Medicaid Transportation Policy Manual

New York State Medicaid Transportation Provider Policy Manual

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1. Definitions

For the purposes of the Medicaid program, and as used in this Manual, the following terms are defined.

Advanced Life Support Services

Advanced life support (ALS) services are those ambulance services in which the treatment provided is invasive to the patient, or above the level of care provided that can be provided by a NYS Certified Emergency Medical Technician-Basic. Such invasive treatment may include but not be limited to:

- Advanced Prehospital patient assessment
- 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/electric pacing of the patient's heart
- Administration or monitoring of most medications given by mouth, injection or IV drip, and
- Communication with a physician and the transmission of patient data, such as ECG

From Public Health Law, Article 30, §3001(11) – "Advanced life support care means definitive acute medical care provided, under medical control, by advanced emergency medical technicians within an advanced life support system." Such advanced life support care must be provided in accordance with the New York State Department of Health Collaborative Advanced Life Support Adult and Pediatric Treatment Protocols.
https://www.health.ny.gov/professionals/ems/docs/collaborative_protocols.pdf

Advanced Life Support Assistance

An advanced life support assist is an emergency ALS response***, in conjunction with an emergency ambulance transport*** provided by another, basic life support (BLS) ambulance service.

It this type of response, an ambulance service, or advanced life support first response service, is dispatched to an emergency medical call, to assist the primary BLS ambulance service, by providing medical necessary ALS services, which the primary BLS ambulance service is not authorized to provide. Please see further on in this manual for reimbursement in such situations.

Advance Life Support First Response Service

Advanced life support first response service means an organization which provides advanced life support care but does not transport patients.

Adult Day Health Care

Adult Day Health Care (ADHC) programs are community-based programs licensed by the New York State Department of Health which provide comprehensive medically supervised care in a congregate setting to individuals with a physical or mental impairment.
https://www.health.ny.gov/health_care/medicaid/program/longterm/addc.htm

Ambulance (Category of Service 0601)

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

Ambulance Service

Ambulance Service means 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 currently certified or registered by the NYS Department of Health (NYSDOH or The Department) as an ambulance service. https://www.health.ny.gov/professionals/ems/policy/06-06.htm

Ambulette (Category of Service (0602)

Ambulette or paratransit vehicle means a special-purpose vehicle, designed and equipped to provide nonemergency transport, that has wheelchair-carrying capacity, stretcher-carrying capacity, or the ability to carry disabled individuals.

Basic Life Support Services

Basic Life Support (BLS) services are ambulance services in which the treatment provided to the patient is within the scope of practice for a NYS-certified EMT Basic, and in accordance with the New York State Department of Health Statewide Pre-Hospital Treatment Protocols bls_protocols.pdf (ny.gov)

Common Medical Marketing Area (CMMA)

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, or a portion of the State, a city or 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 a Medical-eligible individual 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 offered by the Office for People with Developmental Disabilities (OPWDD) or the Office of Mental Health (OMH).

Department-Established Reimbursement Fee

A Department-established 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 enrollee to obtain necessary medical care or services.

Emergency Ambulance Transportation

Emergency ambulance transportation means the provision of ambulance transportation for the purpose of obtaining hospital services for a Medicaid enrollee who suffers from severe, life-threatening or potentially disabling conditions, which require the provision of emergency medical services while the enrollee is being transported.

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 triage, treat and transport (ET3) model

Emergency triage, treat, and transport (ET3) model means an innovative payment and service delivery model established by the United States Department of Health and Human Services to lower costs and improve quality of care to Medicare enrollees by requiring ambulance service suppliers selected by the Center for Medicare and Medicaid Innovation (CMMI), or successor agency or office, to partner with qualified health care practitioners to deliver treatment in place and/or transport to alternative destination sites, such as primary care physician offices, urgent care centers, federally qualified health centers, and mental health or substance use disorder crisis centers.

On or after November 24, 2021, and subject to federal financial participation, Medicaid payments will be made to ambulance service vendors that participate in an ET3 model as follows:

In order to participate in this model for Medicaid payment purposes, an ambulance service provider shall submit:

1. A copy of its ET3 application as submitted to CMMI;
2. A copy of the approval letter from CMMI; and,
3. Any other documentation deemed necessary by the Department to confirm Medicare ET3 payments are being made to the vendor

The Department established fees for services provided under an ET3 model, which may include value-based payments, shall be fore:

1. Transport to an alternative non-hospital destination, a base fee plus a mileage charge; and
2. Treatment in place without transport, a base fee without a mileage charge.
3. Ambulance service vendors receiving Medicaid payments in accordance with this subdivision shall submit to the Department copies of all reports provided to CMMI during the course of the Medicare demonstration.
4. Medicaid payments under the ET3 model will continue only for the duration of the Medicare demonstration approved by CMMI and will be terminated when either the demonstration period expires or upon termination of Medicare participation by CMMI at any time for any reason.

Please Note: The Centers for Medicare and Medicaid Services has decided to end ET3 as of December 31, 2023, due to lower than expected participation and lower than projected interventions. https://innovation.cms.gov/innovation-models/et3

Livery Vehicles (Category of Service 0605)

Livery Vehicles are defined in New York State Department of Motor Vehicles and Traffic Law Article 1 § 121-e. as every motor vehicle, other than a taxicab or a bus, used in the business of transportation passengers for compensation. However, it shall not include vehicles which are rented or leased without a driver. This category of service is a curb to curb service, is exclusive to NYC and requires proper taxi/limousine commission licensure.

Local Departments of Social Services

The Local Department of Social Services (LDSS) is the locality that authorizes a Medicaid enrollee's eligibility for Medicaid for all counties outside of New York City. The Human Resources Association (HRA) authorizes a Medicaid enrollee's eligibility for Medicaid in the 5 boroughs of New York City. There are sixty (60) LDSS in New York State, including the five (5) boroughs encompassing New York City, as well as both the New York State OMH and the OPWDD.

Locally Established Fee

Locally established fee means the fee for any given mode of transportation which the Transportation Broker has determined will ensure the efficient provision of appropriate transportation for Medicaid enrollees in order for the enrollees to obtain necessary medical care or services.

Locally Prevailing Fee

Locally prevailing fee means 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 payor, 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 the Office for People with Developmental Disabilities (OPWDD)

OMH and OPWDD are two State agencies operating as local departments of social services in New York State. Upon eligibility verification, OMH is represented by county code 97 and OPWDD by county code 98. The Department's prior authorization official (transportation broker) shall be responsible for the prior authorization of both emergency and non-emergency medical transportation services for enrollees assigned to them.

Non-Emergency Ambulance Transportation

Non-emergency ambulance transportation means the provision of ambulance transportation for the purpose of obtaining necessary medical care or services to a Medicaid enrollee whose medical condition requires transportation by an ambulance service.

New York State Medicaid Payment System

New York State Medicaid payment system means an automated system, such as eMedNY, used to process Medicaid fee-for-service claims submitted by Medicaid enrolled providers for services provided to Medicaid enrollees.

Ordering Practitioner

Ordering practitioner means the Medicaid enrollee's attending physician or other medical practitioners, who has not been excluded from enrollment in the Medicaid program, and who is requesting transportation on behalf of the Medicaid enrollee so that the Medicaid enrollee may obtain medical care or services which are covered under the Medicaid program. The ordering practitioner is responsible for initially determining when a specific mode of transportation to a particular medical care of service is medically necessary.

Personal Assistance

Personal Assistance means the provision of physical assistance by a provider of transportation services to a Medicaid enrollee for the purpose of assuring safe access to and from the enrollee's place of residence, the transportation provider's vehicle, and the Medicaid-covered health service provider's place of business. Personal assistance is the rendering of physical assistance to the enrollee to enable walking, climbing or descending stairs, ramps, curbs, or other obstacles; opening or closing doors; accessing a 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 enrollee. In providing personal assistance, the provider or the provider's employee will physically assist the enrollee which shall include touching, or, if the enrollee prefers not to be touched, guiding the enrollee 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. An enrollee who can walk to and from a vehicle to their home and place of medical services without such assistance is deemed not to require personal assistance.

Prior Authorization/Prior Approval

Prior authorization means a prior authorization official's determination that payment for a specific mode of 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 enrollee's transportation costs.

Prior Authorization Number

The 11-digit number obtained by the transportation provider through the transportation broker, or available through the NYS DOH MMIS system. The transportation provider uses this number to complete claims for payment in eMedNY.

Prior Authorization Official

Prior authorization official means the Department, the transportation broker, or such other entity under contract with, or specifically permitted by, the Department of Health, as applicable.

Provider Network

The Transportation Broker's established collection of transportation providers used to complete non-emergency medical transportation trips for NYS Medicaid members. The network providers must sign a network service agreement with the Transportation Broker and be Medicaid enrolled.

Service Agreement

Service Agreement means an agreement between a vendor and a transportation broker that includes, but is not limited to, vendor service standards and fees to be established for the provision of non-emergency transportation services to Medicaid enrollees.

Service Animal

Service animals are defined as dogs that are individually trained to do work or perform tasks for people with disabilities. Examples of such work or tasks include guiding people who are blind, alerting people who are deaf, pulling a wheelchair, alerting and protecting a person who is having a seizure, reminding a person with mental illness to take prescribed medications, calming a person with Post Traumatic Stress Disorder (PTSD) during an anxiety attack, or performing other duties. Services animals are working animals, not pets. The work or task a dog has been trained to provide must be directly related to the person's disability. Dogs whose sole function is to provide comfort or emotional support do not qualify as service animals under the ADA. ADA Information and NYS Information.

Stretcher Ambulette (Category of Services 0602)

Stretcher service is considered non-emergency transportation of a Medicaid enrollee who must be transported to and from medical care, is confined to bed, cannot sit in a wheelchair, and does not require medical attention/monitoring during transport. These transports are normally completed in a retro fitted ambulette vehicle.

Taxicab (Category of Service 0603)

Taxi vehicles are defined in New York State Department of Motor Vehicle and Traffic Law (VTL) Article 1, §148-a. as every motor vehicle, other than a bus, used in the business of transporting passengers for compensation, and operated in such business under a license of permit issued by a local authority. However, it shall not include vehicles which are rented or leased without a driver. Taxicab is a curb to curb service.

Trip Attestation

Trip attestation is defined as the confirmation that a trip has been completed by the transportation provider. The transportation provider is required to follow any system or communication procedures defined by the transportation broker to attest that a trip has been completed. Trip attestation is required to receive a prior authorization number and to submit a claim for payment.

Transportation Attendant

Transportation Attendant is any individual authorized by the prior authorization official to accompany and assist the Medicaid enrollee in receiving safe transportation.

Transportation Brokers

Transportation management broker(s) or transportation broker(s) means the entity or entities with which the commissioner contracts to cost-effectively administer non-emergency transportation services to Medicaid enrollees in accordance with Social Services Law section 365-h(4)(b).

Transportation Network Company TNC (Category of Service 0609)

Transportation Network Company or TNC means a person, corporation, partnership, sole proprietorship, or other entity that is licensed pursuant to Vehicle and Traffic Law Chapter 71 Title 8 Article 44-B Section 1691 and is operating in New York State exclusively using a digital network to connect transportation network company passenger to transportation network

company drivers who provide TNC prearranged trips.
https://www.nysenate.gov/legislation/laws/VAT/1691

Transportation Services
Transportation services means:

1. Transportation by public transit, self-drive mileage reimbursement, ambulance, ambulette, or paratransit vehicle, taxicab/livery, transportation network company/high-volume for-hire services vehicle (TNC), common carrier, or other means appropriate to the Medicaid enrollee's medical condition' and
2. A transportation attendant to accompany the Medicaid enrollee, if necessary. Such services may include the transportation attendant's transportation, meals, lodging and salary, however, salary will not be paid to a transportation attendant who is a member of the Medicaid enrollee's family.

Undue Financial Hardship
Undue financial hardship means transportation expenses which the Medicaid enrollee cannot be expected to meet from monthly income or from available resources. Such transportation expenses may include those of a recurring nature or major one-time costs.

