside in counties outside NYC.

For these recipients who reside outside NYC and travel outside NYC, the rule for ordering mileage reimbursement is the same as that which applies to all other recipients of that county.

Reporting of Vehicle and Driver License Numbers

Transportation providers billing for ambulette services (category of service 0602) are required to:

- Include the **driver license number** of the individual driving the vehicle on their claim.
- Include the **license plate number** of the vehicle used to transport the Medicaid client on their claim.

If a different driver and/or vehicle returns the recipient from the medical appointment, the license number of the driver and vehicle used for the origination of the trip should be reported on the claim.

Personal Assistance, Escorts and Carry-Downs by an Ambulette Service

Additionally, there is no separate reimbursement for the escort of a Medicaid recipient.

Necessary escorts are to be provided by the ambulette service at no additional charge.

Personal assistance by the staff of the ambulette company is **required** by the Medicaid Program and consists of the rendering of physical assistance to the ambulatory and non-ambulatory (wheelchair bound) recipient in:

- walking, climbing or descending stairs, ramps, curbs or other obstacles,
- opening or closing doors,

- accessing an ambulette vehicle, and
- the moving of wheelchairs or other items of medical equipment and the removal of obstacles as necessary to assure the safe movement of the recipient.

There is no enhanced reimbursement for a person traveling in a wheelchair or a person needing to be carried down steps.

Stretcher Transportation Provided by an Ambulette Service

Stretcher transportation of a Medicaid recipient by an ambulette service is allowed under the Medicaid Program.

The ambulette service is not allowed to provide any medical service to the recipient.

Stretcher transport is appropriate when the recipient is not in need of any medical care or service enroute to one's destination and the recipient must be transported in a recumbent position.

The ambulette vehicle must be configured to be able to hold a stretcher securely during transport .

The ambulette service should establish a reimbursement amount with the LDSS before beginning this service.

Rules for Ordering Ambulette Transportation (NYCRR Section 505.10(c)(2))

A request for prior authorization for transportation by ambulette or invalid coach must be supported by the order of an ordering practitioner who is the Medicaid recipient's:

- attending physician,
- physician's assistant,
- nurse practitioner,
- dentist,
- optometrist,
- podiatrist or
- other type of medical practitioner designated by the district and approved by the Department.

A diagnostic and treatment clinic, hospital, nursing home, intermediate care facility, long term home health care program, home and community based services waiver program, or managed care program may order ambulette transportation services on behalf of the ordering practitioner.

Ambulette transportation may be ordered if any of the following conditions is present:

- The recipient needs to be transported in a recumbent position and the ambulette service is able to transport a stretcher;
- The recipient is wheelchair-bound and is unable to use a taxi, livery service, bus or private vehicle;
- The recipient has a disabling physical condition, which requires the use of a walker or crutches and is unable to use a taxi, livery service, bus or private vehicle;
- An otherwise ambulatory recipient requires radiation therapy, chemotherapy, or dialysis treatments, which result in a disabling physical condition after treatment, making the recipient unable to access transportation without personal assistance provided by an ambulette service.

Ambulette transportation may be ordered if:

- The recipient has a disabling physical condition other than one described above or a disabling mental condition requiring [personal assistance](#) provided by an ambulette service; and,
- The ordering practitioner certifies in a manner designated by and submitted to the department that the recipient cannot be transported by a taxi, livery service, bus or private vehicle and there is a need for ambulette service;
- The ordering practitioner must note in the recipient's patient record the recipient's condition, which qualifies the use of ambulette services.

An ordering practitioner, or facilities and programs ordering on the practitioner's behalf, which do not meet the above rules, may be sanctioned according to Section 515.3 of the regulations established by the Department of Health.

Department of Health Regulations governing this policy can be found at:

<http://www.health.state.ny.us/nysdoh/phforum/nycrr18.htm>.

Taxi/Livery Services

Prior Authorization

Prior Authorization of taxi/livery services is required to ensure that a recipient uses the means of transportation most appropriate to his medical needs.

Orders for taxi/livery services shall be made in advance by either the recipient or the recipient's medical practitioner.

In New York City, all livery transportation must be ordered by the recipient's medical practitioner.

Rules for Ordering New York City Livery Transportation

A request for prior authorization for transportation by New York City livery must be supported by the order of an ordering practitioner who is the Medicaid recipient's attending physician, physician's assistant, nurse practitioner, dentist, optometrist, podiatrist or other type of medical practitioner designated by the district and approved by the department.

