NEW YORK STATE
MEDICAID PROGRAM

TRANSPORTATION MANUAL
POLICY GUIDELINES

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Section I – Requirements for Participation

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

Generally, the Medicaid Program expects of its providers:

- Timely service;
- Rides in duration of less than one hour;
- Provider employee sensitivity to the population;
- Courteous provider employees;
- Adequate vehicle staffing;
- Clean, non-smoking vehicles;
- Diligent care provided to all passengers (e.g., passenger delivered to a responsible caretaker, not dropped off alone at the curb); and
- Appropriately, adequately heated and air conditioned vehicles (i.e., heat in winter, air conditioning in summer).

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

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

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

Qualifications of Ambulette Providers – Category of Service 0602

Only lawfully authorized ambulette services may receive reimbursement for the provision of ambulette transportation. Ambulettes must be in compliance with all New York State Department of Transportation (NYSDOT) licensing, inspection and operational requirements, including those identified at Title 17 NYCRR Section 720.3(A).

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

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

Some local departments of social services (LDSS) require local certification of new ambulette services prior to new ambulette companies enrolling into the Medicaid Program. Potential new vendors should contact the LDSS in the area/s in which they intend to operate to inquire about local certification requirements.

Annual Ambulette Survey

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

The information will be requested, and a survey form provided, in each January edition of the *Medicaid Update*.

Qualifications of Taxi (Category of Service 0606) 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. Additionally, taxi/livery companies must receive support from the appropriate county department of social services in the area where the taxi/livery intends to operate in order to enroll into the Medicaid Program unless they fall under the purview of a local Taxi and Limousine Commission.

Section II – Transportation Services

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

The Medicaid Program must assure that necessary transportation is available to Medicaid beneficiaries. The requirement is based upon the recognition that unless needy individuals can actually get to and from providers of Medicaid covered services, the entire goal of the Medicaid Program is inhibited at the start. This assurance requirement means that Medicaid will consider assisting with the costs of transportation when the costs of transportation become a barrier to accessing necessary medical care and services covered under the Medicaid Program. The decision to assist with the costs of transportation is called the "prior authorization process." The Medicaid Program will cover the costs of all emergency ambulance and non-emergency transportation, when necessary, as well as the necessary transportation expenses incurred by a Medicaid beneficiary who must travel an extraordinary distance to receive medical care.

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

Approved requests for prior authorization are communicated to the transportation provider via a roster, which lists the information necessary to submit a valid claim to the Medicaid Program. The information on the claim must match the information on the prior authorization as one condition for the claim to be paid.

Non-emergency transportation services are distinguished by three separate modes of transportation:

- Ambulance (ground and air);
- Ambulette (wheelchair van); and
- Taxi/livery.

The mode of transportation used by a Medicaid beneficiary may involve a medical practitioner, who is best able to determine the most appropriate mode. Each of these categories of providers may provide single, episodic transports. Ambulette and taxi/livery providers may also provide group ride transports to and from a daily program.

The Medicaid Program intends to authorize transports using the least costly, most medically-appropriate mode of transport. If a Medicaid beneficiary uses the public transit system for the events of daily life, then transportation for the beneficiary should be requested at a mode of transportation no higher than that of the public transit system.

Record Keeping Requirements

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

- Medicaid beneficiary's name and Medicaid client identification number (CIN);
- Both the origination and destination of the trip;
- Date and time of service; and,
- Name of the driver transporting the beneficiary.

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

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

Service Complaints

Medicaid beneficiaries or their representatives, and/or medical providers or their representatives file complaints against transportation providers when it is believed that quality transportation services were not provided to a Medicaid beneficiary.

Information regarding the nature of complaints regarding the services provided by entities transporting Medicaid enrollees is forwarded to the transportation provider regarding whom the complaint was lodged, the county department of social services (DSS) and any agent coordinating transportation on behalf of the DSS, as well as the Office of the Medicaid Inspector General.

