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. In addition to the policies set forth in this Manual and other directives related to Medicaid policy, the Medicaid Program expects of its providers:

- Timely service;
- Rides in duration of less than one (1) 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 enrollees, and that every effort will be made to meet the needs of those enrollees 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 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 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.

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) 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.

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.

Qualifications of 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).

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 enrollees 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 enrollees. 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 enrollee who must travel an extraordinary distance to receive medical care.

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

Approved requests for prior authorization are communicated to the transportation provider via a weekly 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 enrollee may involve a medical practitioner who is best able to determine the most appropriate mode. Each of these categories of transportation providers may provide single, episodic transports. Ambulette and taxi/livery providers may also provide group ride transports to and from a daily program.

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

Record Keeping Requirements

Transportation providers will be reimbursed only when acceptable records verifying a trip's occurrence are complete and available to auditors upon request.

Ambulance Service Providers
Ambulance service providers are responsible for maintaining the Pre-Hospital Care Report, a complete record of the ambulance trip that satisfies Medicaid's trip documentation requirements.

Ambulette, Taxi, Livery, and Group Ride Providers
For each leg of the trip, verification should be completed at the time of the trip and must include, 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; and
- The full printed name of the driver providing the transportation.

Although the driver's signature is not required at this time, it is advised that providers include an attestation in the trip documentation that states, *"I provided the indicated transportation services,"* and request the driver's signature. Additionally, the weekly eMedNY-generated prior authorization roster listing all authorized trips should be reserved.

The documentation above is required for **every leg** of a trip. If any of the information above is lacking, illegible, or false, a claim will be denied.

Note: 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:

- 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.

Source: May 2010 Medicaid Update

Service Complaints

Medicaid enrollees or their representatives, and/or medical practitioners or their representatives file complaints against transportation providers when it is believed that quality transportation services were not provided to a Medicaid enrollee. Additionally, when necessary, transportation providers may register a complaint about a prior authorization official, policy, or other issue relative to their services.

Information regarding the nature of complaints regarding the services provided by entities transporting Medicaid enrollees is forwarded to the transportation provider or entity regarding whom the complaint was lodged, the county department of social services (DSS) and any agent coordinating transportation on behalf of the DSS, and, where applicable, the Office of the Medicaid Inspector General. ***Complainant identifying information is not disclosed.***

Complaints are received via the following methods:

Telephone: (518) 473-2160

Fax: (518) 486-2495

Email: MedTrans@health.state.ny.us

Postal Mail: Director, Medicaid Transportation Policy Unit
New York State Department of Health
Office of Health Insurance Programs
Division of Financial Planning and Policy
Corning Tower, Empire State Plaza
OCP - 720
Albany, NY 12237

Reimbursement Fees

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

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

Medicaid Managed Care Involvement

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#MEVS/DVS.

For enrollees covered by Managed Care 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.

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 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.

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.

Advanced Life Support Assist/Paramedic ALS Intercept/Fly-Car Service

Since Advanced Life Support (ALS) services can only be provided by specific personnel, at times, a responding ambulance company must call upon the services of such personnel. Paramedic ALS Intercept means EMT-Paramedic services provided by a second ambulance service that does not furnish the ambulance transport (*Source: 42 Code of Federal Regulations Chapter IV §414.601 10/1/02*).

This 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 enrollee in the provider's vehicle. It is unacceptable for either ambulance

service to bill Medicaid for both the physical trip and the Paramedic Intercept service. Rather, if Service A provides Paramedic Intercept services to Service B, Medicaid should see two bills:

- one from Service B providing the ground transport, and
- one from Service A for the paramedic intercept.

Note: ALS-assist services can only be billed if the county has an established, DOH-approved unique reimbursement amount for the service.

Advanced Life Support First Response Services

Due to advancing technology, ambulance service has enabled the provision of emergency care to move out of the emergency department to the scene of the emergency. Advanced trained personnel (paramedics) can provide invasive procedures (advanced life support) such as administering drugs, starting intravenous solutions, and shocking the heart while in communication with emergency department medical personnel. This onsite and en route care has improved patient outcomes.

The Department's Bureau of Emergency Medical Services now licenses entities called "Advanced Life Support –First Responders (ALSFR)," paramedic-level individuals who can provide advanced life support services but ***not*** the transportation as the transportation is provided by an ambulance service. Often these ALSFR are municipal fire departments or privately-owned companies. This practice now occurs in rural areas, which are covered by volunteer ambulance services; and in some cities, which are covered by proprietary ambulance services.

ALSFR is *not* Paramedic ALS-assist. An approved ALSFR is not permitted to enroll in and submit claims to the Medicaid Program. Further, only the transporting ambulance service submits a claim to Medicaid.

Paramedic ALS-assist is provided by a Medicaid-enrolled ambulance service licensed to deliver ALS service, while the transporting response ambulance service is licensed to provide only basic life support. In this case, both ambulance services are enrolled in Medicaid and submit a claim specific to the service rendered.