A diagnostic and treatment clinic, hospital, nursing home, intermediate care facility, long term home health care program, home and community based services waiver program, or managed care program may order transportation services on behalf of the ordering practitioner.

Day Treatment/Day Program

Day treatment/day program transportation is unique, in that this transportation can be provided by an ambulance, ambulette, taxi, or livery provider.

The difference is that a typical transport involves a group of individuals traveling to and from the same site, at the same time, on a daily or regular basis.

The economies of this group ride transport are reflected in a different reimbursement amount than that reimbursed for an episodic medical appointment.

Providers of transportation to a day treatment/day program must adhere to the same requirements listed above for their specific provider category.

Section III - Basis of Payment for Services Provided

Reimbursement rates are established by the local department of social services, the transportation coordinator acting on behalf of the LDSS or the State agency that is fiscally responsible for the Medicaid recipient (Department of Health, Office of Mental Health (OMH), or Office of Mental Retardation and Developmental Disabilities (OMRDD)).

The transportation provider must contact the Transportation Unit staff at the local department of social services or State agency for procedure codes and rates.

The extent to which transportation services are paid through the Medicaid fiscal agent varies from one LDSS to another.

In order to determine who to bill, please consult the fiscally responsible LDSS, the OMH (County Code 97) or the OMRDD (County Code 98).

Reimbursement is provided to lawfully authorized transportation providers (ambulance, ambulette, taxi, and livery) for passenger-occupied services to and from Medicaid covered-services for Medicaid payment and local payment.

Payment rates for coordinated transportation must be obtained from the transportation coordinator.

Payment will not be made for unauthorized services.

Prior Authorization

Prior Authorization is *required* for all non-emergency transportation. This includes ambulance, ambulette, livery, taxi and group transports such as day treatment/day program.

The prior authorization of non-emergency transportation services is required to ensure that the recipient uses the mode of transportation most appropriate to the recipient's medical needs and that an adequate but less costly transportation plan cannot be arranged.

Payment will not be made for non-emergency transports if the transportation vendor does not receive authorization for the transport.

Prior authorization must be obtained from one of the following fiscally responsible entities:

- The LDSS (county codes 01–57);
- The New York State OMH (county code 97);

- The New York State OMRDD (county code 98);
- The New York State Department of Health (county code 99); or,
- The Medicaid fiscal agent, Computer Sciences Corporation, for non-emergency transports of NYC Medicaid recipients (County 66).

Procedures for obtaining prior authorization differ from one county to another.

It is important to contact the transportation staff in the recipients' fiscally responsible local department of social services, including the OMH, the OMRDD and DOH, to determine the appropriate procedures to be followed.

In general, prior authorization is obtained by either the ordering provider (physician, physician's assistant or nurse practitioner) or other medical personnel designated by the ordering provider.

If authorization is granted, the transportation provider will receive notification of authorization and sufficient recipient and destination information to allow the provider to render transportation services.

Prior authorization usually must be obtained before each trip (or round trip) taken by the recipient.

If a recipient requires regular transportation due to extended treatment (such as dialysis) and the recipient's medical appointment is at the same location, and if the same provider is to transport the recipient, prior authorization may be granted for an extended period as determined by the local department of social services.

Whenever such prior authorization for non-emergency transportation is not obtained, reimbursement will be denied. *However, prior authorization does not guarantee payment.*

For example, provider eligibility and recipient eligibility requirements that are not met may result in the denial of a claim payment.

Comprehensive billing information can be found in the Transportation Billing Guidelines manual, available online at:

<http://www.emedny.org/ProviderManuals/Transportation/index.html>.

Weekend and Holiday Transportation

When a recipient requires an appointment for a medical service on a weekend or holiday, and the appointment is made on that same weekend or holiday, authorization may not be obtained until the next business day.

In such cases, the transportation provider receives the transportation request directly from the ordering practitioner's office or medical facility at which the recipient has the medical appointment.

The transportation provider shall contact the ordering provider for NYC recipients or the fiscally responsible local department of social services for all other recipients on the next business day in order to obtain authorization for services rendered.

All authorization guidelines must be followed before authorization is granted to the transportation provider.

Mileage Within New York City

Mileage within urban areas, such as New York City, is difficult to control. Therefore, New York City has established fixed reimbursement amounts for trips occurring within the five boroughs encompassing the City for **all modes of transportation**.

