

**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. Generally, the Medicaid Program expects:

- timely service;
- rides in duration of less than one hour;
- provider employee sensitivity to the population;
- courteous provider employees;
- adequate vehicle staffing;
- clean, non-smoking vehicles;
- diligent care provided to a passenger (e.g., passenger delivered to a responsible caretaker, not dropped off alone at the curb); and
- appropriately, adequately heated and air conditioned vehicles (i.e., heat in winter, air conditioning in summer).

We understand it is often difficult to accommodate the needs of such a medically-fragile population. Regardless, we expect the appropriate transportation for all Medicaid enrollees, and that every effort will be made to meet the needs of those enrollees utilizing Medicaid-funded transportation.

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://nyhealth.gov/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). Information regarding NYSDOH ambulance certification is located online at:

<http://nyhealth.gov/nysdoh/ems/main.htm>.

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 must be in compliance with all New York State Department of Transportation (NYSDOT) licensing, inspection and operation requirements; including those at [Title 17 NYCRR §720.3\(A\)](#).

Ambulette drivers must be qualified under Article 19A of the New York State Department of Motor Vehicles' [Vehicle and Traffic Law](#).

Where applicable, proof of licensure by the local Taxi and Limousine Commission is required as a condition of [enrollment](#).

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.

Annual Ambulette Survey

As indicated in [Title 18 NYCRR §502.6\(b\)](#), providers of ambulette service (enrollment category of service 0602) are required to submit vehicle information **annually** to the Office of the Medicaid Inspector General. Each ambulette provider must disclose, in writing, information concerning those vehicles currently owned or leased by the provider. An ambulette provider who fails to disclose the requested information is subject to termination from the Medicaid Program.

The information will be requested, and a survey form provided, in each January edition of the [Medicaid Update](#).

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. Additionally, taxi/livery companies must receive support from the appropriate county department of social services 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.

Section II - Transportation Services

Medicaid reimbursement is available to lawfully authorized transportation providers for transportation furnished to Medicaid enrollees 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 Medicaid enrollees. The requirement is based on the recognition that unless needy individuals can actually get to and from providers of Medicaid covered 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 a Medicaid enrollee who must travel an extraordinary distance to receive medical care.

The costs of emergency ambulance transportation do not require prior authorization. All other modes of transportation, while available to a Medicaid enrollee, must 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 Medicaid enrollee 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, most medically-appropriate mode of transport.*

If a Medicaid enrollee 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.

Record Keeping Requirements

Payment to ambulette, taxi/livery/van and day treatment transportation providers who transport Medicaid enrollees to Medicaid-covered services will only be made for services documented in contemporaneous records. Documentation shall include the following:

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

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

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

Ambulance Services

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

In **non-emergency** situations, a determination must be made by the appropriate prior authorization official 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 Medicaid enrollee's physician, physician's assistant, or nurse practitioner **must** order non-emergency ambulance services.

In cases of **emergencies**, emergency medical services are provided without regard to the enrollee's ability to pay and no order is required. Payment will only be made if transportation was provided to the client.

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 Medicaid payment.

Billing for Advanced 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 fee, which is established for those providers who deliver ALS and transport the Medicaid enrollee in the provider's vehicle.

ALS-assist services can only be billed if the county has an established, 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 as the provision of advanced life support services **includes** the delivery of basic life support services. This type of billing is incorrect for those counties that have established separate fees for advanced life support and basic life support services.

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

Ambulance Transportation of Neonatal 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. 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. RPCs have affiliation agreements with community hospitals within their region.

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

Neither air transportation of neonatal infants nor maternal transportation is covered under the Regional Perinatal Center Program.

Information regarding the Regional Perinatal Center Program is available at:

http://www.nyhealth.gov/community/pregnancy/health_care/perinatal/regionalization_description.htm.

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 enrollee is admitted to a hospital licensed under Article 28 of the Public Health Law, the hospital is reimbursed their inpatient fee, Diagnostic Related Group (DRG) and per diem. This reimbursement **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 Medicaid enrollee. 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 enrollee.

Fixed-Wing Air Ambulance

The following fixed-wing air ambulance services are reimbursable:

- Base Fee (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); and
- Destination Ground Ambulance Charge (to be charged only when the destination is out of state).