Value-based payment
Value-based payment means an additional fee for certain transportation services determined by the Department that may be paid to vendors that achieve certain quality and/or efficiency targets established by the Department or a transportation broker.

Vendor
Vendor means a lawfully authorized provider of transportation services who is enrolled in the Medicaid program pursuant to Part 504 of this Title and authorized to receive payment for transportation services directly from the New York State Medicaid payment system or pursuant to a service agreement with a transportation management broker, as applicable. The term vendor does not mean a Medicaid enrollee or another individual who transports a Medicaid enrollee by means of a private vehicle.

Wheelchair
A manually operated or power-driven device designed primarily for use by an individual with a mobility disability for the main purpose of indoor or of both indoor and outdoor locomotion.

2. General Requirements and Background

2.1 Transportation Populations and Coverage

Both emergency and non-emergency medical transportation are benefits covered by the New York State Medicaid program. Emergency medical transportation is always provided by ambulance providers.

Non-emergency medical transportation (NEMT) is an important benefit for enrollees who need to get to and from medical services but have no means of transportation. The Code of Federal

Regulations [42 CFR § 440.170(a)] requires States to ensure that eligible, qualified Medicaid enrollees have NEMT to take them to and from medical providers.

https://www.cms.gov/medicare-medicaid-coordination/fraud-prevention/medicaid-integrity-education/downloads/nemt-booklet.pdf

Medicaid Managed Care Involvement

One of the Medicaid Redesign Team's (MRT) Transportation Reform initiatives was the carveout of transportation from the Medicaid (mainstream) Managed Care benefit package. The non-emergency transportation of mainstream managed care enrollees transitioned to the Department's contracted Medicaid transportation managers/broker on December 1, 2015.

Sources: *October 2015 Medicaid Update; August 2015 Medicaid Update*

However, some Managed Care Plans (also referred to as Prepaid Capitation Plans or Medicaid Health Maintenance Organizations) currently include transportation (emergency, non-emergency or both emergency and non-emergency) within their scope of benefits. Covered services are identified in the eligibility verification process. For more information, please consult the Medicaid Eligibility Verification System (MEVS) Manual, online at:

https://www.emedny.org/ProviderManuals/AllProviders/supplemental.aspx

For enrollees covered by plans that include transportation as a covered benefit, claims coming to Medicaid for the transportation of such enrollees will be denied. The provider must contact the Managed Care Plan for reimbursement.

Questions concerning Medicaid eligibility verification should be addressed to the eMedNY Call Center at (800) 343-9000.

Managed Long Term Care Involvement

The Department is transitioning to a Transportation Management Broker. Beginning in 2024, the Department will begin "carving out" transportation from the Managed Long Term Care benefit. The "carve out" will be phased in over several months.

Transportation Under the Family Planning Benefit Program

Effective November 1, 2012, the Family Planning Benefit Program (FPBP) includes transportation of eligible enrollees to family planning services covered by the FPBP.

Source: *November 2012 Medicaid Update*

Programs and Facilities Certified by the OPWDD

OPWDD Day Treatment, Day Habilitation, Community Habilitation, Prevocational Services, and Employment Services agencies must provide or pay for transportation to and from their programs using their day program reimbursement.

OPWDD 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 (911-generated) 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 (ADHC) Transportation

Many ADHC programs either contract separately with Medicaid-enrolled transportation providers or own vehicles to transport registrants to and from the program. In these cases, the ADHC, ***not the Medicaid program***, reimburses the transportation provider ***directly*****.** Prior authorization for transportation of registrants to and from such programs, excluding transportation for ad hoc medical appointments that take place on the same date as an ADHC visit, will not be granted.

2.2 New York State Medicaid Transportation Services

Medicaid reimbursement is available to lawfully authorized transportation providers for transportation furnished to eligible Medicaid enrollees when necessary to obtain medical care covered by the Medicaid program. Payments for transportation services are limited to the provision of Medicaid enrollee passenger-occupied transportation to or from Medicaid-covered services.

The Medicaid program must assure that necessary transportation is available to Medicaid enrollees.

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.”

Emergency ambulance transportation does 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. Approved prior authorization numbers are 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.

Non-emergency transportation services may include the following modes of transportation:

- Ambulance (ground and air);
- Ambulette (wheelchair van or van with stretcher-carrying capacity); and
- Taxi/livery
- Rideshare/Transportation network company (TNC)
- Public Transportation
- Mileage reimbursement

The Medicaid program shall authorize transports using the most cost effective, medically-appropriate mode of transport. If a Medicaid enrollee uses the public transit system for the activities of daily life, then, in most circumstances, transportation for the enrollee should be requested at a mode of transportation no higher than that of the public transit system.

The mode of transportation used by a Medicaid enrollee must be decided by a medical practitioner who is directly involved in the patient's care, and therefore, best situated and qualified to determine the most appropriate mode.

All Medicaid medical transportation must be in accordance with Department regulation at Title 18 of the New York Code of Rules and Regulations (NYCRR) Section 505.10

https://regs.health.ny.gov/volume-c-title-18/content/section-50510-transportation-medical-care-and-services

In addition to all State requirements, 42CFR §1902(a)(87) requires that all State Medicaid plans must include certain minimum requirements.

These federal minimum requirements under the state plan must include that:

(A) Each provider and individual driver are not excluded from participation in any federal health care program (as defined in section 1128B(f) of the Act) and is not listed on the exclusion list of the Inspector General of the Department of Health and Human Services;

(B) Each such individual driver has a valid driver's license;

(C) Each such provider has in place a process to address any violation of a state drug law; and

(D) Each such provider has in place a process to disclose to the state Medicaid program, the driving history, including any traffic violations, of each such individual driver employed by such provider..

https://www.medicaid.gov/federal-policy-guidance/downloads/cib071221.pdf

2.3 Prior Authorization

Prior Authorization Process

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

Prior authorization must be obtained from the applicable prior authorization official as identified in section 2.3.

To determine the appropriate procedures, please consult the transportation broker identified in the eligibility verification process using the contact list available online at:

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

In most instances, approval must be obtained prior to 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 enrollee's medical appointment is at the same location, and if the same provider is to transport the enrollee, a standing order prior approval may be granted for an extended period. Whenever such prior authorization for non-emergency transportation is not obtained, reimbursement will be denied.

Any changes to trip details, such as location, and/or day, must be approved by the prior authorization official prior to providing the service. Failure to do this may result in non-payment.

Prior authorization does not guarantee payment. Unmet provider and enrollee eligibility requirements may result in the denial of reimbursement. Comprehensive billing information can be found in the Billing Guidelines Manual, available online at:

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

NYSDOH-Contracted Prior Authorization Official

The NYSDOH has contracted with professional transportation management entities to manage transportation on behalf of Medicaid enrollees.

Effective on or after August 1, 2023, based on a competitive procurement, non-emergency medical transportation will be transitioned by the State from the current Medicaid Transportation managers to one Medicaid Transportation Broker (Medical Answering Services, LLC or MAS) to ensure that Medicaid eligible individuals receive reliable, high quality NEMT services using the mode that is appropriate for each individual. MAS will assume Medicaid Transportation Broker responsibilities for all counties except Nassau and Suffolk on August 1, 2023. Nassau and Suffolk counties will transition to MAS for all Medicaid Transportation Broker responsibilities on December 1, 2023. The Medicaid Transportation Broker will contract directly with transportation providers to develop an adequate network, ensure compliance with transportation network driver and vehicle requirements, and negotiate fee-for-service transportation provider reimbursement.

The NYSDOH-contracted transportation broker has no vehicles and will not provide transportation in competition with existing Medicaid-enrolled transportation vendors. ***Transportation vendors will need to agree to and sign a service agreement with the***

transportation broker in order to participate in their transportation network and receive trip assignments. **Medicaid enrollment does not guarantee acceptance in the transportation broker's provider network.** The transportation broker is allowed to utilize all transportation vendors who participate in their network, to whatever extent determined by the transportation broker***.***

The Department expects that transportation vendors will adhere to the Department's standards concerning trip reroutes, i.e., if a trip cannot be accommodated, the vendor will notify the transportation broker as required.

Through this contract with NYSDOH, the transportation broker is primarily tasked with:

- accepting requests for non-emergency Medicaid-funded transportation in their call center, via the web, or by email;
- assigning approvable trips based first upon the medically appropriate mode of transportation, then by enrollee's choice among participating transportation vendors, and finally, at the discretion of the transportation broker.
- generating prior authorizations according to the parameters established by the NYSDOH;
- accepting, investigating and resolving complaints from Medicaid enrollees, medical providers and transportation vendors;
- developing grouped rides to common medical destinations;
- referring identified potential abuse and proposing potential cost savings initiatives to NYSDOH; and
- performing quality assurance surveys.

All participating transportation vendors should obtain access to the transportation broker's web-based systems to attest, cancel or request changes to trips, etc.

Transportation vendors, enrollees and medical providers in should consult MAS by visiting their website: https://www.medanswering.com/.

Inappropriate Prior Authorization Practices

Generally, prior authorization must be obtained before transportation expenses are incurred. Prior authorization is not required for emergency ambulance transportation or Medicare-approved transportation by an ambulance service provided to an MA-eligible person who is also eligible for Medicare Part B payments. If transportation services are provided in accordance with section 505.10(e)(7), the individualized education program or interim or final individualized family services plan of an MA eligible person will qualify as the prior authorization required by this subdivision. Requests for prior authorization may be made by the MA enrollee, his or her

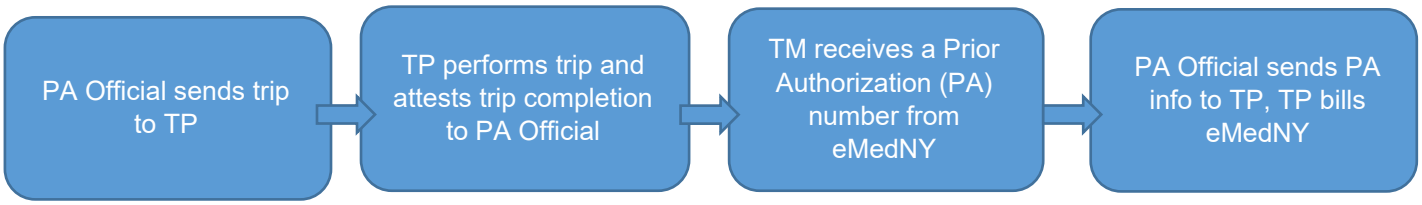
representative, or an ordering practitioner. The enrollee, his or her representative, or ordering practitioner must make the request in the manner required by the prior authorization official.

Each social services district must inform applicants for and enrollees of MA of the need for prior authorization in order for transportation expenses to be paid under the MA program and of the procedures for obtaining such prior authorization. The prior authorization official may approve or deny a request for prior authorization or require the ordering practitioner to submit additional information before the request is approved or denied.

It is inappropriate for a transportation provider (TP) to request prior authorization from the Prior Authorization Official.

Requests for Prior Authorization

Generally, all trips must be prior approved before the trip takes place. The Medicaid program requires all Medicaid providers to submit a claim for payment for a completed trip within ninety (90) days of the date of service unless submission of the claim is outside the control of the provider. Since the prior authorization process is an inherent step in the claiming process, it is also governed by the 90-day claiming regulation at 18 NYCRR §540.6.
Please see the diagram below on the process of obtaining a Prior Authorization (PA) number which is required to submit a claim for payment.



Many requests for prior authorization submitted greater than 90 days after the date of service are done so because transportation providers cannot confirm an enrollee's Medicaid eligibility as the eligibility determination is pending action by the local department of social services or other eligibility gateway. In these instances, the Medicaid program considers the request and claim submission to be outside the transportation provider's control. **Consequently, the Medicaid program expects transportation providers to diligently monitor the eligibility verification system to determine when Medicaid eligibility is retroactively approved, and the date for which eligibility is effective.**

All trip attestations should be sought within thirty (30) days of the date of service. Requests submitted beyond this time are subject to payment disallowance.

- If the enrollee does not become Medicaid eligible for transportation services on the date of service, the request for prior authorization will be denied.