When a trip occurs within any of the five boroughs, i.e., Queens to Manhattan, mileage should not be ordered.

When a New York City recipient requires long-distance transportation, i.e., Manhattan to Suffolk County, mileage may be ordered, **beginning at the City limits**.

For long distance trips that occur outside the five boroughs, NYC does allow for mileage reimbursement in addition to the fixed payment amounts, beginning at the city limits.

NYC Medicaid recipients are generally expected to obtain their medical care and services within five miles from their residence. This five-mile geographic area is considered the common medical marketing area (CMMA).

Transportation can be ordered for trips greater than five miles from the recipient's residence, when the medical care or service is unavailable within the CMMA.

The difficulty orderers of transportation face is when a recipient resides in a borough contiguous with Westchester (Bronx) or Nassau County (Queens), and the recipient is traveling into the other county for medical care and service.

In these situations, mileage can be ordered when the transport is over five miles from the recipient's residence.

If the one-way trip is greater than five miles, the mileage begins at the NYC/other county border (not the recipient's residence).

For example, if a recipient travels ten miles from Queens to Nassau County, and two miles are traveled in Queens and eight additional miles are traveled in Nassau County, then the one-way mileage is eight miles.

Transports to the medical care or service within five miles of the recipient's residence should never receive a mileage add-on.

Ordering Non-Emergency Transportation for Restricted Recipients

The LDSS and the Department may restrict a recipient's access to Medicaid covered care and services if, upon review, it is found that the recipient has received duplicative, excessive, contraindicated or conflicting health care services, drugs, or supplies (NYCRR Section 360-6.4).

In such cases, the LDSS and the Department may require that the recipient access specific types of medical care and services through a designated primary provider or providers.

The State medical review team designated by the Department performs recipient utilization reviews and identifies candidates for the Recipient Restriction Program.

The primary provider is a health care provider enrolled in the Medicaid Program who has agreed to oversee the health care needs of the restricted recipient. The primary provider will provide and/or direct all medically necessary care and services for which the recipient is eligible, within the provider's category of service or expertise.

Primary providers include:

- ▶ Physicians,
- ▶ Clinics,
- ▶ Inpatient Hospitals,
- ▶ Pharmacies,
- ▶ Podiatrists,
- ▶ DME dealers,
- ▶ Dentists, and

- ▶ Dental clinics.

When a recipient is restricted to a primary physician or primary clinic and a primary dentist or primary dental clinic, the primary physician or primary clinic will be the only allowed orderer of transportation services.

This applies to all modes of non-emergency transportation, including ambulance, ambulette, taxi, livery, public transportation and day treatment/program.

This includes cases where the recipient's primary physician or clinic has referred the patient to another provider. In such situations ordering transportation services remains the responsibility of the primary physician or clinic.

Transportation providers should use the Medicaid ID Number of the primary physician or clinic when obtaining eligibility information via MEVS as well as when submitting claims.

Department of Health Regulations governing this policy can be found at:

<http://www.health.state.ny.us/nysdoh/phforum/nycrr18.htm>.

Transportation Rosters

Transportation providers and ordering providers who either render or order transportation services for Medicaid eligible recipients will receive a Transportation Roster on a weekly basis.

Transportation prior authorizations will appear on your weekly rosters as they are generated by the local district or Computer Sciences Corporation for New York City Medicaid recipients.

In the majority of cases (especially for New York City recipients), the authorizations will be for up to six months.

These prior authorizations will only appear on the roster when they are first entered into the system, or if changes are made.

The Roster lists all prior authorized transportation services requested by an ordering provider.

The Transportation Provider's Roster lists the ordering provider for which prior authorizations was issued as well as the information required to complete a claim form for billing purposes.

Rosters received by ordering providers list prior authorized transportation services that have been ordered by the provider during a weekly period. The Roster sent to the

ordering provider verifies those services that have been prior authorized and lists the transportation provider identification number of the authorized provider.

The following information is listed on the weekly rosters:

- **Recipient** information including:
 - ▶ Name;
 - ▶ Date of birth;
 - ▶ Sex;
 - ▶ Medicaid Client Identification Number.
- **Authorization** information including:
 - ▶ Authorized period of service;
 - ▶ Prior authorization number;
 - ▶ Procedure code;
 - ▶ Occasions of services authorized.

Description of Fields on Transportation Roster

Transportation rosters will be produced by the Department on a weekly basis.

When a LDSS enters a prior authorization into the prior authorization system, it will appear on the roster that you will receive weekly.