Complaints can be made to the attention of the Medicaid Transportation Unit via any of the following methods:

Telephone: (518) 408-4825

Fax: (518) 486-2495

Email: MedTrans@health.state.ny.us

Postal Mail: Office of Health Insurance Programs
Medicaid Transportation Unit
One Commerce Plaza, Suite 720
Albany, New York 12210.

Reimbursement Fees

Please contact the Medicaid Transportation Unit for a current list of reimbursement fees applicable to medical transportation services.

Qualifications of Ambulance Providers – Category of Service 0601

Only lawfully authorized ambulance services may receive reimbursement for the provision of ambulance transportation rendered to Medicaid beneficiaries. An ambulance service must meet all requirements of the New York State Department of Health (NYSDOH). Information regarding NYSDOH ambulance certification is located online at:

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

An ambulance service may provide ambulette in addition to ambulance services; however, each ambulance 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.

Ambulance Services

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 service, livery service or public transportation. The Medicaid enrollee's physician, physician's assistant, or nurse practitioner must order non-emergency ambulance services.

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

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

Billing for Advanced Life Support Assist/Fly-Car Service

Advanced Life Support Assist/Fly-Car Service is an emergency advanced life support response in conjunction with an emergency ambulance transport provided by another ambulance service.

This type of service should not be billed at the established Advanced Life Support (ALS) reimbursement fee, which is established for those providers who deliver ALS and transport the beneficiary in the provider's vehicle. ALS-assist services can only be billed if the county has an established, unique reimbursement amount for this service.

Billing for Advanced Life Support vs. Basic Life Support Services

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. This type of billing is incorrect for those counties that have established separate fees for ALS and BLS services.

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

Ambulance Transportation of Neonatal Infants to Regional Perinatal Centers

Surface 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 NYSDOH to assure that each infant who requires intensive care receives it as expeditiously as possible in the appropriate facility. RPCs have affiliation agreements with community hospitals 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 a 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.

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 LDSS.

Please note that 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:

http://nyhealth.gov/community/pregnancy/health_care/perinatal/regionalization_descrip.htm.

Source: August 2008 *Medicaid Update*.

Air Ambulance Guidelines and Reimbursement

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

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

- The patient is at a hospital that is unable to properly manage the medical condition;
- The patient needs to be transported to a uniquely qualified hospital facility 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.

A case-by-case prepayment review of the ambulance provider's Prehospital Care Report will enable the LDSS to determine if these guidelines were met.

Transportation of a Hospital Inpatient

When a Medicaid beneficiary is admitted to a hospital licensed under Article 28 of the Public Health Law, the hospital is reimbursed their inpatient fee, Diagnostic Related Group (DRG) and per diem. This reimbursement includes all transportation services for the patient.

If the admitting hospital sends a patient 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 patient. 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/beneficiary.

Source: October 2006 *Medicaid Update*.

Fixed Wing Air Ambulance

The following fixed wing air ambulance services are reimbursable:

- Base Fee (lift-off/call-out);
- 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 can 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 beneficiary under any circumstance when billing the Medicaid Program, other individuals or a facility, except when a third party insurance is billed, in which case the provider will be reimbursed as follows:

    - 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 medically unnecessary, the provider will not bill the Medicaid Program. If the third party insurance pays at the ground ambulance fee, Medicaid will reimburse as described 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 Air Ambulance

The following helicopter air ambulance services are reimbursable:

- Lift off from base and
- Patient occupied flight mileage.

Please contact the Medicaid Transportation Unit for currently established reimbursement fees.

Transport from an Emergency Room to a Psychiatric Center

An ambulance may be requested to transfer a Medicaid beneficiary 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.

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

An ambulance service may be requested to transfer a Medicaid beneficiary 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.

Ambulance Transportation by Volunteer Ambulance Services

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

- The Voluntary Ambulance Service has been authorized by the local department of social services and/or the Department to bill Medicaid at a fee established for such transportation; and

- The Voluntary Ambulance Service first bills all other applicable third party insurances.