- For enrollees with effective retroactive eligibility, a transportation provider may submit a trip attestation up to 120 days from the date eligibility is established on the eligibility verification system.

- Requests submitted beyond this 120-day period will be denied.

All modifications/corrections must be requested prior to attestation (within 30 days of eligibility verification). For requests involving changes/corrections to existing prior authorizations, the following applies:

- If the request is submitted within 90 days of the date of service, the Department (or Department's prior authorization official) may approve the request to change the existing prior authorization.

- If the request is more than 90 days from the date of service but less than 30 days from the date the prior authorization was issued, the Department (or the Department's prior authorization official) may approve the request to change the existing prior authorization.

- If the request was more than 90 days from the date of service, and more than 30 days have passed since the date that the prior authorization was originally issued, the Department (or the Department's prior authorization official) may deny the request for a change in the authorization.

For requests involving third party insurance denials (which pertain primarily to ambulance providers):

- All requests will require a written copy of the denial

- If the request is submitted within 90 days of the date of service, the Department (or Department's prior authorization official) may approve the request to issue a prior authorization.

- If the request is more than 90 days from the date of service but less than 30 days from the date of the remittance statement from the third-party insurance company denying payment, the Department (or Department's prior authorization official) may approve the request to change the existing prior authorization.

- If the request was more than 90 days from the date of service, and more than 30 days have passed since the date of the remittance statement from the third-party insurance company denying payment, the Department (or Department's prior authorization official) may deny the request for a change in the authorization.

Requests dated more than 90 days beyond the service date must be sent to the Department of Health via either of the following methods:

eFax: (518) 486-2495

Email: MedTrans@health.ny.gov

Non-Emergency Transportation of Restricted Enrollees

The Department may restrict an enrollee's access to Medicaid covered care and services if, upon review, it is found that the enrollee has received duplicative, excessive, contraindicated or conflicting health care services, drugs or supplies (18 NYCRR §360-6.4).

The State medical review team designated by the Department performs Medicaid enrollee utilization reviews and identifies candidates for the Restriction Program. In these cases, the Department may require that the enrollee access specific types of medical care and services through a designated primary provider or providers.

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 enrollee. The primary provider will provide and/or direct all medically necessary care and services for which the enrollee is eligible within the provider's category of service or expertise. Primary providers include:

- Physicians
- Clinics
- Inpatient Hospitals
- Pharmacies
- Podiatrist
- DME Dealers
- Dentists
- Dental Clinics

When a Medicaid enrollee has been restricted to a primary provider, only the primary provider is allowed to order transportation services for the enrollee. This applies to all modes of non-emergency transportation and includes cases where the enrollee's primary physician or clinic has referred the enrollee to another provider. In such situations, requesting transportation remains the responsibility of the primary provider. Transportation providers should use the identification number of the primary provider when obtaining eligibility information and submitting claims.

2.4 Transportation Provider Requirements and Responsibilities

To participate in the New York State Medicaid program, a provider must meet all applicable Federal, State, County and Municipal requirements for legal operation. In addition to the policies set forth in this Manual, and in other directives related to Medicaid policy, the Medicaid program expects the following of all providers:

- All drivers, during their employment, must be at least eighteen (18) years of age and have a current, valid driver's license from New York or another state to operate the transportation

vehicle to which they are assigned.

- All drivers and escorts will be courteous, patient, and helpful to all passengers and be neat and clean in appearance.
- Driver or escorts must not use alcohol, narcotics, illegal drugs or drugs that impair ability to perform while on duty and no driver shall abuse alcohol or drugs at any time.
- At no time will drivers or escorts smoke while in the vehicle, while involved in enrollee assistance, or in the presence of any enrollee.
- Drivers and escorts shall provide necessary assistance, support, and oral directions to passengers.
- Transportation providers can only provide transportation services that have been authorized by the prior authorization official(s).
- Transportation providers shall wait at least fifteen (15) minutes after the scheduled pick-up time before “no-showing” the enrollee at the pick-up location. The network provider shall document all “no shows.”
- Rides in duration of less than one (1) hour (barring exceptions based on location or acute circumstances such as inclement weather and unexpected traffic situations).
- All vehicles must be registered with the NYS Department of Motor Vehicles, in the appropriate registration class, and be properly insured.
- Have two-way radio or cellular phone communication capability.
- Provide valid DMV registration with expiration date and valid insurance ID card with expiration date.
- Be equipped with properly functioning air conditioner/heater/defrosters.
- Each vehicle shall have the ability to properly secure child safety seats, when provided by an enrollee or caregiver.
- Be equipped with a properly functioning speedometer and odometer.
- Have a clean interior and exterior.
- Have a smoking prohibition use notice posted in all vehicle interiors, easily visible to the passengers.
- Include a vehicle information packet containing vehicle registration, insurance card, and accident procedures and forms. The accident procedure will include a requirement that the transportation provider informs the Transportation Broker of all accidents and incidents within 48 hours.
- Be sufficiently stocked with personal protective equipment for drivers in accordance with OSHA Standards 1910.1030 and 1910.134, and any other applicable statute or regulation.
- All vehicles are equipped with GPS capability and transmit coordinates and other related data to the broker as required.
- Follow all Cleaning/Disinfection requirements and reporting as outlined by the Department.
- Passengers must have their seat belts buckled while they are inside the vehicle. The driver shall assist passengers who are unable to fasten their own seat belts if requested.
- The driver shall not put the vehicle in motion until all passengers have been properly secured.
- The number of persons in the vehicle, including the driver, shall not exceed the vehicle manufacturer’s approved seating capacity.
- Upon arrival at the destination, the vehicle shall be parked or stopped so that passengers do not have to cross streets to reach the entrance of their destination.
- If passenger behavior or other conditions impede the safe operation of the vehicle, the

driver shall park the vehicle in a safe location out of traffic and notify their dispatcher or 911 to request assistance.

Providers of all levels of medical transportation will encounter patients/passengers who may have infectious diseases. To protect the health and well-being of everyone, all providers must follow CDC Standard Precautions for All Patient Care - https://www.cdc.gov/infectioncontrol/basics/standard-precautions.html

Transportation providers cannot refuse to pick up a Medicaid member based on their medical condition or status. Any pattern of transport denial linked to an enrollee's physical appearance, disability, and other protected classes is strictly prohibited. 42 USC 12182: Prohibition of discrimination by public accommodations

Additionally, as employers, all transportation providers must abide by OSHA Standards 1910.1030 (Bloodborne Pathogens), 1910.134 (Respiratory Protection), as well as OSHA's "General Duty Clause".
https://www.osha.gov/laws-regs/regulations/standardnumber/1910/1910.1030
https://www.osha.gov/laws-regs/regulations/standardnumber/1910/1910.134

Transportation Provider Network Credentialing

For purposes of credentialing, transportation providers must provide to the Transportation Broker or the Department:

- Valid New York or other valid state driver license.
- Valid vehicle registration.
- Valid vehicle inspection.
- Valid Certificate of Insurance.
- Valid insurance identification cards.
- Confirmation of enrollment as a Medicaid transportation provider.

Medicaid Enrollment Does Not Supplant Local Regulations

Title 18 NYCRR §505.10(e)(6) indicates that providers must, regardless of Medicaid enrollment status, comply with applicable regulatory requirements. For ambulette, taxi and livery companies, this may include local licensure by a municipality or a Taxi and Limousine Commission.

Failure to comply with local regulations may result in termination from Medicaid enrollment, as well as action by the local regulatory entity.

Source: *November 2009 Medicaid Update*

Vehicle Ownership or Leasing the Insurance for Categories of Service 0601, 0602, and 0603

Medicaid program transportation service providers for category of service 0601 (Ambulance), 0602 (Ambulette), and 0603 (Taxi) are personally and directly responsible for their fleet of

vehicles. These category of service providers must own the vehicles outright or be personally responsible for the vehicles pursuant to a vehicle lease agreement. The provider may enter into a lease agreement with a motor vehicle manufacturer or with a licensed vehicle dealership. Vehicle leases are acceptable as long as the lease agreement is in the name of the Medicaid-enrolled transportation service provider and the vehicle is registered to the Medicaid-enrolled transportation service provider.

Further, vehicles must be insured and maintained by the Medicaid-enrolled transportation service provider.

It is unacceptable for a Medicaid-enrolled transportation service provider to enter into any arrangement whereby the provider uses, or leases vehicles registered to, insured and/or maintained by another individual or entity. Such an arrangement has the potential of bypassing significant safety and financial controls that are fundamental to the integrity of the Medicaid program and the safety of the Medicaid enrollees.

Providers in violation of this policy must continue to meet these standards concerning vehicle ownership, registration, maintenance, and insurance. Those providers deemed in violation of this policy are subject to penalty, including disenrollment from the Medicaid program. Note: New transportation provider applicants must adhere to these requirements at the time of application.
Source: December 2015 Medicaid Update

Vehicle Ownership for Exemption for Categories of Service 0605 and 0609

Medicaid transportation providers enrolled in categories of service **0605 Livery/Black Car (NYC Only) or 0609 Transportation Network Company/High Volume For-Hire-Service** are **exempt** from the requirements listed in the section above “Vehicle Ownership or Leasing the Insurance for Categories of Service 0601, 0602, and 0603”. Under these two categories of service, providers may employ drivers who own and operate their own vehicles. Please note, Medicaid transportation providers that are enrolled in these categories of service must comply with all local municipal requirements, including being licensed by the applicable Taxi and Limousine Commission governing the service area, and with all requirements of the NYS Department of Motor Vehicles.

Source: December 2018 Medicaid Update

Subcontracting Transports

Medicaid program transportation service providers are personally and directly responsible for transporting Medicaid enrollees. These responsibilities may not be assigned, delegated or subcontracted out. Such an arrangement has the potential of bypassing significant safety and financial controls that are fundamental to the integrity of the Medicaid program and the safety of Medicaid enrollees.

Due to mechanical breakdowns and other acute circumstances, transportation providers may face times when the number of available vehicles registered to the provider does not meet the need for services. Formerly, the Medicaid program allowed on a short-term basis Medicaid-enrolled Provider A to subcontract with or lease vehicles from Medicaid-enrolled Provider B or

other entity in order to ensure the provision of services to the enrollee. **The Medicaid program no longer allows these arrangements.**

If a Medicaid transportation provider encounters a circumstance when his supply of provider-registered vehicles does not meet the need for services, the provider must alert the appropriate transportation broker as soon as possible so that the transportation broker may find an available provider to perform the necessary trip or trips. Please be reminded that Medicaid transportation brokers are accessible 24/7 by telephone and can be identified using the contact list available online at http://www.emedny.org/ProviderManuals/Transportation/index.html.

Source: *December 2015 Medicaid Update*

Updated Requirements for Volunteer Driver Organizations

The New York State Department of Health recognizes that volunteer drivers are a valuable component of the Medicaid Transportation Program, especially in transporting enrollees to necessary medical services in rural areas.

All volunteer driver organizations must be enrolled as Medicaid providers and can only assign trips to volunteer drivers who are affiliated with their organization.

Volunteer driver organizations are required to:

- Perform criminal background checks and driver's license verifications before assigning any Medicaid funded trips to a volunteer driver; and
- Ensure that all drivers maintain the appropriate vehicle liability insurance.

Volunteer drivers must:

- Maintain a valid license that is appropriate for the size and type of vehicle they are operating;
- Provide curb to curb transportation;
- Maintain all required records necessary to support a Medicaid transportation claim;
- Meet or exceed Medicaid quality standards (e.g., no smoking, vehicle cleanliness, etc.); and
- Maintain at least the minimum insurance requirements in accordance with the New York State Department of Motor Vehicles.

Source: March 2016 Medicaid Update

Vehicles used by volunteer drivers must follow all requirements outlined in section 2.4.

2.5 Record Keeping Requirements and Reporting

In accordance with Title 18 NYCRR §504.3(a) and 517.3(b), transportation providers will be reimbursed only when contemporaneous, complete, acceptable, verifiable records are available upon request to the State in connection with an audit, investigation or inquiry. The documentation below is required for **every leg** of a trip and must be maintained for a period of six (6) years following the date of payment. If any of the required information is incomplete, or deemed

unacceptable or false, any relevant paid reimbursement will be recouped, and the provider may be subject to other statutory or regulatory liability, financial damages and sanctions.