All data on the roster will appear as it was data-entered.

You should check the data to verify its accuracy prior to billing for the service.

If there are any errors in the data, contact the LDSS responsible for the data entry as soon as possible and have them make the necessary corrections.

The following is an explanation of each field on the roster:

PROCESS DATE

This is the date that the roster was produced by eMedNY.

BILLING PROVIDER ID

This is the Medicaid provider ID for your transportation company. This is followed by the master file name of your transportation company.

CLIENT ID

This is the recipient's Medicaid identification number. This number has two alphabetic characters in the first two positions, then five numbers, and the last character is alphabetic.

Example: AB12345C

RECIPIENT NAME

This is the recipient name as it appears on master file, last name first. Your rosters will appear in alphabetic order by recipient name.

DATE OF BIRTH

This is the recipient's date of birth as it appears on the master file.

SEX

This is the recipient's sex as it appears on the master file.

CNTY FISC RESP

This is the county who retains fiscal responsibility of the client. A list of county codes is available in the MEVS Provider Manual, online at:

<http://www.emedny.org/ProviderManuals/AllProviders/supplemental.html#MEVSPMI>.

ORDERING PROVIDER ID

This is the eight-digit provider ID of the Medicaid provider who ordered the transportation.

If it is the State License Number for the provider, the number would appear as eleven digits with the first three being the profession code.

PROCEDURE CODE

This is the procedure code for the trip. The procedure codes for each LDSS vary and can be obtained from the LDSS transportation unit.

PRIOR AUTHORIZATION NUMBER

This is the eleven-digit prior authorization number for this specific trip or trips. This number must be placed on your claim in the appropriate field in order to secure payment.

DETERMINATION

Codes in this field indicate the authorization status.

RSN REJECTED

If the determination is “rejected”, then the rejection code will appear in this field.

PERIOD OF SERVICE FROM/TO

The beginning and ending dates of service are found in this field. If the prior authorization is for one day, the dates will be the same.

APPROVED QUANTITY

The number of units of service that a provider has been authorized to provide to a client.

APPROVED AMOUNT

This is the maximum dollar amount that a provider can be paid for providing a unit of service to a Medicaid client. This amount will be \$0.00 unless the prior authorization agent has approved a specific amount per unit.

RENDERED QUANTITY

This is the total number of units and claims rendered for this prior authorization.

TOTAL NUMBER OF ENTRIES ON THIS ROSTER

This number is the total number of prior authorization lines of service appearing on this roster.

Subcontracting Transports

Medicaid rules allow only the provider of service (or the billing agent for that provider) to submit claims for services rendered.

Due to mechanical breakdowns or other circumstances, transportation providers will face times when the number of available vehicles does not meet the demand for services. At these times, providers may choose to lease vehicles from another operator, or subcontract with another provider:

- It is expected that the leased/subcontracted vehicle will have current required inspection stickers.
- The driver of the leased/subcontracted vehicle must be in compliance with all applicable regulations.
- The provider must maintain adequate records to support billing for Medicaid regardless of whether the trip is subcontracted.

In essence, you remain the provider of service and the transportation service provided is clearly identified with your company. When these conditions are met, then you are allowed to bill Medicaid for rendered transportation services.

As long as the vehicle and driver used to perform the transportation service are properly licensed by all regulatory agencies and the trip can be documented showing the actual driver and the actual vehicle that performed the trip, then the use of any duly licensed vehicle and driver to perform the transportation service is permitted.

The practice of subcontracting trips to another provider for a certain percentage or amount of the resulting Medicaid reimbursement, without identifying the vehicle and driver, is prohibited under Medicaid.

This ad hoc subcontracting practice subverts Medicaid's role to insure that only enrolled providers who meet all regulatory requirements are allowed to deliver Medicaid transportation services.

The practice of assigning trips to another provider, for the purpose of billing and receiving a percentage on each paid claim, is prohibited. A provider must show, when audited, in addition to billing for the service, an accounting of the cost associated with that trip (i.e., dispatching, fuel, insurance, office expense, etc.).