The established fees 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 portion 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 fee 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 enrollee (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 established Medicaid

reimbursement fee. If the insurance company pays more than the Medicaid fee, 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 fee, Medicaid will reimburse as described in a) or b).
- The mileage fee 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 Mileage.

The Department should be contacted for the current reimbursement fees.

Transport from an Emergency Room to a Psychiatric Center

An ambulance service may be requested to transfer a Medicaid enrollee, 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 ambulance or taxi. These ambulance transports should be treated as an **emergency** transport. Prior authorization from the LDSS is not required.

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.

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

An ambulance service may be requested to transfer a Medicaid enrollee 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 enrollee when the following conditions are met:

- The Voluntary Ambulance Service has been authorized by the LDSS to bill Medicaid at a fee established for this transportation; and,
- The Voluntary Ambulance Service first bills all other applicable 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 enrollee'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 Medicaid enrollee is in need of services that can only be administered by an ambulance service. The ordering practitioner must note in the Medicaid enrollee's patient record the Medicaid enrollee'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

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 Medicaid enrollee 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.

Generally, 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 fee 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 §360-7.3 applicable to this policy can be found at:

<http://nyhealth.gov/nysdoh/phforum/nycrr18.htm>.

Medicaid Subrogation Notice

When a Medicaid enrollee has both commercial insurance in which the ambulance company is not a participating provider, and active Medicaid coverage, the ambulance company can send a "[Medicaid Subrogation Notice](#)" to the commercial insurance company advising them to pay the ambulance provider as an agent of the NYSDOH. The Medicaid Subrogation Notice can be obtained from the local department of social services.

Providers not participating in Medicare can not bill Medicare regardless of the New York State Subrogation Laws.

Ambulance Providers and the National Provider Identifier

Effective **September 1, 2008**, the Medicaid Program will require the National Provider Identifier (NPI) on claims. Ambulance providers (**category of service 0601**) must have a NPI.

For **emergency claims**, ambulance providers must identify themselves as the service provider on the claim via the **NPI**.

For **non-emergency prior authorizations and claims**, ambulance providers must identify themselves via their **eight-digit Medicaid identification number**.

Ambulette Services

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

The Prior Authorization official 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 Medicaid Program at the current Medicaid reimbursement fee may not refuse Medicaid transportation within the ambulette service's area of operation. Refusal of an ambulette service to provide transportation within the service's 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 and possible revocation of operation authority, as determined by NYSDOT. Ambulette services whose operating authority has been revoked by the NYSDOT will be disenrolled from the 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 may provide stretcher services when the vehicle is appropriately configured.

An ambulette may provide taxi (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. The Medicaid Program does 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 enrollee 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 enrollee to the final destination and drop-off of all Medicaid enrollees.

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

Ace is authorized to transport Mrs. Jones to her Friday morning clinic appointment, a one-way mileage of 13 miles; and Mr. Frank to the same clinic at the same time, a one-way mileage of 7 miles.

Ace will pick up both Medicaid enrollees in the same vehicle because they live along the same route.

Ace should claim the base fee and the mileage fee of 13 miles for Mrs. Jones, who is the first one picked up. Ace should only claim the base fee 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 an ambulette or van provider is reimbursed on a one-way pickup fee only (no mileage reimbursement), such as those providers operating within the City of New York, regardless of the number of miles transported, then this policy does **NOT** apply.

For the Medicaid enrollees who reside outside the City of New York and travel outside the City of New York, **the rule for ordering mileage reimbursement is the same as that which applies to all other Medicaid enrollees of that county.**

Toll Reimbursement

The Medicaid Program will reimburse only for the actual costs incurred by a transportation provider while transporting a Medicaid enrollee. When tolls are incurred, the toll is assessed per vehicle, not per rider, and should be billed according to the **actual toll charged**. If a vehicle is transporting **more than one rider** on the same trip, the provider may bill **one unit per round trip crossing**, not one unit per passenger.

NYC Ambulette and Livery Tolls

In the City of New York, ambulette and livery providers may bill Medicaid according to the following procedure codes:

Ambulette	Livery
NY117	NY227

When billing these codes, the provider may claim only the **actual toll amount charged**.