Attestation and Claim Detail (Applicable to All Providers Except Ambulance)

Effective March 1, 2016, in addition to historically required acceptable trip verification, the Department requires the full printed name and signature of the driver providing the transport attesting that the referenced trip was completed. The full list of required trip verification information now includes, at a minimum:

- The Medicaid enrollee's name and Medicaid identification number;
- The date of the transport;
- Both the origination of the trip and time of pickup;
- Both the destination of the trip and time of drop off;
- The vehicle license plate number;
- The driver's license number;
- The full printed name and signature of the driver providing the transport; and
- An attestation from the driver that the trip was completed. (Indication of no show if trip did not take place).

Electronic Records

The Department will allow transportation providers to comply with these record keeping requirements by: **(1) substituting the written signature of the driver providing the transport with a unique identifying electronic signature, and (2) requiring drivers attest that the trip has been completed by using an electronic verification transmission that records both the trip drop-off and pick-up destination coordinates.**

Therefore, the driver "clicking" to confirm trip completion verification at the end of each ride can be used as long as it satisfies the Department's requirement for a "contemporaneous, complete, acceptable, verifiable" record that the driver has both provided the trip and attested to its completion to support Medicaid claims - and that the transportation provider can produce this documentation with an accurate, system-generated, unmodifiable date and time stamp for each leg of a billable trip, including the pickup and drop-off, ***for the required six-year period***.

The use of the electronic signature option ***does not*** exempt transportation providers from any of the current record keeping requirements or prospective audit of such record keeping by enforcement agencies.

Source: January 2019 Medicaid Update

Supplemental Documentation

The following items presented as the only evidence of a trip are not considered acceptable documentation. However, these documents may be considered supplemental to additional required documentation and can be presented to supplement required documentation:

- A driver/vehicle manifest or dispatch sheet;
- Issuance of a prior authorization by an approved official with subsequent checkmarks;
- A prior authorization roster; or
- An attendance log from a day program.

Reminder – Requirements under 505.10 Transportation for Medical Care and Services
Providers must comply with 18 NYCRR § 505.10 in its entirety.
https://regs.health.ny.gov/volume-c-title-18/content/section-50510-transportation-medical-care-and-services

Source: December 2015 Medicaid Update

Accident/Incident Reporting

An "accident" is defined as a vehicle colliding with another vehicle, a physical structure, an object, a person, or an animal.

An "incident" is defined as an occurrence, breakdown, or public disturbance that interrupts the trip causing the driver to stop the vehicle, such as when a passenger or driver becomes unruly or ill.

All New York State (NYS) Medicaid-enrolled transportation providers must follow expanded accident/incident reporting protocol. Effective January 1, 2022, all events must be reported using the NYSDOH NEMT Accident and Incident Report.

All providers should report these events to the prior authorization official and/or Department, in accordance with the 10 NYCRR Part 800.21:

> (q) upon discovery by or report to the governing authority of the ambulance service, report to the Department's Area Office by telephone no later than the following business day and in writing within 5 working days every instance in which:
>
> (1) a patient dies, is injured or otherwise harmed due to actions of commission or omission by a member of the ambulance service;
>
> (2) an EMS response vehicle operated by the service is involved in a motor vehicle crash in which a patient, member of the crew or other person is killed or injured to the extent requiring hospitalization or care by a physician;
>
> (3) any member of the ambulance service is killed or injured to the extent requiring hospitalization or care by a physician while on duty;
>
> (4) patient care equipment fails while in use, causing patient harm;
>
> (5) it is alleged that any member of the ambulance service has responded to an incident or treated a patient while under the influence of alcohol or drugs while on duty.
>
> (r) on or in a form approved by the department, maintain a record of all unexpected, authorized EMS response vehicle and patient care equipment failures that could have

resulted in harm to a patient and the corrective actions taken. A copy of this record shall be submitted to the department with the EMS service's biennial recertification application.

Ambulance providers may submit the Bureau of Emergency Medical Services (BEMS) *Reportable Incident Form (DOH-4461)* in place of the NYSDOH NEMT Accident and Incident Report. Transportation providers must submit the forms to their transportation brokers within 48 hours of the events. The NEMT Accident and Incident Report and additional detail on reporting requirements are found on the transportation brokers websites.

Source: November 2021 Medicaid Update

GPS Compliance Requirement

Effective April 3, 2023, New York State NYSDOH requires all Transportation Providers (TP) to be fully Global Positioning System (GPS) compliant.[1] For a trip to be considered fully GPS-compliant, the Transportation Provider will submit the starting point, end point, and all GPS coordinates along the trip ("breadcrumb data") to the Transportation Broker. Transportation Providers must take necessary steps to ensure GPS compliance.

The use of GPS data will be used to increase program integrity, ensure enrollee safety, aid in the development of future policies, and assist in the reduction of fraud, waste, and abuse.

For Transportation Providers currently using a Third-Party Intermediary (TPI) / Advanced Transportation Management Systems (ATMS) billing or routing software:

- Make sure all drivers have GPS capability and that each trip's GPS data is being accurately routed.
- For a complete list of TPIs/ATMS that are compliant with the appropriate brokers software or to ensure that your TPI/ATM is compliant please contact the transportation broker.

Loss of Records Due to Unforeseen Incident

Federal law and State regulations require Medicaid providers to maintain financial and health records necessary to fully disclose the extent of services, care, and supplies provided to Medicaid enrollees. This is stated in Title 18 of the New York Code of Rules and Regulations at §504.3:

By enrolling, a provider agrees:

To prepare and maintain contemporaneous records demonstrating its right to receive payment under the Medicaid program and to keep for a period of six years from the date the care, services or supplies were furnished, all records necessary to disclose the nature and extent of services furnished and all information regarding claims for payment submitted by, or on behalf of, the provider and to furnish such records and information, upon request.

Additional record keeping requirements for transportation providers can be found in the previous section of this Manual.

[1] GPS compliance is required unless special exemption is granted by the NYS Department of Health

Transportation providers whose paper and/or electronic records are damaged by fire, flood or other disaster are required to notify the New York State Office of the Medicaid Inspector General (OMIG) of the loss of their records. This self-reporting notification must include specific details of the event causing the loss of records, type of required records lost, date/s of service impacted by the loss, and documents/photographs substantiating the loss. Information on self-reporting can be found online at https://omig.ny.gov/submission-checklist-and-faqs.

Additionally, providers must notify any other State or local regulatory agency of its loss as required by those regulatory agencies, including a Taxi and Limousine Commission (taxi, livery, and ambulette providers), or the New York State Department of Health (ambulance providers), and/or the New York State Department of Motor Vehicles (ambulette providers).

Source: September 2016 Medicaid Update

2.6 Complaints and Complaint Reporting

Transportation Broker Complaints

Medicaid enrollees or their representatives and/or medical providers or their representatives and/or transportation providers may file complaints against transportation brokers to the Department. The Department will review all complaints and investigate credible complaints as appropriate. ***Confidentiality of complainant-identifying information is maintained to the extent practicable.***

Complaints are received by the NYSDOH via the following methods:
Telephone: (518) 473-2160
Email: MedTrans@health.ny.gov

Service Complaints

Medicaid enrollees or their representatives, and/or medical practitioners or their representatives, may file complaints against transportation providers when it is believed that safe and quality transportation services were not provided to a Medicaid enrollee.

Information regarding the nature of complaints received regarding the services provided by entities transporting Medicaid enrollees is forwarded to the transportation provider or entity regarding whom the complaint was lodged, and/or the county department of social services (DSS), and/or the State's contracted transportation broker, and, where applicable, the Office of the Medicaid Inspector General and/or other enforcement agencies. ***Confidentiality of complainant-identifying information is strictly maintained.***

Service Complaints can be directed to MAS at: https://www.medanswering.com/comments-or-concerns/ or to the NYSDOH. Service complaints received by NYSDOH will be routed to MAS.

2.7 Claims and Reimbursement

Reimbursement Fees

The current Medicaid transportation fee schedule is located online at:
https://www.emedny.org/ProviderManuals/Transportation/index.aspx

The transportation broker is responsible for negotiating reimbursement directly with network transportation providers. The negotiated rates will supersede the current fee schedule.

It is illegal for any transportation provider to pay, or even offer to pay a Medicaid enrollee, in exchange for using its services. In this context, pay means provide or offer to provide anything of value, including but not limited to money, drugs, free or discounted personal transportation or housing.
Medicaid members shall never pay a copay for NEMT, and drivers and transportation providers shall never request payment directly from a member.

Multiple Dates of Service

For each date of service, a provider transports an enrollee; a separate claim line must be submitted. For example, Mrs. Jones was transported round trip on July 1, 2 and 3.Three separate claim lines should reflect two units on each of date of service.

Note: Claim edit code definitions are listed on the last page/s of a remittance statement.

Additionally, claim edit 7–0 - PA UNITS OR PAYMENT AMOUNT EXCEED–D - will deny claims which contain more daily units than allowed by a prior authorization.

Source: July 2009 Medicaid Update

Contracted Billing Agents

Due to the complexities involved with billing insurance companies for services rendered, many transportation vendors use a private billing agent to submit claims to the Medicaid program on their behalf.

Transportation vendors should note that they, not their contracted billing agent, are ultimately responsible for any inappropriate billing identified post-payment which is attributed to their company. Therefore, it is imperative that transportation vendors, in addition to their billing agents, be aware of and compliant with all applicable Medicaid policies.

Additionally, billing agents must enroll as a “Service Bureau” with the New York State Medicaid program. Even if the billing agent is enrolled as a Medicaid service vendor, they must separately enroll as a Service Bureau in order to submit claims on behalf of another vendor.

Source: February 2010 Medicaid Update

Enhanced Mileage Accuracy

Transportation providers historically have submitted mileage claims that round the fractional mileage distance from the nearest tenth of a mile traveled to the next highest whole number (e.g., from 2.7 miles to 3.0 miles). The New York State Department of Health (the Department) has determined that the current capabilities of the prior authorization and claims payment systems can accommodate fractional mileage claims that reflect distance to the nearest tenth of a mile. The submission of fractional mileage claims enhances payment accuracy, reduces Medicaid overpayments, achieves alignment with current Medicare mileage reimbursement policy, and better reflects the advent of geocoded trip recording technologies.

Effective for dates of service on or after August 1, 2019, claims for loaded mileage must be reported as fractional units to the tenth of a mile (for trips totaling less than one mile, enter a **"0"** before the decimal point (e.g. 0.9). Rounding mileage units up to the nearest whole number is ***not*** allowed for claims with dates of service on or after August 1, 2019. **Rounded-up claims may be deemed fraudulent and therefore subject to any recoveries and associated penalties by enforcement agencies.** Transportation providers who are unable to comply with the August 1, 2019 fractional mileage reporting requirement, due to software limitations or other reasons, may round mileage units ***down*** to the nearest lowest whole number until a time determined by the Department.

As always, the Medicaid program will only reimburse transportation providers for "loaded" miles. Loaded miles are those miles during which an enrollee occupies the vehicle.

Source: May 2019 Medicaid Update

Rides Grouped by the Transportation Provider

All ambulette, taxi, or van providers who transport more than one Medicaid enrollee at the same time in the same vehicle and who are reimbursed for passenger-laden mileage should claim only for the actual number of miles from the first pick-up of an enrollee to the final destination and drop-off of the last Medicaid passenger.

> For example, Ace Company's reimbursement has been established at $20.00 per one- way pick-up 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 thirteen (13) miles; and Mr. Frank to the same clinic at the same time, a one-way mileage of seven (7) miles.
>
> Ace will pick up both enrollees in the same vehicle as they live along the same route. Ace should claim the base fee and mileage fee of 13 miles for Mrs. Jones, as she was the first passenger to be picked up. Ace should only claim the base fee for Mr. Frank. The 7 miles authorized for Mr. Frank duplicate the concurrent mileage paid under Mrs. Jones' claims. Ace should not claim these 7 miles.