Situations Where Medicaid Will Not Provide Reimbursement

Reimbursement is not provided for any mode of transportation when any of the following situations exist:

- The consumer is not eligible for Medicaid on the date of service;
- Prior authorization for the transport is not secured;
- The claim is not submitted to the Medicaid Program in the required format with the required information;
- The medical service to which the transportation occurred is not covered by the Medicaid program (i.e., Medicaid will only consider payment of transportation services to and from care and services covered under the Medicaid Program);
- The transportation service is available to others in the community without charge;
- The recipient is restricted to a primary provider, and the claim uses another ordering provider Medicaid ID number;
- There is a rate listed but effort is never made to collect the fee from individuals who are not enrolled in the Medicaid Program;
- The provider is out of compliance with licensure requirements;

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- The service is provided by a medical institution or program and the cost is included in that institution's or program's Medicaid rate; or
- Transportation services are not actually provided to a Medicaid recipient.

Section IV - Definitions

For the purposes of the Medicaid Program and as used in this Manual, the following terms are defined to mean:

Advanced Life Support Services

Advanced life support (ALS) services are those ambulance services in which the treatment provided is **invasive** to the patient inclusive and above the level of care provided by a NYS Certified EMT. Such treatment includes:

- Advanced prehospital patient assessment and appropriate transport destination determination;
- The initiation and monitoring of intravenous (IV) fluids;
- Cardiac monitoring (ECG);
- Intubation/insertion of an airway tube, manual ventilations or the monitoring of an electronic ventilation device;
- Manual defibrillation and/or electric pacing of the patient's heart;
- Administration or monitoring of medications given by mouth, injection or IV drip as prescribed by protocol and/or a physician's order.
- Communication with a physician and the transmittal of patient data such as the ECG.

Advanced Life Support Assist/Fly-Car Service

An advanced life support assist/fly-car service is an emergency advanced life support response in conjunction with an emergency ambulance transport provided by another ambulance service.

In this type of response, an ambulance service employee with ALS training and equipped with ALS equipment is dispatched to the emergency scene to assist the primary ambulance service by providing necessary ALS in which the primary ambulance service personnel have no training.

Ambulance

An ambulance is a motor vehicle, aircraft, boat or other form of transportation designed and equipped to provide emergency medical services during transit.

Ambulance Service

An ambulance service is any entity, as defined in Section 3001 of the Public Health Law, which is engaged in the provision of emergency medical services and the transportation of sick, disabled or injured persons by motor vehicle, aircraft, boat, or

other form of transportation to or from facilities providing hospital services and which is certified or registered by the NYSDOH as an ambulance service.

Ambulette or Invalid Coach

Ambulette or invalid coach is a special-purpose vehicle designed and equipped to provide non-emergency care that has either wheelchair-carrying capacity or the ability to carry disabled individuals.

Ambulette Service

An ambulette service is an individual, partnership, association, corporation, or any other legal entity which transports the invalid, infirm or disabled by ambulette to or from facilities which provide medical care.

An ambulette service provides the invalid, infirm or disabled with **personal assistance**.

Basic Life Support Services

Basic life support (BLS) services are ambulance services in which the treatment provided to the patient is **noninvasive** and/or within the scope of practice for a NYS certified EMT Basic.

These services include the following services and all other services that are not listed as Advanced Life Support (ALS) Services:

- Use of anti-shock trousers (treatment of shock);
- Monitoring of a patient's blood pressure;
- Administration of oxygen;
- Administration of nebulized Albuterol;
- Administration of Epinephrine Auto-Injector (Epi-Pen) for allergic reactions;
- Control of bleeding;
- Splinting fractures;
- Cardiopulmonary resuscitation;
- Delivery of babies.

Common Medical Marketing Area

The common medical marketing area is the geographic area from which a community customarily obtains its medical care and services.

Community

A community is either the State, a portion of the State, a city or a particular classification of the population, such as all persons 65 years of age and older.

Conditional Liability

Conditional liability is the responsibility of the prior authorization official for making payment only for transportation services which are provided to Medicaid eligible individuals in accordance with the requirements of Title 18 (the regulations of the New York State Department of Social Services).

Day Treatment Program or Continuing Treatment Program

A day treatment program or continuing treatment program is a planned combination of diagnostic, treatment and rehabilitative services certified by the Office of Mental Retardation and Developmental Disabilities or the Office of Mental Health.

Department Established Rate

A department established rate is the rate for any given mode of transportation that the department has determined will ensure the efficient provision of appropriate transportation to Medicaid recipients in order for the recipients to obtain necessary medical care or services.

Emergency Medical Services

Emergency medical services are services for the provision of initial urgent medical care including, but not limited to, the treatment of trauma, burns, and respiratory, circulatory and obstetrical emergencies.