Online Location of Various Toll Schedules

Highway/Bridge/Tunnel	Location
<ul style="list-style-type: none"> New York State Thruway Tappan Zee Bridge Taconic Parkway Grand Island Bridges Fixed Barriers (Spring Valley/New Rochelle/Harriman/Yonkers) 	http://www.nysthruway.gov/tolls/toll-files.html
<ul style="list-style-type: none"> George Washington Bridge Holland/Lincoln Tunnels 	http://www.panynj.gov/CommutingTravel/bridges/html/tolls.html
<ul style="list-style-type: none"> Throgs Neck Bridge Bronx-Whitestone Bridge Triborough Bridge Queens-Midtown Tunnel Verrazano Narrows Bridge Brooklyn-Battery Tunnel Henry Hudson Bridge Marine Pkwy-Gil Hodges Memorial Bridge Cross Bay Veterans Memorial Bridge 	http://www.mta.info/bandt/traffic/btmain.htm
<ul style="list-style-type: none"> Rip Van Winkle Bridge Kingston-Rhinecliff Bridge Newburgh-Beacon Bridge Mid-Hudson Bridge Bear Mountain Bridge 	http://www.nysba.state.ny.us/

Note: [E-ZPass](#) users are charged less than those who pay tolls with cash. Therefore, E-ZPass users should bill Medicaid for the **actual toll amount** charged to their E-ZPass

account while transporting a Medicaid enrollee. Providers may enroll in the E-Z Pass program online at:

<http://www.e-zpassny.com>.

Reporting of Vehicle and Driver License Numbers

Transportation providers billing for services when an ambulette **vehicle** is used 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 Medicaid enrollee/s 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

There is no separate reimbursement for the escort of a Medicaid enrollee. 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) Medicaid enrollees 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 Medicaid enrollee.

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 enrollee by an ambulette service is allowed under the Medicaid Program. The ambulette service is not allowed to provide any medical service to the Medicaid enrollees.

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

The ambulette vehicle must be appropriately 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

Per [18 NYCRR §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 enrollee'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 Medicaid enrollee needs to be transported in a recumbent position and the ambulette service is able to transport a stretcher;

- The Medicaid enrollee is wheelchair-bound and is unable to use a taxi, livery service, bus or private vehicle;
- The Medicaid enrollee 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 Medicaid enrollee requires radiation therapy, chemotherapy, or dialysis treatments, which result in a disabling physical condition after treatment, making the Medicaid enrollees unable to access transportation without personal assistance provided by an ambulette service.

Ambulette transportation may be ordered if:

- The Medicaid enrollee 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 Medicaid enrollees 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 Medicaid enrollee's patient record the Medicaid enrollee'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 18 NYCRR §515.3, which can be found online at:

<http://nyhealth.gov/nysdoh/phforum/nycrr18.htm>.

Taxi/Livery Services

Prior Authorization

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

Orders for taxi/livery services shall be made in advance by either the Medicaid enrollees or the Medicaid enrollee'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 enrollee'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.

The following providers may order transportation services on behalf of the ordering 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.

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 fees are established by the local department of social services (LDSS), the transportation coordinator acting on behalf of the LDSS or the State agency that established eligibility for the Medicaid enrollee (i.e., Department of Health, Office of Mental Health, or Office of Mental Retardation and Developmental Disabilities). The appropriate LDSS or State agency is identifiable by checking the enrollee's [eligibility](#) for Medicaid services.

It is critical that, before a transport is provided to a Medicaid enrollee, the transportation provider verify the eligibility of the enrollee on the date of service. **Reimbursement will not be made for services rendered to ineligible persons.**

The extent to which transportation services are paid through the Medicaid fiscal agent varies from one LDSS to another. To determine who to bill, please consult the LDSS or State agency identified in the eligibility verification process.

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 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 Medicaid enrollee uses the mode of transportation most appropriate to the Medicaid enrollee's medical needs and that a medically 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 entities:

- The LDSS (county codes 01–57 and 99);
- The New York State Office of Mental Health (county code 97);
- The New York State Office of Mental Retardation and Developmental Disabilities (county code 98); or
- The Medicaid fiscal agent, Computer Sciences Corporation, for non-emergency transports of NYC Medicaid enrollees (county code 66).