If a provider is reimbursed on a one-way pickup (i.e., flat) fee only (no mileage reimbursement), regardless of the number of miles transported, then this policy does not apply.

For Medicaid enrollees who reside outside their county of eligibility, the rule for ordering mileage reimbursement is the same as that which applies to all other Medicaid enrollees of the residential county.

Preferred Provider Opportunities (PPO)

Preferred Provider Opportunities (PPO) are designed to promote collaboration between medical and transportation providers to improve communication and operational practices that result in better access to healthcare for Medicaid enrollees.

Once established, PPOs are monitored by the NYSDOH to ensure Medicaid enrollees' access to healthcare is being achieved. Regular stakeholder meetings are mandatory to ensure challenges and concerns of all parties are addressed. Furthermore, quality assurance and Medicaid enrollee satisfaction are measured regularly to determine the program's success in meeting its goals.

Expectations:

- No PPO Trip Invoice can be refused or reassigned.
- Maintain compliance with all NYSDOH Medicaid NEMT Policies and Procedures (i.e., all vehicles are required to provide GPS data for all transports).
- On time performance for picking up enrollees - within 15 minutes of scheduled pick-up time.
- On time performance for hospital discharges. TP must be at Hospital within 60 minutes of Trip Invoice Assignment.
- NYSDOH, Medicaid Provider, and Transportation Providers are required to attend stakeholder meetings regularly.
- Excellent, frequent, and appropriate communication between the TP and Medical provider is expected and required.

Multiple Riders from the Same Location

Medicaid does not pay for transportation of cohabitants needing transportation to the same destination, even if each cohabitant has a medical appointment. For example, a mother and her son live at 1 Cherry Tree Lane, and both have appointments at 7 Murray Avenue on November 1st. In this circumstance, the Medicaid program will authorize one trip, and indicate there will be an additional rider. The transportation vendor will not be authorized a separate compensable trip for the additional rider.

Typically, cohabitants that fall under this category are those related by marriage or birth, but may include roommates, friends, etc. who are residing, temporarily or otherwise, at the address.

This policy does not apply to persons residing in apartment complexes where each person lives in a separate apartment, nor does it apply to adult homes, nursing facilities, etc.

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. ***Therefore, if a vehicle is transporting more than one rider on the same trip, the provider may bill one unit per charged crossing, not one unit per passenger.***

E-Z Pass Customers

E-Z Pass customers, should bill Medicaid for the ***actual toll amount charged*** to their E-Z Pass account while transporting a Medicaid enrollee or enrollees. Non E-Z Pass customers who pay tolls by mail, will only be reimbursed at the current E-Z Pass rate. Current toll rates can be found here: Toll Rates | New York State Bridge Authority (ny.gov)

Providers may enroll in the E-Z Pass program online at http://www.e-zpassny.com.

Congestion Surcharge Pricing and Reimbursement Affecting Medicaid Transportation Providers

The enacted 2018-19 State Budget (S.7509-C / A.9509-C) contained statutory provisions to reduce traffic in a "congestion zone" in the **New York City Borough of Manhattan, south of and excluding 6th Street**. **Effective January 1, 2019**, *for-hire* transportation for a single passenger that originates, terminates, or enters the congestion zone from anywhere in the State must pay a surcharge of **$2.75 per trip**. *Pool vehicles* that transport two or more passengers with separately requested transportation will be surcharged **$0.75** per passenger.

Accordingly, this surcharge will be applied to Medicaid transportation providers conducting multi-loaded or group rides. This surcharge will be applied to Medicaid taxi / livery, green car, black car, and ridesharing / transportation network vehicles (ambulance and ambulette vehicles are exempt from the surcharge).

Registration and Fee:

Medicaid transportation providers, like other transporters subject to the surcharge, must file an application for a *Certificate of Registration* in a manner prescribed by the Commissioner of Taxation and Finance. A registration fee of $1.50 must accompany the application. However, transportation providers who will be subject to the surcharge **no more** than one time in any single calendar month are not required to register. Registration is valid for three years and then subject to renewal upon payment of the registration fee. The Certificate of Registration will indicate the transportation provider's vehicle or vehicles and is **not** assignable or transferrable to other companies.

Paying the Surcharge:

Medicaid transportation providers, like other transporters subject to the surcharge, must file a monthly return with the Commissioner of Taxation and Finance within 20 days after the end of each month that indicates the number of trips and pool passengers. The form of the return, which can be electronic, will be prescribed by the Commissioner. At the time of filing the return, transportation providers must pay the amount of all surcharges to the Commissioner. Failure to pay the surcharge when due will result in a 200 percent surcharge amount penalty. Transportation providers must **not** ask Medicaid enrollees to pay the surcharge.

Reimbursement for Fee-for-Service Transportation Providers:

Transportation providers will be reimbursed for the cost of the surcharge through the Medicaid Fee-for-Service (FFS) billing system. **Medicaid Transportation providers will use the A0170 Procedure Code for tolls with the ”TU" modifier for a single trip ($2.75) and the ”TK" modifier for pool trips ($0.75 per person).**

Reimbursement for Managed Long Term Care Transportation Providers:

Managed Long Term Care plans receive a regional adjustment to the capitated rate. Transportation providers receive payment in accordance with the terms of the contract with the Managed Long Term Care plan.

Record Keeping:

Transportation providers subject to the surcharge must keep records of every trip provided or arranged and amounts paid in a form required by the Commissioner of Taxation and Finance.

Source: *November 2018 Medicaid Update*

Situations Where Medicaid Will Not Provide Reimbursement and/or May Seek Post-Payment Recoupment

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

- The individual is not eligible for Medicaid on the date of service;
- Prior authorization for the non-emergency transport was not obtained;
- The claim is not submitted to the Medicaid program within the required timeframe in the required format with 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 by the Medicaid program);
- The transportation service is available to others in the community without charge;
- The Medicaid enrollee is restricted to a primary provider, and the claim identifies another ordering provider’s identifying information;
- 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 applicable 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.

Reporting of Vehicle and Drive License Numbers

On claims for which an ambulette vehicle was ***used***, providers are required to include ***both***:

- The driver license number of the individual driving the vehicle; and
- The license plate number of the vehicle used to transport the enrollee.

If a different driver and/or vehicle returns the enrollee 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.

Source: November 2005 Medicaid Update

The Department has reached agreement with the Office of the Medicaid Inspector General and the Attorney General's Medicaid Fraud Control Unit to require that claims submitted by **taxi/livery providers include both the driver license and vehicle license plate number.** The Department agrees that reporting this information will aid in its intent to ensure quality services and program integrity.

Effective May 24, 2018, claims that do not include the required fields will be denied for edit 00267, "VEHICLE LICENSE PLATE / DRI'ER'S LICENSE NUMBER REQUIRED."

Sources: December 2015 Medicaid Update; April 2018 Medicaid Update

Ambulance Services – Use of Claim Modifier

All ambulance providers are required to include the appropriate base fee procedure code (HCPCS Code), and mileage code (when applicable), on submitted ambulance (category of service 0601) claims. Ambulance providers must also include an origin/destination modifier in each claim submission

The origin/destination modifier is not required on the Prior Authorization generated for the service.

Similar to Medicare, for each base line item, the trip origin is reported by using a modifier in the first position and the destination is reported using a modifier in the second, as follows:

- D = Diagnostic or therapeutic site other than P or H when these are used as origin codes
- E = Residential, domiciliary, custodial facility (other than 1819 facility)
- G = Hospital-based End-Stage Renal Disease (ESRD) facility
- H = Hospital
- I = Site of transfer (e.g. airport or helicopter pad) between modes of ambulance transport
- J = Freestanding ESRD facility
- N = Skilled nursing facility
- P = Physician's office
- R = Residence
- S = Scene of accident or acute event
- X = Intermediate stop at physician's office on way to hospital (destination code only)

Source: May 2009 Medicaid Update

Ambulance Services that have been approved to participate CMS Emergency Medical Triage, Treat, and Transport (ET3) Model and in NYS Medicaid's parallel model, may use the following additional destination modifiers when appropriate.

W = Treated in Place
O = Physician's Office
U = Urgent Care Facility
F = Federally Qualified Health Center
C = Community Mental Health Center (Includes Substance Use Treatment Centers)

No Additional Compensation for a Nursing Home-Provided Attendant

A number of nursing home administrators have inquired as to whether Medicaid residents or their families may be charged a fee when a nursing home staff member accompanies a resident to and from medical appointments outside the facility. For example: Nursing home personnel travels with a resident to a medical appointment to provide necessary personal care services and/or ensure effective communication between residents and medical practitioners. No additional fee or compensation will occur in these scenarios and facilities cannot utilize an elevated mode of transportation to accommodate facility staff.

3. Specific Minimum Qualifications by Category of Service

3.1 Ambulance Providers – Category of Service 0601

Only lawfully authorized ambulance services may receive reimbursement for the provision of ambulance transportation rendered to Medicaid enrollees. An ambulance service must meet all requirements of the NYSDOH. Ambulance services that are enrolled as NYS Medicaid providers, but licensed to operate in a different state, must meet all requirements of their home state.

Both non-emergency and emergency ambulance services are covered by the New York State Medicaid program.

In non-emergency situations, a determination must be made by the appropriate prior authorization official whether the use of an ambulance is medically necessary as opposed to a non-specialized mode such as an ambulette, taxi/livery service, or public transportation.

A request for prior authorization for non-emergency ambulance transportation must be supported by the Verification of Medicaid Transportation Abilities (Form 2015) of an ordering practitioner who is the Medicaid enrollee's attending physician, physician assistant, or nurse practitioner.

In cases of emergencies, emergency medical services are provided without regard to the enrollee's ability to pay, and no order or prior authorization is required. Payment will be made only if transportation was actually provided to the enrollee. The only exception to this rule is for treatment in place, provided by CMS and NYS Medicaid ET3-approved ambulance services.

Ambulance services are granted operating authority 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.

Information regarding NYSDOH ambulance certification is located online at: https://www.health.ny.gov/professionals/ems/

Rules for Requesting Non-Emergency Ambulance Transportation

A request for prior authorization for nonemergency ambulance transportation must be supported by the documented order of a practitioner approved by the Department or prior authorization official. All requests for ambulette and non-emergency ambulance transportation must include a written form verifying MA transportation abilities as specified by NYSDOH.

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.

The ordering practitioner must document in the enrollee's patient record the condition which necessitates the practitioner's ordering of a particular mode of transportation.

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

National Provider Identifier

Ambulance providers must obtain and register a national provider identifier (NPI).

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

For non-emergency prior authorizations and claims, ambulance providers will be identified via **either** their eight-digit Medicaid identification number or NPI.

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

Territory

Ambulance services are certified to operate in an explicit primary geographic area, or territory. Per Article 30 PHL §3010, every ambulance service certificate or statement of registration issued under this article shall specify the primary territory within which the ambulance service shall be permitted to operate. An ambulance service shall receive patients only within the

primary territory specified on its ambulance service certificate or statement of registration, except:

(a) when receiving a patient which it initially transported to a facility or location outside its primary territory;
(b) as required for the fulfillment of a mutual aid agreement authorized by the regional council;
(c) upon express approval of the department and the appropriate regional emergency medical services council for a maximum of sixty days if necessary to meet an emergency need; provided that in order to continue such operation beyond the sixty day maximum period necessary to meet an emergency need, the ambulance service must satisfy the requirements of this article, regarding determination of public need and specification of the primary territory on the ambulance service certificate or statement of registration; or
(d) an ambulance service or advanced life support first response service organization formed to serve the need for the provision of emergency medical services in accordance with the religious convictions of a religious denomination may serve such needs in an area adjacent to such primary territory and, while responding to a call for such service, the needs of other residents of such area at the emergency scene.

Nothing contained in this section shall be construed to prohibit any ambulance service authorized by its governing authority to do so from transportation any sick or injured resident of its primary territory from any general hospital or other health care facility licensed by the Department, whether or not such general hospital or health care facility is within the service's primary territory, to any other general hospital or health care facility licensed by the Department for further care, or to such resident's homes.