Emergency ambulance transportation is transportation to a hospital emergency room generated by a "Dial 911" emergency system call or some other request for an immediate response to a medical emergency.

Because of the urgency of the transportation request, insurance coverage or other billing provisions are not addressed until after the trip is completed.

Local Department of Social Services

The local department of social services (LDSS) is the locality that authorizes the Medicaid recipients' eligibility for Medicaid and is fiscally responsible for the payment of the recipients' medical bills.

There are 58 LDSS in New York State, including the five boroughs of New York City, which comprise one LDSS.

Locally Established Rate

The locally established rate is the rate for any given mode of transportation which the social services official has determined will ensure the efficient provision of appropriate transportation for Medicaid recipients in order for the recipients to obtain necessary medical care or services.

Locally Prevailing Rate

The locally prevailing rate is a rate for a given mode of transportation which is established by a transit or transportation authority or commission empowered to establish rates for public transportation, a municipality, or a third-party payer, and which is charged to all persons using that mode of transportation in a given community.

New York State Office of Mental Health (OMH) and Office of Mental Retardation and Developmental Disabilities (OMRDD)

OMH and OMRDD are two State agencies operate as Counties of fiscal responsibility in New York State. OMH is district 97 and OMRDD is district 98.

They are responsible for the authorization of non-emergency transportation services for recipients for which they retain fiscal responsibility.

Additionally, emergency ambulance transportation services are also authorized by these two agencies for their recipients.

Non-Emergency Ambulance Transportation

Non-emergency ambulance transportation is the provision of ambulance transportation for the purpose of obtaining necessary medical care or services by a Medicaid recipient whose medical condition requires transportation in a recumbent position.

Non-emergency ambulance transportation is transportation of a pre-planned nature where the patient must be transported on a stretcher or requires the administration of life support equipment, such as oxygen, by trained medical personnel.

Ordering Practitioner

An ordering practitioner is the Medicaid recipient's attending physician or other medical practitioner who has not been excluded from or denied enrollment in the Medicaid program and who is requesting transportation on behalf of the Medicaid recipient in order for the Medicaid recipient to receive medical care or services covered under Medicaid.

The ordering practitioner is responsible for initially determining when transportation to a particular medical care or service is medically necessary.

Personal Assistance

The provision of physical assistance by the provider of ambulette services or the provider's employee to Medicaid recipient for the purpose of assuring safe access to and from the recipient's place of residence, ambulette vehicle or Medicaid-covered health service provider's place of business.

Personal assistance is the rendering of physical assistance to the recipient in walking, climbing or descending stairs, ramps, curbs or other obstacles, opening or closing doors, accessing an ambulette vehicle, the moving of wheelchairs or other items of medical equipment and the removal of obstacles as necessary to assure the safe movement of the recipient.

In providing personal assistance, the provider or the provider's employee will physically assist the recipient which shall include touching, or, if the recipient prefers not to be touched, guiding the recipient in such close proximity that the provider of services will be able to prevent any potential injury due to a sudden loss of steadiness or balance.

A recipient who can walk to and from a vehicle, his or her home, and a place of medical services without such assistance is deemed not to require personal assistance.

Prior Authorization

A prior authorization official's determination that payment for transportation is essential in order for a Medicaid recipient to obtain necessary medical care and services and that the prior authorization official accepts conditional liability for payment of the recipient's transportation costs.

Prior Authorization Official

A prior authorization official is an official from the LDSS, the OMH, the OMRDD or their designated agents.

Transportation Attendant

A transportation attendant is any individual authorized by the prior authorization official to assist the Medicaid recipient in receiving safe transportation.

Transportation Expenses

Transportation expenses are the costs of transportation services; and the costs of outside meals and lodging incurred when going to and returning from a provider of medical care and services when distance and travel time require these costs.

Transportation Services

Transportation services are services by ambulance, ambulette or invalid coach, taxicab, common carrier or other means appropriate to the recipient's medical condition; and transportation attendant to accompany the Medicaid recipient, if necessary.

Such services may include the transportation attendant's transportation, meals, lodging and salary; however, no salary will be paid to a transportation attendant who is a member of the Medicaid recipient's family.

Vendor

A vendor is a lawfully authorized provider of transportation services who is either enrolled in the Medicaid program pursuant to Part 504 of this Title or authorized to receive payment for transportation services directly from a local department of social services or other agent designated by the Department.

The term vendor does not mean a Medicaid recipient or other individual who transports a Medicaid recipient by means of a private vehicle.