Rules for Ordering Non-emergency Ambulance Transportation

A request for prior authorization for non-emergency ambulance transportation must be supported by the order of a practitioner who is the Medicaid beneficiary's attending physician, physician's assistant or nurse practitioner. A diagnostic and treatment clinic, hospital, nursing home, intermediate care facility, long term home health care program, home and community based services waiver program, or managed care program may order non-emergency ambulance transportation services on behalf of the ordering practitioner.

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

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

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 carrier when transportation has been provided to a Medicare eligible person. Upon approval by Medicare of the claim, a claim may be submitted to Medicaid. Claims for ambulance services will be reviewed by the Medicaid Program to determine if the Medicaid beneficiary has Medicare and if the provider billed Medicare prior to 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 to and from another hospital or freestanding facility to receive specialized treatment not available at the first hospital.

- The ambulance service is included in the hospital's Medicare Part A payment.
- In such situations when an ambulance service transports a hospital inpatient covered under Medicare to medical care not available at the hospital, the ambulance service shall seek reimbursement from the hospital.
- The provider shall not seek authorization from the Prior Authorization Official nor shall the provider submit a claim to Medicaid for reimbursement.

Reimbursement for ambulance transportation of a hospital inpatient covered only under Medicaid to and from another hospital or freestanding facility to receive specialized treatment not available at the first hospital may be included in the hospital's reimbursement or may be available as a separately billed service. The provider shall contact the Prior Authorization Official to determine whether reimbursement should be sought from the hospital or claimed through eMedNY.

Generally, when an original admitting hospital sends a Medicaid inpatient to another hospital 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 carrier.

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 Section 360-7.3, applicable to this policy, can be found online at:

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

Medicare Denied "Excess Mileage"

Medicare will reimburse ambulance providers mileage to the closest 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. For example, the beneficiary was in Cortland County when his pacemaker began to fail. His heart doctor,

who installed the pacemaker, is in Syracuse, and wanted the person to get to St. Francis Hospital (Syracuse) as soon as possible. Medicare only paid for the miles to the nearest hospital in Cortland, leaving the ambulance provider 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 beneficiary 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.***

Subrogation Notice

When a Medicaid enrollee has both commercial insurance in which the ambulance company is not a participating provider, and active Medicaid coverage, the ambulance company can send a "Medicaid Subrogation Notice" to the commercial insurance company advising them to pay the ambulance provider as an agent of the New York State Department of Health. The Medicaid Subrogation Notice can be obtained from the local department of social services.

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

Source: April 2008 *Medicaid Update*.

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.

Source: September 2008 *Medicaid Update*.

Ambulette Services

Medicaid reimbursement is available to lawfully authorized ambulette providers for ambulette transportation furnished to Medicaid beneficiaries 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.

Ambulette services are bound by the operating authority granted them by the New York State Department of Transportation (NYSDOT). In accordance with NYSDOT procedures, each service is given the authority to operate within a specific geographic area. In that specified area, 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 Section 146 which reads ***"…It shall be the duty of every motor carrier to provide adequate service, equipment and facilities under such rules and regulations as the Commissioner may prescribe."*** Ambulette services found guilty of violating 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.

An ambulette may not be used as an ambulance to provide emergency medical services. An ambulette may transport a person who requires oxygen, as long as the passenger self-administers the oxygen. An ambulette may provide stretcher services when the vehicle is appropriately configured, and may provide taxi (curb-to-curb) service as long as the ambulette maintains the proper authority and license to operate as an ambulette. The Medicaid Program does not require the ambulette to be separately licensed as a taxi/livery services; rather, it operates as an ambulette providing taxi/livery service.

Group Rides and Mileage Reimbursement

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

> For example, Ace Company's reimbursement has been established at $20 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 13 miles; and Mr. Frank to the same clinic at the same time, a one-way mileage of 7 miles.
>
> Ace will pick up both beneficiaries 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 an ambulette or van provider is reimbursed on a one-way pickup fee only (no mileage reimbursement), such as those providers operating within the City of New York, regardless of the number of miles transported, then this policy does not apply.