In instances where no ambulance service possessing NYSDOH operating authority is able or willing to accept a trip, the Broker will by necessity, and by the authority granted the Department under the Mutual Assistance Plan of January 2, 2018, solicit assistance from an ambulance service that does not currently have operating authority.

Questions regarding a company's primary territory can be addressed by contacting the NYSDOH Bureau of Emergency Medical Services at (518) 402-0996.

Source: February 2010 Ambulance Policy Reminder Letter

Basic Life Support (BLS) and Advanced Life Support (ALS)

In NYS, pre-Hospital care is delivered at either the basic life support (BLS) or advanced life support (ALS) levels. At times, a basic life support ambulance may encounter a seriously ill or injured patient who is in need of advanced life support care.

In these instances, the basic life support ambulance will often solicit assistance from either another ambulance service, which is approved to provide advanced life support care, or from an advanced life support first response service (ALSFR), which is a non-transporting entity that is also authorized by the NYSDOH to provide ALS care.

Only the **transporting** ambulance service may bill the Medicaid program (ALSFRs are prohibited from enrolling as Medicaid providers).

Policy for Ambulance Services Cooperating with ALS Ambulance Services, or ALSRFs, to Provide ALS Care:

BLS Ambulance services that have a cooperative arrangement with an ALSFR, or with an ALS ambulance service shall, in the event of acooperative emergency response where ALS services are provided to the patient, be allowed to submit a claim for ALS and share the Medicaid reimbursement with the ALSFR or ALS ambulance service.

As a precondition to reimbursement at the ALS fee, such ambulance services must:

1. Complete and submit to the Department the following form to effectuate affirmation of contract/agreement in place between ALSFR, or ALS ambulance service, and the transporting ambulance service to the Department.
2. Retain copies of any such contracts/agreements to be presented upon request to Department officials.
3. Ensure that the ALSFR, or ALS ambulance service, maintains a copy of the same agreement to be presented uponrequest of Department officials.
4. Ambulance services certified for basic life support only will submit claims for ALS service when ALS service is rendered by the ALSFR, or ALS ambulance service, and reimburse the ALSFR, or ALS ambulance service according to the contract/agreement.
5. Only ambulance services that have submitted affirmation of contract/agreement to the Department will be allowed to submit a claim for ALS rendered by an ALSFR.
6. For auditing purposes, maintain complete records, including, but not limited to, claims, contracts/agreements and the amount paid to the ALSFR, or ALS ambulance service.

Source: September 2010 Medicaid Update

Ambulance companies may ***not*** bill for both Basic Life Support (BLS) and Advanced Life Support (ALS) services when ALS is provided. The provision of ALS services ***includes*** the delivery of BLS services. Therefore, when an ambulance is sent to the scene of an emergency, and personnel provide ALS transportation services, only the ALS service may be billed to the Medicaid program.

Source: November 1999 Medicaid Update

ALS services must be provided by an advanced emergency medical technician. If an ambulance company has not been properly certified to provide ALS services to patients, then the company may not bill Medicaid for ALS services.

Questions regarding an ambulance services' approved level of care can be addressed by the NYSDOH Bureau of Emergency Medical Services staff at (518) 402-0996.

Specific Transportation Scenarios

Ambulance Transportation of Neonatal Infants to Regional Perinatal Centers

Ground ambulance transportation of critically ill neonates/newborns from community hospitals to Regional Perinatal Centers (RPCs) is the responsibility of the RPC. Regionalization of neonatal services into a single system of care was established by the Department 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 in their region.

The RPC will arrange for necessary ground ambulance services from the community hospital to the RPC and the RPC is reimbursed directly by Medicaid for the costs of such transportation. The RPC is responsible to find an RPC hospital bed and arrange for neonatal 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 as needed. Upon discharge of the infant, transportation from the RPC back to the community hospital is paid fee-for-service by Medicaid. Prior authorization of the transport must be sought from the appropriate Prior Authorization Official.

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

Information regarding the RPC program is available at: https://www.health.ny.gov/community/pregnancy/health_care/perinatal/regionalization_descrip.htm

Source: August 2008 Medicaid Update

Transportation of a Hospital Inpatient

When a Medicaid enrollee is admitted to a hospital licensed under Article 28 of the Public Health Law, the reimbursement paid to the hospital includes all necessary transportation services for the inpatient.

If the admitting hospital sends an inpatient **round trip** to another hospital for the purposes of obtaining a diagnostic test or therapeutic service, the original admitting hospital is responsible for the provision of the transportation services. Therefore, the admitting hospital is responsible to reimburse the ambulance (or other transportation) service for the transport of the inpatient. For example, an admitting hospital arranges for the round trip 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/enrollee.

Source: October 2006 Medicaid Update

Transportation from an Emergency Room to a Psychiatric Center

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

For the safety of the patient, law enforcement, and hospital officials, when dealing with such a person, must use an ambulance vehicle to transport that person to acute psychiatric care; not non-emergency modes of transportation such as ambulette or taxi. The patient is in immediate need of acute psychiatric care to be provided by such a facility. These ambulance transports are considered emergency transports; therefore, prior authorization is not required and this should be billed as a FFS emergency trip.

Transportation from an Emergency Room to a Trauma/Cardiac Care/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 are considered emergency transports; therefore, prior authorization is not required and this should be billed as a FFS emergency trip.

Transportation from an Emergency Room to an Emergency Room

At times, ambulance service may be requested to transport a Medicaid enrollee from an emergency room to another emergency room. These ambulance transports are considered emergency transports; therefore, prior authorization is not required and this should be billed as a FFS emergency trip.

Transportation from an Emergency Room to Another Facility

Those urgent ambulance trips from an emergency department to another facility are also considered by the Medicaid program an emergency and do not require prior authorization and this should be billed as a FFS emergency trip.

Emergency Transport from One Hospital to Another Hospital, for a Higher Level of Care

*Prior authorization is **not** required – do **not** contact the Transportation Broker*

An ambulance may be requested to transfer a patient from one hospital to another hospital, in emergency situations, when the patient requires specialized medical services that are not available at the originating hospital. Examples of this include but are not limited to: transfers to trauma, cardiac, burn, or stroke centers, or to another emergency room.

These ambulance transports are considered emergency transports; therefore, prior authorization is not required.

Air Ambulance Guidelines and Reimbursement

In determining whether air ambulance transportation reimbursement will be authorized, the following guidelines are used:

- The patient has a catastrophic, life-threatening illness or condition;

- The patient needs to be transported to a uniquely qualified hospital facility and ground transport 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.

Fixed Wing Air Ambulance

The following fixed wing air ambulance services are reimbursable when the transport physically occurs:

- Base fee;
- 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 (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 must be billed to the Medicaid program by the ground ambulance provider that provided transportation between the airport and hospital at the established basic life support fee.
- These amounts will be applied regardless of time or date of transport, i.e., day, night, weekend and holiday.
- The provider will not seek nor accept additional reimbursement from the Medicaid enrollee under any circumstance when billing the Medicaid program, other individuals or a facility, except when a third-party insurance is billed, in which casethe provider will be reimbursed as follows:
    - For patients covered by Medicare, Medicaid will pay the coinsurance and deductible amount.
    - For patients covered by other third-party insurances, Medicaid will pay the coinsurance and deductible amount **up to the established Medicaid reimbursement fee**. If the insurance company pays more than the established Medicaid fee, Medicaid will not make any additional reimbursement.
    - When an air ambulance bill is rejected by a third-party insurance with the determination that the trip was medical 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 above.
- The mileage fee will be applied only to patient loaded miles – those miles during which the patient occupies the aircraft. Unloaded miles – those miles when the aircraft is in transit to receive the patient or while the aircraft is returning to base – will not be charged.

Helicopter (Rotary Wing) Air Ambulance

The following helicopter air ambulance services are reimbursable:

- Base fee
- Patient occupied flight mileage

Insurance Clarifications

Submitting a Claim Deemed by the Primary Insurer to be Non-Emergency

When submitting a claim to the Medicaid program for a transport deemed by Medicaid to be emergency pursuant to the policies stated in this Manual, but to be non-emergency by the enrollee's primary insurer, the ambulance vendor submits a claim to Medicaid using the applicable procedure code (i.e., that code used to bill the primary insurer) **with the emergency indicator checked**. Please read and review the billing manuals on the eMedNY website: https://www.emedny.org/ProviderManuals/Transportation/index.aspx

Additionally, the claimant must properly complete the third-party payment fields on the claim.

Subrogation Notice

When a Medicaid enrollee has both commercial insurance in which the ambulance company is not a participating provider, and has 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.

Note: Providers not participating in Medicare cannot bill Medicare regardless of the New York State Subrogation Laws.

The Medicaid Subrogation Notice can be obtained from the local department of social services.

Source: April 2008 Medicaid Update

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 when the patient:

- Was transported in an emergency situation (e.g., as a result of an accident, injury or acute illness);
- Needed to be restrained;
- Was unconscious or in shock;

- Required administration of oxygen or other emergency treatment on the way to the destination;
- Had to remain immobile due to 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 Administrative Contractor (MAC) when transportation has been provided to a Medicare eligible person. Upon approval by Medicare of the claim, a claim may be submitted to Medicaid for cross-over payment. 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 submission of the claim 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 (e.g., 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, **round-trip**, 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 for Medicaid for reimbursement.

Generally, when an original admitting hospital sends a Medicaid inpatient to another hospital, **round-trip**, for the 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 patient. The transport will not be authorized by the Prior Authorization Official, 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 Administrative Contractor (MAC).

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

Regulation 18 NYCRR §360-7.3, applicable to this policy, can be found online at: http://www.health.ny.gov/regulations/nycrr/title_18/.

Medicare Denied "Excess Mileage"

Medicare will reimburse ambulance providers mileage to the closest appropriate hospital. If the ambulance travels to a more distant hospital, only the mileage to the closest hospital is covered; any additional mileage is not covered by Medicare. Appropriate is defined as a hospital capable of caring for the patient in their current medical condition.

For example, the enrollee was in Cortland County when his pacemaker began to fail. His cardiologist, who installed the pacemaker, is in Syracuse, and wanted to see the patient at St. Francis Hospital (Syracuse) as soon as possible. Medicare only paid for the miles to the nearest hospital in Cortland (presuming that the hospital in Cortland is able to care for a patient with a failing pacemaker), leaving the ambulance provider thirty-three (33) unreimbursed miles.

Below is Medicaid's policy regarding the 33 miles left unreimbursed by Medicare:

> ***When an ambulance service delivers a transport of a Medicaid enrollee who is also covered under Medicare, the ambulance provider must bill Medicare, and then Medicaid will pay the coinsurance and deductible amounts on the approved Medicare claim.***
>
> ***This issue of unreimbursed miles is an issue between the ambulance provider and Medicare; Medicaid will not authorize reimbursement for extra miles denied by Medicare. These miles are a Medicare-covered service, Medicare has considered them for payment, and adjudicated the claim.***

Payment under the fee schedule for ambulance services:

- Includes a base fee payment plus a payment for mileage;
- Covers both the transport of the enrollee to the nearest appropriate facility and all items and services associated with such transport; and
- Precludes a separate payment for items and services furnished under the ambulance benefit.

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c15.pdf

3.2 Ambulette Providers – Category of Service 0602

Only lawfully authorized ambulette services may receive reimbursement for the provision of ambulette transportation. Ambulettes must comply with all NYS Department of Transportation (NYSDOT) licensure, inspection and operational requirements,including those identified 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.

Ambulette as Taxi/Livery

An ambulette may provide taxi (curb-to-curb) service as long as the ambulette maintains the proper authority and license(s) to operate as an ambulette. The Medicaid program does not require the ambulette to be separately licensed as a taxi/livery service; rather, it operates as an ambulette providing taxi/livery service. In these situations, the ambulette will be assigned the taxi level procedure codes required for billing.

Where applicable, proof of licensure by the local Taxi and Limousine Commission is required as a condition of enrollment. In such instances, compliance with local Taxi and Limousine Commission regulations is required.