Procedures for requesting and obtaining prior authorization differ from one LDSS to another. To determine the appropriate procedures to be followed, please consult the LDSS or state agency identified in the eligibility verification process.

If authorization is granted, the transportation provider will receive notification of authorization and sufficient Medicaid enrollees 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 Medicaid enrollee. If a Medicaid enrollee requires regular transportation due to extended treatment (such as dialysis) and the Medicaid enrollee's medical appointment is at the same location, and if the same provider is to transport the Medicaid enrollees, 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.

Prior authorization does not guarantee payment. Provider eligibility and Medicaid enrollee 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>.

Inappropriate Prior Authorization Practices

It is inappropriate for a transportation provider to request prior authorization from the Prior Authorization Agent. Requests for prior authorization of transportation services must come from the ordering practitioner or other designated requestor.

Inappropriate orders for transportation are referred to the Office of the Medicaid Inspector General for review.

Weekend and Holiday Transportation

When a Medicaid enrollee 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 Medicaid enrollee has the medical appointment. The transportation provider shall contact the ordering provider for NYC Medicaid enrollees or the appropriate local department of social

services for all other Medicaid enrollees on **the next business day** in order to obtain authorization for services rendered.

All authorization guidelines must be followed before authorization is granted.

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 nor billed to the Medicaid Program.

NYC Medicaid enrollees 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 Medicaid enrollee's residence, when the medical care or service is unavailable within the CMMA. 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**.

The difficulty orderers of transportation face is when a Medicaid enrollees resides in a borough contiguous with Westchester (Bronx) or Nassau County (Queens), and the Medicaid enrollee 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 Medicaid enrollee's residence. If the one-way trip is greater than five miles, the mileage begins at the **NYC/contiguous county border** (not the Medicaid enrollee's residence).

For example, if a Medicaid enrollee 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 Medicaid enrollee's residence should never receive a mileage add-on.

Non-Emergency Transportation for Restricted Medicaid Enrollees

The LDSS and the Department may restrict a Medicaid enrollee's access to Medicaid covered care and services if, upon review, it is found that the Medicaid enrollee has received duplicative, excessive, contraindicated or conflicting health care services, drugs, or supplies (18 NYCRR §360-6.4). In such cases, the LDSS and the Department may require that the Medicaid enrollee 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 Medicaid enrollee utilization reviews and identifies candidates for the 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 Medicaid enrollee. The primary provider will provide and/or direct all medically necessary care and services for which the Medicaid enrollee 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 Medicaid enrollee 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 and includes cases where the Medicaid enrollee's primary physician or clinic has referred the enrollee to another provider. In such situations ordering transportation services remains the responsibility of the primary physician or clinic.

Transportation providers should use the identification number of the primary physician or clinic when obtaining eligibility information as well as when submitting claims.

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

<http://nyhealth.gov/nysdoh/phforum/nycrr18.htm>.

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 **acute** circumstances, transportation providers will face times when the number of available vehicles does not meet the demand for

services. At these times, Provider A may choose to lease vehicles from another operator, or subcontract with another provider (Provider B):

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

In essence, Provider A remains the provider of service and Provider B's transportation service provided is clearly identified with Provider A. When these conditions are met, then Provider A is 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, upon audit, 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 non-emergency 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 Medicaid enrollees is restricted to a primary provider, and the claim uses another ordering provider Medicaid ID number;
- There is a fee 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;
- The service is provided by a medical institution or program and the cost is included in that institution's or program's Medicaid fee; or
- Transportation services are not actually provided to a Medicaid enrollee.

OMRDD Certified Programs and Facilities

Office of Mental Retardation and Developmental Disabilities (OMRDD) Day Treatment and Day Habilitation agencies must provide or pay for transportation to and from their programs using their day program reimbursement.

OMRDD certified Intermediate Care Facilities (ICF/DDs), Supervised Community Residences, and Supervised and Supportive Individualized Residential Alternatives must provide or pay for all resident transportation to medical and clinical appointments at no additional cost to the Medicaid Program.