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

Toll Reimbursement

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

Source: May 2008 *Medicaid Update*.

New York City Ambulette and Livery Tolls

In the City of New York, ambulette and livery providers may claim the actual toll amount charged, according to the following procedure codes:

Ambulette	Livery
NY117	NY227

Online Location of Various Toll Schedules

Highway/Bridge/Tunnel	Location
• New York State Thruway • Tappan Zee Bridge • Taconic Parkway • Grand Island Bridges • Fixed Barriers (Spring Valley/New Rochelle/Harriman/Yonkers)	http://www.nysthruway.gov/tolls/toll-files.html
• George Washington Bridge • Holland/Lincoln Tunnels	http://www.panynj.gov/CommutingTravel/bridges/html/tolls.html

Highway/Bridge/Tunnel	Location
• Throgs Neck Bridge • Bronx-Whitestone Bridge • Triborough Bridge • Queens-Midtown Tunnel • Verrazano Narrows Bridge • Brooklyn-Battery Tunnel • Henry Hudson Bridge • Marine Pkwy-Gil Hodges Memorial Bridge • Cross Bay Veteran's Memorial Bridge	http://www.mta.info/bandt/traffic/btmain.htm
• Rip Van Winkle Bridge • Kingston-Rhinecliff Bridge • Newburgh-Beacon Bridge • Mid-Hudson Bridge • Bear Mountain Bridge	http://www.nysba.state.ny.us/

E-Z Pass Customers

E-Z Pass customers are charged less per toll than those who pay tolls with cash. Therefore, E-Z Pass customers should bill Medicaid for the ***actual toll amount charged*** to their E-Z Pass account while transporting a Medicaid beneficiary or beneficiaries. Providers may enroll in the E-Z Pass program online at http://www.e-zpassny.com.

Reporting of Vehicle and Driver 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 beneficiary.

If a different driver and/or vehicle returns the beneficiary 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*.

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 beneficiaries 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 beneficiary.

There is no separate reimbursement for the escort of a Medicaid beneficiary. 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 beneficiary. 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 beneficiary 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 beneficiary is to receive Medicaid-covered medical services.

Source: August 2002 *Medicaid Update*.

Stretcher Transportation Provided by an Ambulette Service

Stretcher transportation of a Medicaid beneficiary by an ambulette service is allowed under the Medicaid Program; however, the ambulette service is not permitted to render any medical services to the beneficiary. The ambulette vehicle must be appropriately configured to securely accommodate a loaded stretcher during transport.

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

The ambulette service should establish a reimbursement amount with the Department prior to commencing this service.

Rules for Ordering Ambulette Transportation

Per 18 NYCRR Section 505.10(c)(2), a request for prior authorization for transportation by an ambulette/invalid coach must be supported by the order of a practitioner who is the Medicaid beneficiary's:

- Attending physician;
- Physician's assistant;
- Nurse practitioner;
- Dentist;
- Optometrist;
- Podiatrist or
- Other type of medical practitioner approved by the Department.

A diagnostic and treatment clinic, hospital, nursing home, intermediate care facility, long term home health care program, home and community based services waiver program, or managed care program may order 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 beneficiary's condition which qualifies use of an ambulette transport.

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

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

Ambulette transportation may be requested if:

- The Medicaid beneficiary has a disabling physical condition other than one described above or a disabling mental condition requiring personal assistance provided by an ambulette service; or
- The ordering practitioner certifies in a manner designated by and submitted to the Department that the Medicaid beneficiary cannot be transported by a taxi, livery, private vehicle, or public transportation, necessitating use of an ambulette service.

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 Section 515.3.