Potential new vendors should contact the prior authorization official in the area(s) in which they intend to operate to inquire about local certification requirements.

New York City Taxi & Limousine Licensure Requirement for Ambulette Companies Having Contract Carrier Permits Issued by the New York State Department of Transportation

Effective January 28, 2016, the Department no longer requires that New York City ambulette providers who have been granted contract carrier permits by the New York State Department of Transportation (NYSDOT) be licensed by the New York City Taxi and Limousine Commission (NYCTLC).

Ambulettes vehicles are regulated by NYSDOT. The NYSDOH recognizes that some ambulette providers added sedans and minivans to their fleets in order to transport ambulatory patients in need of curb-to-curb transportation billable to the Medicaid program under livery procedure codes. NYSDOT will not inspect these sedans and mini vans. Consistent with current practices of the NYSDOT, only Medicaid transports performed by ambulette providers in ambulette vehicles, must be performed in vehicles inspected semi-annually by the NYSDOT and by drivers certified under Article 19A of Vehicle and Traffic Law. Accordingly, ambulette providers may continue to use sedans and minivans to provide livery transports.

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 of transportation such as taxi or public transportation, is medically necessary. An ambulette may not be used as an ambulance to provide emergency medical services.

Ambulette services are bound by the operating authority granted them by the NYSDOT. In accordance with NYSDOT procedures, each service is given the authority to operate within a specific geographic area. In that specified area, unless contraindicated by the ambulette

services' NYSDOT-issued license, transportation is to be "open to the public" and 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 to provide Medicaid transportation within the ambulette service's area of operation, as this constitutes a violation of New York State Transportation Law §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 New York State Transportation laws may face fines and possible revocation of operating authority, as determined by NYSDOT. Those ambulette services whose operating authority has been revoked by the NYSDOT will be disenrolled from the Medicaid program, thus precluding Medicaid payment.

Source: *March 2011 Medicaid Update*

Stretcher Ambulette

Stretcher service is considered non-emergency transportation of a Medicaid enrollee who must be transported to and from medical care, is confined to bed, cannot sit in a wheelchair, and does not require medical attention/monitoring during transport**.**

A stretcher service can transport a person who self-administers oxygen. The employee of the stretcher service is not permitted to assist with the supply oxygen at any time to an enrollee. Further, at no time shall the transportation provider and his/her employees offer oxygen to a passenger, nor shall a stretcher ambulette be equipped with oxygen or oxygen delivery supplies.

A stretcher service shall not transport an enrollee who requires medical attention/monitoring or any type of medical treatment.

A stretcher service shall not transport an enrollee who is medically sedated.

The stretcher service requires at least two (2) employees to transport the enrollee. At all times, the stretcher service must supply the needed personnel to safely lift and transport a Medicaid enrollee.

The stretcher service is expected to move the stretcher over impediments such as curbs and doorways, and up and down steps where an elevator or ramp is unavailable. Necessary personnel, and/or supplemental equipment, must be available to overcome such impediments.

Requirements for Participation as a Stretcher Service

To participate in the New York State Medicaid program, a provider must meet all applicable State, County and Municipal requirements for legal operation; as well as the quality performance indicators listed in this Manual.

The Broker may require certification from stretcher transportation vendors that the expectations listed in this manual are met or exceeded .

Equipment/Safety Requirements for Stretcher Service

Every stretcher ambulette shall be equipped with a wheeled stretcher (cot), which must be used strictly in accordance with the manufacturer's instructions

Every stretcher ambulette shall be equipped with the stretcher (cot) manufacturer's supplied patient restraint straps, which must be used strictly in accordance with the manufacturer's instructions.

Every stretcher ambulette shall be equipped with a stretcher (cot) retention device, which must:

1. Be securely attached to the vehicle in accordance with the manufacturer's instructions.
2. Be compatible with the vehicle's stretcher (cot) and be manufactured by the same entity as the stretcher.
3. Be used strictly in accordance with the manufacturer's instructions, at all times.

Oxygen tanks must be secured while in the vehicle.

Stretcher Vehicle Requirements

A. Each vehicle shall comply with applicable requirements of the NYSDOT, the NYCTLC (when operating in New York City), or any other local agency that regulates the operation of a stretcher carrying vehicle.
B. Each vehicle shall be staffed with **at least** a driver and one (1) assistant, commensurate with the needs of the individual being transported, and shall only be used to transport an individual who needs transportation to or from a non-emergency medical appointment or service, is convalescent or otherwise non-ambulatory and cannot use a wheelchair, and who does not require medical monitoring, medical aid, medical care or medical treatment during transport.
C. The assistant shall be seated in the passenger compartment while the vehicle is transporting a patient and shall notify the driver immediately of any sudden perceived change in the individual's condition.

Ambulettes and "Star of Life" Logo

The "Star of Life" logo is to be used to identify emergency response vehicles that respond to an emergency situation that may necessitate medical care.

It is inappropriate for this symbol to be affixed to a vehicle operated by a non-medical provider.

The Star of Life is a registered ® image owned by the National Highway Safety Administration's Office of EMS https://www.ems.gov/staroflife.html

Source: November 2009 Medicaid Update

Rules for Requesting Ambulette Transportation

Per 18 NYCRR Section 505.10(d)(8) a request for prior authorization for transportation by ambulette or paratransit vehicle must be supported by the written order of an ordering practitioner who is the Medicaid enrollee's attending physician, physician assistant, nurse practitioner, dentist, optometrist, podiatrist or other type of medical practitioner approved by the department. All requests for ambulette and non-emergency ambulance transportation must include a written form verifying MA transportation abilities as specified 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 non-emergency ambulance transportation services on behalf of the ordering practitioner.

Note: The ordering practitioner must note in the patient's medical record the Medicaid enrollee's condition which qualifies use of ambulette transportation.

The ordering practitioner must document in the enrollee's patient record the condition which necessitates the practitioner's ordering of a particular mode of transportation.

Any ordering practitioner or entity ordering transportation on the practitioner's behalf that orders transportation which is deemed not to meet the above rules may be sanctioned according to 18 NYCRR §515.3.

Enrollee Assistance

Personal Assistance, Escorts and Carry-Downs

Personal assistance by the staff of the transportation 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 and closing doors;
- Accessing an ambulette vehicle; and
- The moving of obstacles as necessary to assure the safe movement of the Medicaid enrollee.

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 or enhanced charge.

The Medicaid program does not limit the number of stairs or floors in a building that a provider must climb in order to deliver personal assistance to a Medicaid enrollee. The ambulette provider is required to provide personal assistance and door-to-door service at no additional or enhanced charge. This means the staff must transport the enrollee from his/her front door (including apartment door, nursing home room, etc.) no matter where it is located; to the door of the medical practitioner from whom the enrollee is to receive Medicaid-covered medical services.

Please note that the Office of the Medicaid Inspector General (OMIG) has conducted preliminary on-site field reviews of various ambulette services and found that many service providers did not provide personal assistance as required. If, upon audit, the OMIG finds personal assistance was not provided by the ambulette service provider, the provider who billed for ambulette service may be subject to financial or other provider-specific sanctions, as designated by the OMIG.

Source: September 2002 Medicaid Update ; August 2011 Medicaid Update

Transporting a Medicaid Enrollee Who Needs to be Lifted onto an Examination Table

Medicaid will reimburse for the most appropriate mode of transportation required to transport an eligible enrollee to a Medicaid-covered service. Due to the increasing number of wheelchair users with excessive weight issues and other disabilities that are unable to transfer out of a wheelchair, the enrollees are faced with the prospect of requiring a lift out of the wheelchair onto an examination table.

When a wheelchair user is unable to move from the wheelchair and needs to be lifted (i.e., transferred) from the wheelchair onto an examination table, this transfer is the responsibility of a personal aide of the enrollee and/or medical practitioner. Lifting of the enrollee is not the responsibility of the transportation driver.

It is not appropriate to request the stretcher mode of transportation for an enrollee in order for the enrollee to be transferred easily onto the examination table by the stretcher personnel. Stretcher mode is inappropriate for transportation purposes when the enrollee can be safely transported in a wheelchair.
For wheelchair users who need assistance in getting out of their chair, providers who order transportation need to coordinate the enrollee's medical care among those practitioners who are able to accommodate the lifting of the enrollee onto the examination table.

Transportation vendors shall not be required to:

- accompany the enrollee throughout their appointment for the purposes of relaying treatment information to the nursing home staff or caregiver;
- enter an examination room for the purposes of transferring the enrollee on or off of an examination table; nor,
- leave provider-owned equipment (i.e., a stretcher) at the treating facility in order for the medical practitioner to render necessary treatment.

Source: December 2011 Medicaid Update

Surety Bond Requirement

The OMIG has found that several ambulette providers have gone out of business or changed ownership while having outstanding debts owed to the Medicaid program. Medicaid regulations allow for financial security, provided in the form of surety bonds, to be required as a condition of participation or continued enrollment in the Medicaid program for providers where claims submitted for payment are expected to exceed $500,000 in a single year or $42,000 in any month.

The OMIG has determined that applicants for ambulette services located in **Nassau, Westchester, Monroe, Erie, Orange and Suffolk Counties** that submit their applications on or after March 1, 2011, will be required to submit a surety bond prior to enrollment if the ambulette provider is determined to be otherwise eligible for enrollment.

In New York City, ambulette providers enrolled as a result of an ownership change will be required to submit a bond.

The surety bond requirement will apply to all applicants for new enrollment in the Medicaid program with service addresses in the counties listed above, and for enrollment as a result of an ownership change in New York City and the counties listed above where there is a new entity purchasing the company. The initial bond must be submitted prior to enrollment and the term of the bond must be for at least one calendar year.

The applicant will be contacted by the OMIG once an initial determination has been made that enrollment can otherwise be granted. At that time, the provider will be asked to submit a surety bond within 90 days in order to secure enrollment. If an applicant fails to provide a bond, the application will be denied.

The OMIG will request surety bonds for ambulette providers in the amount of $100,000 per year per applicant, or $25,000 per year for each ambulette owned or used by the applicant, whichever amount is **lower**. All surety bonds must be renewed annually. If the amount initially requested is less than $100,000, the amount of the bond may increase, up to $100,000, upon renewal if the number of ambulettes owned or used by the applicant increases. It should be noted that surety bonds are issued by insurance companies and the amount of the bond would be much higher than the actual cost to the applicant.

If an applicant estimates that the company will bill less than $500,000 for ambulette services in the first full year of Medicaid enrollment, the applicant may submit a letter with the company's enrollment application stating this and requesting an exception to the bond requirement. The letter must include an estimate of the company's annual Medicaid billings, as well as the number of ambulettes the company owns or leases and plans to purchase or lease in the first year of operation. OMIG will review this information, as well as billings of similar companies, to make a determination as to whether the bond will be required.

In addition to the pre-enrollment bond requirement in the counties listed above, all applicants approved for enrollment for ambulette services that submit an application on or after March 1, 2011, **regardless of where the company is located**, will be subject to a review of claims after

enrollment to determine if Medicaid billings exceed $500,000 per year or $42,000 in any month. If billings exceed that threshold, a surety bond for $100,000 per year (or $25,000 per year for each ambulette owned or used by the applicant during the period reviewed if that amount is lower), will be required for continued enrollment. Failure to provide a bond within 90 days will result in termination from the Medicaid program.

All surety bonds must be renewed annually while the provider is enrolled in the Medicaid program. The provider will be given notice that renewal is required at least sixty days prior to the expiration date. **Failure to renew a bond by the expiration date will result in termination from the Medicaid program.** If a provider's billings have dropped below the required threshold of $500,000 per year for the year that the surety bond was in effect, the provider may submit a request to be relieved of the obligation to provide a bond at the time renewal is required by Medicaid.

Source: *March 2011 Medicaid Update*

3.3 Taxi (Category of Service 0603) and NYC Livery (Category of Service 0605) Providers

To participate in the Medicaid program, a taxi/livery provider must meet all applicable State, County, and Municipal requirements for legal operation (including local Taxi and Limousine Commission licensure, where applicable).