Ambulance services should not be utilized for routine transportation to medical or clinical visits, or to and from day programs. **Emergency (9-1-1) ambulance services, or ambulance discharge from a hospital, may be billed separately to the Medicaid Program on a fee-for-service basis.**

Adult Day Health Care Transportation

Most adult day health care programs (ADHC) contract separately with transportation providers to transport registrants to and from the ADHC.

In these cases, the ADHC reimburses the transportation provider directly, not the Medicaid Program. Prior authorization for transportation of registrants to and from these ADHC programs, excluding transportation for medical appointments that take place on the same date as an ADHC visit, will not be granted.

Transportation Rosters

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

Transportation prior authorizations will appear on weekly rosters as they are generated by the LDSS or Computer Sciences Corporation for New York City Medicaid enrollees. These prior authorizations will only appear on the roster when they are first entered into the system, or if changes are made. In the majority of cases (especially for New York City Medicaid enrollees), the authorizations will be for up to six months.

The Transportation Provider's Roster lists the ordering provider for which prior authorization 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.

Description of Fields on Transportation Provider Roster

Transportation rosters are produced by the Department on a weekly basis. When a prior authorization is entered into the prior authorization system or a change is made to an existing prior authorization, it will appear on the weekly roster sent to the transportation provider. All data on the roster will appear as it was data-entered.

Providers should verify the accuracy of the roster **prior to billing for the service**. Any errors in the data should be reported to the LDSS responsible for the data entry as soon as possible.

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

CLIENT ID/NAME

This is the client's Medicaid identification (*Example: AB12345C*) and name as it appears on master file (last name first). Rosters appear in alphabetic order by enrollee last name.

DATE OF BIRTH

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

SEX

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

CNTY FISC RESP

This is the county who established eligibility for the enrollee. A list of county codes is available in the MEVS Provider Manual, online at:

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

ORDERING PROVIDER NUM

This is the ten-digit national provider identifier of the practitioner/facility who ordered the transportation.

PROCEDURE CODE

This is the procedure code authorized for the trip.

PA 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 TIMES

The number of times/days covered by the authorization.

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.

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 NYCRR.

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 Reimbursement Fee

A department established reimbursement fee is the fee for any given mode of transportation that the Department has determined will ensure the efficient provision of appropriate transportation to Medicaid enrollees in order for the Medicaid enrollee 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 "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 enrollees' eligibility for Medicaid. There are 58 LDSS in New York State, including the five boroughs of New York City, which comprise one LDSS.

The LDSS is identified by county code during the eligibility verification process (e.g., 01-Albany, 02-Allegany, etc.). A list of county codes is available in the Medicaid Eligibility Verification System Manual online at:

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

Locally Established Fee

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

Locally Prevailing Fee

The locally prevailing fee is a fee for a given mode of transportation which is established by a transit or transportation authority or commission empowered to establish fees 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 Medicaid enrollees for which they retain fiscal responsibility.

Emergency ambulance transportation services are also authorized by these two agencies for their Medicaid enrollees.

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 enrollee 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 enrollee'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 enrollee in order for the Medicaid enrollee 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 enrollees for the purpose of assuring safe access to and from the Medicaid enrollee'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 Medicaid enrollees 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 Medicaid enrollees.

In providing personal assistance, the provider or the provider's employee will physically assist the Medicaid enrollees which shall include touching, or, if the Medicaid enrollees prefers not to be touched, guiding the Medicaid enrollees 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 Medicaid enrollees 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 enrollee to obtain necessary medical care and services and that the prior authorization official accepts conditional liability for payment of the Medicaid enrollee's transportation costs.

Prior Authorization Official

A prior authorization official is an official from:

- the local department of social services,
- the Office of Mental Health,
- the Office of Mental Retardation and Developmental Disabilities; or
- their designated agents.

Transportation Attendant

A transportation attendant is any individual authorized by the prior authorization official to assist the Medicaid enrollee 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 Medicaid enrollee's medical condition; and transportation attendant to accompany the Medicaid enrollee, if necessary.

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

Vendor

A vendor is a lawfully authorized provider of transportation services who is either enrolled in the Medicaid Program pursuant to [18 NYCRR Part 504](#) 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 enrollee or other individual who transports a Medicaid enrollee by means of a private vehicle.