Rules for the ordering of transportation services on behalf of New York City Medicaid beneficiaries are available in the Prior Authorizations Guidelines manual at:

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

Taxi and Livery Services

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

Rules for Ordering New York City Livery Transportation

A request for prior authorization for transportation via New York City livery service must be supported by the order of a practitioner who the Medicaid beneficiary's:

- Attending physician;
- Physician's assistant;
- Nurse practitioner;
- Dentist;
- Optometrist;
- Podiatrist or
- Other type of medical practitioner approved by the Department.

A diagnostic and treatment clinic, hospital, nursing home, intermediate care facility, long term home health care program, home and community based services waiver program, or managed care program may order 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 beneficiary's condition which qualifies use of an ambulette transport. Please refer to the Prior Authorization Guidelines Manual for more information.

Day Treatment/Day Program

Day treatment/day program transportation is unique in that this transportation can be provided by an ambulance, ambulette, taxi or livery provider. The difference is that a typical transport involves a group of individuals traveling to and from the same site at the same time on a daily or regular basis.

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

Providers of transportation to a day treatment/day program must adhere to the same requirements for their specific provider category, as previously defined.

Section III – Basis of Payment for Services Provided

Reimbursement fees are approved by the New York State Department of Health, and vary by county. It is critical that, before a transport is provided to a Medicaid beneficiary, the transportation provider verify the person's eligibility for Medicaid on the date of service. ***Reimbursement will not be made for services rendered to ineligible persons.*** To determine who to bill, please consult the local department of social services or State agency identified in the eligibility verification process.

Reimbursement is made to lawfully authorized transportation providers (ambulance, ambulette, taxi and livery) for passenger-occupied services to and from Medicaid covered services for Medicaid payment. Payment will not be made for unauthorized services.

Prior Authorization

Prior authorization is required for all non-emergency transportation. This includes ambulance, ambulette, livery, taxi and group transports such as day treatment/day program. The prior authorization of non-emergency transportation services is required to ensure that the Medicaid beneficiary uses the mode of transportation most appropriate to meet their medical needs, and that a medically adequate but less costly transportation plan cannot be arranged.

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

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

- The local department of social services (county codes 01-57 and 99);
- The New York State Office of Mental Health (county code 97);
- The New York State Office of Mental Retardation and Developmental Disabilities (county code 98); or
- The Medicaid eMedNY Contractor, Computer Sciences Corporation, for non-emergency transportation of NYC Medicaid beneficiaries (county code 66).

Procedures for requesting and obtaining prior authorization differ from one local department of social services to another. To determine the appropriate procedures, please consult the county or State agency identified in the eligibility verification process. For NYC authorizations, please consult the Prior Authorization Guidelines Manual, available at:

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

In most instances, prior authorization must be obtained before each trip (or round trip) taken by the Medicaid beneficiary. If a Medicaid beneficiary requires regular transportation due to extended treatment (such as dialysis) and the beneficiary's medical appointment is at the same location, and if the same provider is to transport the beneficiary, prior authorization may be granted for an extended period as determined by the applicable local department of social services. Whenever such prior authorization for non-emergency transportation is not obtained, reimbursement will be denied.

Prior authorization does not guarantee payment. Provider and beneficiary eligibility requirements that are not met may result in the denial of payment. Comprehensive billing information can be found in the Billing Guidelines Manual, available online at:

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

Inappropriate Prior Authorization Practices

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

Weekend and Holiday Transportation

When a Medicaid beneficiary requires an appointment for a medical service on a weekend or holiday, and the appointment is made on that same weekend or holiday, authorization may not be obtained until the next business day. In such cases, the transportation provider receives the request directly from the ordering practitioner at which the Medicaid beneficiary has the medical appointment. The transportation provider shall contact the ordering provider for NYC Medicaid beneficiaries or the appropriate local department of social services for all other Medicaid beneficiaries on the next business day in order to obtain authorization for rendered services.

Mileage Within New York City

Mileage within urban areas is difficult to control. Therefore, New York City has established fixed reimbursement amounts for trips occurring within the five boroughs encompassing the City for all modes of transportation. When a trip occurs within any of the five boroughs, i.e., Queens to Manhattan, mileage reimbursement should not be ordered from nor billed to the Medicaid Program.