All taxi and livery providers transporting Medicaid enrollees must adhere to all local municipal and regulatory agency license plate requirements. This level of service is curb to curb and personal assistance (door through door) is not required.

Rules for Requesting New York City Livery Transportation

A request for transportation via New York City livery service must be supported by the order of a practitioner who is the Medicaid enrollee's medical provider.

Prior authorization of taxi and livery services is required to ensure that a Medicaid enrollee uses the means of transportation most appropriate to his medical needs. Requests for taxi/livery services shall be made in advance by either the enrollee or the enrollee's medical provider.

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

3.4 Transportation Network Companies (TNC) - Category of Service 0609 Providers

To participate in the Medicaid program, a TNC/high-volume-for-hire-service provider must meet all applicable State, County, and Municipal requirements for legal operation (including New York

State Department of Motor Vehicle Transportation Network Company and Limousine Commission licensure, where applicable).

Prior authorization of TNC/high-volume-for-hire-services is required to ensure that a Medicaid enrollee uses the means of transportation most appropriate to his medical needs. Requests for this level of service shall be made in advance by either the enrollee or the enrollee's medical provider.

Information regarding the submission of claims is available in the Billing Guidelines Manual at:

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

Upon request, the Medicaid eMedNY Contractor provides on-site billing training. To schedule such training, please call (800) 343-9000.

4. Document Control Properties

Control Item	Value
Document Name	**Medicaid Transportation Policy Manual**
Document Control Number	2023-1
Document Type	Policy Manual
Document Version	2023-V1
Document Status	Final
Effective date	August 25, 2023

Appendix 1 – Ambulance Service and Advanced Life Support Form

Medicaid Transportation Program
Version 01/11/2012

AFFIRMATION OF CONTRACT/AGREEMENT BETWEEN AMBULANCE SERVICE AND ADVANCED LIFE SUPPORT FIRST RESPONSE SERVICE

Please complete the attached if your company is currently engaged in a contract or agreement with an Advanced Life Support First Response Service (ALSFR). This form should be completed only by representatives of the ambulance service. This information shall be submitted annually by January 31, and anytime changes or additions are necessary; and will serve as affirmation of such contract or agreement; a copy of which shall be retained by the ambulance service to be provided upon request to representatives of the Department. This form shall be submitted to the Director of the Medicaid Transportation Policy Unit via postal mail to: New York State Department of Health, Office of Health Insurance Programs, Division of Financial Planning and Policy, Corning Tower, OCP-720, Empire State Plaza, Albany, NY 12237; or via email to MedTrans@health.ny.gov.

DATE:_____

AMBULANCE SERVICE NAME:		PROVIDER NPI#:
AMBULANCE SERVICE DOH LICENSE #:		
SERVICE ADDRESS:		
PERSON COMPLETING THIS FORM:	TELEPHONE #	EMAIL ADDRESS:

ALSFR NAME Please Print	ALSFR DOH LICENSE NUMBER	AGREEMENT TIME PERIOD	
		From	To
1.			
2.			
3.			

This information must be submitted to the Department annually by January 31, and whenever an addition or change is necessary.

Appendix 2 – Acceptable Claim Modifiers

Acceptable Claim Modifiers

DIAG THERA SITE NOT P OR H ORIG/RES, DOM, CUST FACIL	DE
DIAG THERA SITE NOT P OR H ORIG/HOSP BASE DIALYSIS	DG
DIAG THERA SITE NOT P OR H ORIG/HOSPITAL	DH
DIAG THERA SITE NOT P OR H ORIG/TRANS BETW AMB MOD	DI
DIAG THERA SITE NOT P OR H ORIG/NON-HOSP DIALYSIS	DJ
DIAG THERA SITE NOT P OR H ORIGIN CODES/SNF	DN
DIAG THERA SITE NOT P OR H ORIGIN CDS/PHYS OFFICE	DP
DIAG THERA SITE NOT P OR H CDS/RESIDENCE	DR
DIAG THERA SITE NOT P OR H ORIG/DEST INTERM STOP	DX
RES, DOM, CUST FAC (NOT1819)/DIAG THERA NOT P OR H	ED
RES, DOM, CUST FAC (NOT1819)/HOSP BASE DIALYSIS	EG
RES, DOM, CUST FACILTY(NOT1819)/HOSPITAL	EH
RES, DOM, CUST FAC /SITE TRANSBETWEEN AMBUL MODES	EI
RES, DOM, CUST FAC(NOT 1819)/ NON-HOSP DIALYSIS	EJ
RES, DOM, CUST FAC(NOT 1819)/ SNF1819 FACILITY	EN
RES, DOM, CUST FAC(NOT 1819)/RESIDENCE	ER
RES,DOM,CUST FAC(NOT 1819)/DESTCD INTR STP	EX
HOSP DIALYSIS FAC/ORIG DIAG THERSITE NOT P OR H	GD
HOSP DIALYSIS FAC/RES, DOM, CUST FAC(NOT 1819)	GE
HOSP DIALYSIS FACILITY (HOSPRELATED)/ HOSPITAL	GH
HOSP DIALYSIS FAC/SITE OR TRANSBETW AMBUL MODES	GI
MULTIPLE PATIENT TRANSPORT	GM
HOSP DIALYSIS FAC(HOSPRELATED)/SNF (1819 FAC)	GN
HOSP DIALYSIS FAC(HOSP RELATED)/PHYSICIANS OFFICE	GP
HOSP DIALYSIS FAC(HOSP	GR
HOSPITAL/HOSP DIALYSIS FACILITY(HOSP OR HOSP RELAT)	HG
HOSPITAL/HOSPITAL	HH
HOSPITAL/SITE OF TRANS BETWMODES OF AMBUL TRANSP	HI
HOSPITAL/NON-HOSPITAL BASEDDIALYSIS FACILITY	HJ
HOSPITAL/SKILLED NURSING FACILITYSNF (1819 FAC)	HN
HOSPITAL/PHYSICIAN'S OFFICE	HP
HOSPITAL/RESIDENCE	HR
HOSPITAL/DEST CD INTERM STOP ATPHYS OFC TO HOSP	HX
SITE OF TRAN BETW MODE OFAMB/DIAG THER NOT P OR H	ID
SITE OF TRANS BETW MODE OFAMB/HOSP BASED DIALYSIS	IG
SITE OF TRANS BETWEEN MODES OFAMBULANCE/HOSPITAL	IH
SITE OF TRANS BETWEEN TYPES OFAMBULANCE to SITE OF TRANSFER	II
SITE OF TRANS BETW MODES OFAMB/NON-HOSP DIALYSIS	IJ
SITE OF TRANS BETW MODES OFAMB/SNF (1819 FACILITY)	IN
SITE OF TRANS BETW MODES OF AMBTRANS/PHYS OFFICE	IP
SITE OF TRANS BETW MODES OFAMB/DEST INTERM STOP	IX
NON-HOSP DIALYSIS FAC/DIAG THERAORIGIN NOT P OR H	JD
NON-HOSP DIALYSIS FAC/RES, DOM,CUS FAC (NOT 1819)	JE
NON-HOSPITAL BASED DIALYSISFACILITY/HOSPITAL	JH
NON-HOSP DIALYSIS FAC/SITE OFTRANS BETW MODES AMB	JI
NON-HOSP BASED DIALYSIS FAC/SNF(1819 FACILITY)	JN
NON-HSP-BASED DIALYSISFACILITY/PHYS OFC	JP
NON-HOSPITAL BASED DIALYSISFACILITY/RESIDENCE	JR
NON-HOSP DIALYSIS FAC/DEST CDINTERM STOP AT PHYS	JX
SNF (1819 FACILITY)/DIAG THERAORIGIN(NOT P OR H)	ND
SNF (1819 FACILITY)/HOSP BASEDDIALYSIS(HOSP RELAT	NG
SNF (1819 FACILITY)/HOSPITAL	NH
SNF (1819 FACILITY)/TRANS BETWEENMODES OF AMBUL	NI

SNF (1819 FACILITY)/NON-HOSP BASEDDIALYSIS FACIL	NJ
SNF (1819 FACILITY)/SNF (1819FACILITY)	NN
SNF (1819 FACILITY)/PHYSICIAN'SOFFICE	NP
SNF (1819 FACILITY)/RESIDENCE	NR
SNF (1819 FACILITY)/DEST CD INTERMSTOP PHYS OFFIC	NX
PHYS OFFICE/DIAG THERA SITE ORIGINCDS NOT P OR H	PD
PHYS OFFICE/RES, DOM, CUSFACILITY(NOT 1819 FACIL)	PE
PHYS OFFICE/HOSP BASED DIALYSISFACILITY	PG
PHYSICIAN'S OFFICE/HOSPITAL	PH
PHYS OFC/SITE OF TRANS BETWEMODES OF AMBUL TRANSP	PI
PHYS OFFICE/NON-HOSPITAL BASEDDIALYSIS FACILITY	PJ
PHYSICIAN'S OFFICE/SNF (1819FACILITY)	PN
PHYSICIAN'S OFFICE/RESIDENCE	PR
PATIENT PRNCD DEAD AFTER AMBLNCE	QL
AMBULANCE SERVICES UNDERARRANGEMENT BY A HOSPITAL	QM
AMBULANCE SERVICES FURNISHEDDIRECTLY BY A HOSPITAL	QN
RESIDENCE/DIAG THERA SITE ORIGINCDS NOT P OR H	RD
RESIDENCE/HOSPITAL BASED DIALYSISFACILITY	RG
RESIDENCE/HOSPITAL	RH
RESIDENCE/SITE OF TRANS BETWEMODES OF AMBUL TRANS	RI
RESIDENCE/NON-HOSPITAL BASEDDIALYSIS FACILITY	RJ
RESIDENCE/SKILLED NURSINC FACILITY(SNF)(1819 FAC)	RN
RESIDENCE/PHYSICIAN'S OFFICE	RP
RESIDENCE/DEST CD INTERM STOP ATPHYS OFF TO HOSP	RX
SCENE OF ACCIDENT ACUTE/DIAGTHER ORIG NOT P OR H	SD
SCENE OF ACCIDENT ACUTE EVENT/HOSP BASED DIALYSIS	SG
SCENE OF ACCIDENT ACUTEEVENT/HOSPITAL	SH
SCENE OF ACCIDENT ACUTE/TRANSBETW MODES AMBUL TRA	SI
SCENE OF ACCIDENT OR ACUTE/NON-HOSP BASED DIALYSIS	SJ
SCENE OF ACCIDENT OR ACUTEEVENT/SNF (1819 FAC)	SN
SCENE OF ACCIDENT OR ACUTEEVENT/PHYSICIAN'S OFFIC	SP
DEST CD INTERM STOP AT PHYS OFCON WAY TO HOSP	SX
Residential, Domiciliary, Custodial Facility Other Than SNF/Treat in Place	EW
Residential, Domiciliary, Custodial Facility Other Than SNF/Physician’s Office	EO
Residential, Domiciliary, Custodial Facility Other Than SNF/Urgent Care Facility	EU
Residential, Domiciliary, Custodial Facility Other Than SNF/FQHC	EF
Residential, Domiciliary, Custodial Facility Other Than SNF/Community Mental Health/SUD	EC
SNF/Treat in Place	NW
SNF/Physician’s Office	NO
SNF/Urgent Care Facility	NU
SNF/FQHC	NF
SNF/Community Mental Health/SUD	NC
Physician’s Office/Treat in Place	PW
Physician’s Office/Physician’s Office	PO
Physician’s Office/Urgent Care Facility	PU
Physician’s Office/FQHC	PF
Physician’s Office/Community Mental Health/SUD	PC
Residence/Treat in Place	RW
Residence/Physician’s Office	RO
Residence/Urgent Care Facility	RU
Residence/FQHC	RF
Residence/Community Mental Health/SUD	RC
Scene of Accident or Acute Event/Treat in Place	SW
Scene of Accident or Acute Event/Physician’s Office	SO
Scene of Accident or Acute Event/Urgent Care Facility	SU
Scene of Accident or Acute Event/FQHC	SF
Scene of Accident or Acute Event/ Community Mental Health/SUD	SC