NYC Medicaid beneficiaries are generally expected to obtain their medical care and services within five miles from their residence. This five-mile geographic area is considered the common medical marketing area (CMMA). Approval of transportation can be requested for trips greater than five miles from the beneficiary's residence when the medical care or service is unavailable within the CMMA. Such requests must be justified on applicable forms, as identified in the Prior Authorization Guidelines Manual. For long distance trips outside the five boroughs, NYC does allow for mileage reimbursement in addition to the fixed payment amounts, beginning at the City limits.

The difficulty orderers of transportation face is when a beneficiary resides in a borough contiguous with Westchester (Bronx) or Nassau County (Queens), and the beneficiary is traveling into the other county for medical care and service. In these situations, mileage can be ordered when the transport is greater than five miles from the beneficiary's residence. If the one-way trip is greater than five miles, the mileage calculation begins at the NYC/contiguous county border, not the beneficiary's residence. For example, a beneficiary travels a total of ten miles from Queens to Nassau County. It is two miles from the residence to the county border, and eight miles from the border to the medical site in Nassau County. The one-way mileage is eight miles.

Transports to medical care or services within five miles from the beneficiary's residence should never receive a mileage add-on.

Non-Emergency Transportation of Restricted Beneficiaries

The county and the Department may restrict a beneficiary's access to Medicaid covered care and services if, upon review, it is found that the beneficiary 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 beneficiary utilization reviews and identifies candidates for the Restriction Program. In these cases, the county and the Department may require that the beneficiary 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 beneficiary. The primary provider will provide and/or direct all medically necessary care and services for which the beneficiary is eligible within the provider's category of service or expertise. Primary providers include:

- Physicians;
- Clinics;
- Inpatient hospitals;
- Pharmacies;
- Podiatrists;
- DME Dealers;
- Dentists; and
- Dental Clinics.

When a Medicaid beneficiary has been restricted to a primary provider, only the primary provider is allowed to order transportation services for the beneficiary. This applies to all modes of non-emergency transportation and includes cases where the beneficiary's primary physician or clinic has referred the beneficiary to another provider. In such situations, ordering 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.

Subcontracting Transports

Generally, ambulette providers are to deliver transportation services in vehicles owned or leased by the provider, using drivers employed by the provider. The following

describes the difference between ***allowable*** short-term versus ***unacceptable*** long-term subcontracting.

Short Term Subcontracting
Due to mechanical breakdowns or other acute circumstances, transportation providers face times when the number of available vehicles does not meet the need for services. For example, two vehicles of Provider A are involved in traffic accidents, requiring three weeks of body work.
In this circumstance, Medicaid-enrolled Provider A may subcontract with or lease vehicles from ***Medicaid-enrolled*** Provider B. Provider A remains the provider of service, and can submit a claim for the services delivered by the drivers/vehicles of Provider B. The license plate of the actual vehicle used and driver license of the actual transporting driver must be reported on subsequent claims.

Subcontracting or leasing with a transportation vendor who is not currently enrolled as a Medicaid provider, or has been excluded from participation in the Medicaid Program, is not allowed. To verify that a provider is enrolled in the Medicaid Program, please submit a request to the Department via email (MedTrans@health.state.ny.us).

Long Term Subcontracting
The practice of Provider A reassigning trips to another transportation vendor, in a long term arrangement with no intent to secure its own vehicles and drivers, ***is unacceptable***. Such an arrangement has the potential of bypassing significant safety and financial controls that are fundamental to the integrity of the Medicaid Transportation Program.

Source: December 2008 *Medicaid Update*.

Situations Where Medicaid Will Not Provide Reimbursement

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

- The consumer 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 beneficiaries 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 beneficiary.

OMRDD Certified Programs and Facilities

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

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

Ambulance services should not be utilized for routine transportation to medical or clinical visits, or to and from day programs. ***Emergency (911-generated) ambulance services, or ambulance discharge from a hospital, may be billed separately to the Medicaid Program on a fee-for-service basis.***

Source: April 2008 Medicaid Update

Adult Day Health Care Transportation

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. (Source: http://nyhealth.gov/health_care/medicaid/program/longterm/addc.htm.)

Most adult day health care programs (ADHC) either contract separately with 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 medical appointments that take place on the same date as an ADHC visit, will not be granted.

Transportation Rosters

Both transportation providers who render transportation services and ordering providers listed as requesting the service for Medicaid beneficiaries will receive a roster identifying the services requested.

Transportation prior authorizations will appear on weekly rosters as they are generated by the county department of social services or the Medicaid eMedNY Contractor (for New York City Medicaid beneficiaries). These prior authorizations will only appear on the roster when they are first entered into the system or if any subsequent changes are made. In the majority of cases, especially for New York City beneficiaries, the authorizations will be for up to six months.

The Transportation Provider Roster lists the ordering provider for which prior authorization was requested as well as the information required to complete a claim.

Rosters received by ordering providers list prior authorized transportation services that have been ordered by the provider during a weekly period. The Roster sent to the ordering provider verifies those services that have been prior authorized and identifies the Medicaid beneficiary and transportation provider for whom authorization of services was sought.

Description of Fields on a Transportation Provider Roster

All data on the roster will appear as it was data-entered by the Prior Authorization Official. Providers should verify the accuracy of the roster prior to billing for the service. Any errors in the data should be reported to the Prior Authorization Official responsible for data entry as soon as possible. The following is an explanation of each field on the roster:

PROCESS DATE
This is the date that the roster was produced.

BILLING PROVIDER ID
This is the eight-digit Medicaid provider identification number of the transportation company. This is followed by the master file name of the transportation company.

CLIENT ID/NAME
This is the client's Medicaid identification (Example: AB12345C) and name as it appears on the Medicaid master file. Rosters appear in alphabetic order by beneficiary's last name.

DATE OF BIRTH
This is the Medicaid beneficiary's date of birth from the Medicaid master file.

SEX
This is the Medicaid enrollee's sex (M/F) as it appears on the Medicaid master file.

CNTY FISC RESP
This is the 2-digit county code of the county that established eligibility for the beneficiary. A list of county codes is available in the MEVS Provider Manual.

ORDERING PROVIDER NUM
This is the eight-digit national provider identifier or eight-digit Medicaid identification number of the practitioner, facility or program that ordered the transportation service.

PROCEDURE CODE
This is the procedure code authorized for the trip.

PA NUMBER
This is the electronically-generated eleven-digit prior authorization number for this specific trip or trips. This number must be placed on subsequent claims in the appropriate field in order to secure payment.

DETERMINATION
Codes in this field indicate the authorization status.

RSN REJECTED
If the determination is "rejected", then the rejection code will appear in this field.

PERIOD OF SERVICE FROM/TO
The beginning and ending dates of service are found in this field. If the prior authorization is for one date of service, the dates will be the same.

APPROVED QUANTITY
The number of service units for which a provided has been authorized to provide a beneficiary.

APPROVED TIMES
The number of times/days covered by the authorization.

APPROVED AMOUNT
This is the maximum dollar amount that a provider can be paid for providing a unit of service to a Medicaid beneficiary. This amount will be $0.00 unless the Prior Authorization Official has approved a specific amount per unit.

RENDERED QUANTITY
This is the total number of units and claims rendered against this prior authorization.

TOTAL NUMBER OF ENTRIES ON THIS ROSTER
This number is the total number of prior authorization lines of service appearing on this roster.

Section IV – Definitions

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

Advanced Life Support Services

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

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

Advanced Life Support Assist/Fly Car Service

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

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

In these circumstances, the ALS assist/fly car service may bill Medicaid for the ALS-assist if the county has an established fee for the service. The primary ambulance company may bill for Basic Life Support transportation.

Ambulance

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

Ambulance Service

An ambulance service is any entity, as defined in Section 3001 of the Public Health Law, which is engaged in the provision of emergency medical services and the transportation of the sick, disabled, or injured persons by motor vehicle, aircraft, boat or other form of transportation to and from facilities providing hospital services and which is certified or registered by the New York State Department of Health as an ambulance service.

Ambulette (Invalid Coach)

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

Ambulette Service

An ambulette service is an individual, partnership, association, corporation or any other legally recognized entity which transports the invalid, infirm, or disabled by ambulette to and/or from facilities which provide medical care. An ambulette service provides the invalid, infirm or disabled with personal assistance.

Basic Life Support Services

Basic life support (BLS) services are ambulance services in which the treatment provided to the patient is noninvasive and/or within the scope of practice for a NYS-certified EMT Basic. These services include the following services and all other services that are not listed as Advanced Life Support (ALS) services:

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

Common Medical Marketing Area

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

Community

A community is either the State, 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 Medicaid-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 of Mental Retardation and Developmental Disabilities or the Office of Mental Health.

Department-Established Reimbursement Fee

A Department-established reimbursement fee is the fee for any given mode of transportation that the Department has determined will ensure the efficient provision of appropriate transportation to Medicaid beneficiaries in order for the beneficiary to obtain necessary medical care or services.

Emergency Medical Services

Emergency medical services are services for the provision of initial, urgent medical care including, but not limited to, the treatment of trauma, burns, and respiratory, circulatory and obstetrical emergencies. Emergency ambulance transportation is transportation to a hospital emergency room generated by a “911” emergency system call or some other request for an immediate response to a medical emergency.

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

Local Departments of Social Services

The local department of social services (LDSS) is the locality that authorizes the Medicaid beneficiary’s eligibility for Medicaid. There are 60 LDSS in New York State, including the five boroughs encompassing the City of New York, as well as both the New York State Office of Mental Health and the New York State Office of Mental Retardation and Developmental Disabilities. The LDSS is identified by county code during the eligibility verification process (e.g., 01-Albany, 02-Allegany, etc.). A list of county codes is available in the Medicaid Eligibility Verification System Manual, online at http://www.emedny.org/ProviderManuals/index.html.

Locally Established Fee

The locally established fee is the fee for any given mode of transportation which the social services official has determined will ensure the efficient provision of appropriate

transportation for Medicaid beneficiaries in order for the Medicaid beneficiaries to obtain necessary medical care and services.

Locally Prevailing Fee

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

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

OMH and OMRDD 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 OMRDD by county code 98. These agencies are responsible for the prior authorization of both emergency and non-emergency transportation services for beneficiaries assigned them.

Non-Emergency Ambulance Transportation

Non-emergency ambulance transportation is the pre-planned provision of ambulance transportation for the purpose of obtaining necessary medical care or services by a Medicaid beneficiary whose medical condition requires transportation in a recumbent position and/or the administration of life support equipment such as oxygen, by medically-trained personnel en route to a medical appointment.

Ordering Practitioner

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

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

Personal Assistance

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

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

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

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

Prior Authorization

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

Prior Authorization Official

A prior authorization official is an official from:

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

Transportation Attendant

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

Transportation Expenses

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

Transportation Services

Transportation services are services by ambulance, ambulette, taxi, common carrier or other means of appropriate to the Medicaid beneficiary's medical condition; and the transportation attendant to accompany the beneficiary if necessary. Such services may include the transportation attendant's transportation, meals, lodging and salary; however, no salary will be paid to a transportation attendant who is a member of the beneficiary's family.

Vendor

A vendor is a lawfully authorized provider of transportation services who is either enrolled in the Medicaid Program pursuant to 18 NYCRR Part 504 or authorized to

receive payment for transportation services directly from a local department of social services.

The term vendor does not mean a Medicaid beneficiary or other individual who transports a beneficiary by means of privately owned vehicle.