Action Required: Policy for Ambulance Services Cooperating with ALSFRs

Ambulance services that have a cooperative arrangement with an ALSFR shall, in the event of a cooperative emergency response where ALS is provided by the ALSFR, be allowed to submit a claim for ALS and share the Medicaid reimbursement with the ALSFR. Such ambulance services must:

1. Complete and submit to the Department the following form to effectuate affirmation of contract/agreement in place between ALSFR and transporting ambulance service to the Department.

2. Retain copies of any such contracts/agreements to be presented upon request to Department officials.

3. Ensure the ALSFR maintains a copy of the same agreement to be presented upon request 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, and reimburse the ALSFR according to the contract/agreement.

5. Only ambulance services who 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.

Source: September 2010 Medicaid Update

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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.state.ny.us.

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.

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. Therefore, 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.

Source: November 1999 Medicaid Update.

Advanced Life Support (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 the level of care can be addressed by the DOH Bureau of Emergency Medical Services staff at (518) 402-0996.

Territory

Ambulance services are certified to operate in an explicit primary geographic area, or territory. Per Article 30 PHL §3010, an ambulance company may receive patients only within the primary territory specified on the operating certificate or outside the territory with the exceptions indicated (i.e., upon approval of the Department of Health and the emergency medical services council to meet an emergency need). Consequently, claims for ambulance service may be submitted only when those services originate within the ambulance services' approved territory of operation **or** meet the statutorily prescribed exceptions outlined in Article 30 of Public Health Law, including the fulfillment of a mutual aid agreement authorized by the applicable regional council.

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

Source: February 2010 Ambulance Policy Reminder Letter

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 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.

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 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.

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 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 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.

Abuse of Emergency Medical Services

Per New York State Penal Code §240.50(2), it is a Class A Misdemeanor to report an emergency where none exists. Therefore, if you suspect that an enrollee is abusing ambulance services, please forward the following information to the Medicaid Transportation Policy Unit via email to MedTrans@health.state.ny.us or telephone to (518) 473-2160:

- the Medicaid enrollee's name and Medicaid identification number if available, and
- circumstances about the perceived abuse.

The Medicaid Transportation Policy Unit will catalogue the referral, analyze the transportation claim reports of each referred Medicaid enrollee, respond to the reports and intervene with the Medicaid enrollee as determined necessary.

The Office of the Medicaid Inspector General's Recipient Fraud Unit will investigate referrals made by the Medicaid Transportation Policy Unit and, where appropriate, forward the information to the local district attorney for possible prosecution.

Media reports describe the frustration of ambulance service providers when Medicaid enrollees dial 911 in non-emergency situations in order to get a ride to the hospital. These inappropriate calls reduce the availability of emergency responders for true emergencies that may arise, expend staff time and medical supplies, and pose undue risk of operating an emergency response vehicle.

It is the Department's intent to guide these enrollees to more appropriate modes of transportation while maintaining their right to seek emergency ambulance service when needed. With continuing intervention, enforcement and education, we will provide necessary emergency transportation, while maintaining the fiscal and programmatic integrity of Medicaid emergency services.

Source: May 2011 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 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/enrollee.

Source: October 2006 Medicaid Update

Transport 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.

Transport 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.

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.

Ambulance Transportation by Volunteer Ambulance Services

Volunteer ambulance services may bill the Medicaid Program for the transportation of a enrollee 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 enrollee's attending physician, physician's assistant or nurse practitioner. A diagnostic and treatment clinic, hospital, nursing home, intermediate care facility, long term home health care program, home and community based services waiver program, or managed care program may order non-emergency ambulance transportation services on behalf of the ordering practitioner.

Non-emergency ambulance transportation may be ordered when the Medicaid enrollee is in need of services that can only be administered by an ambulance service. The ordering practitioner must note in the enrollee'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 these 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 enrollee 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 §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 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, 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 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.***

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.

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

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 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 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 §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.

Ambulette Enrollment Changes

Under current Medicaid guidelines, potential Medicaid ambulette providers are denied enrollment in the Medicaid program when the proposed service will operate in New York City and the following counties determined by the New York State Department of Health to have an adequate number of existing ambulette providers:

- Fulton;
- Monroe;
- Nassau;
- Niagara;
- Onondaga;
- Rockland ;
- Suffolk; and
- Westchester.

The Medicaid program considers an exception to this policy when the new applicant has purchased an existing ambulette provider in one of the counties listed above, or has received a transfer of stock from the existing owner. In these **change of ownership** instances, there is no increase in the number of ambulette providers in the county. The new owner is required to enroll in the Medicaid program, and upon Department approval, a new Medicaid provider identification number is issued effective the final date of sale or transfer of stock.

Effective September 1, 2011, a transfer of ownership from one company or corporation to another, or the addition of new owners, stockholders or partners, for an ambulette provider operating in New York City or any of the counties listed above will only be approved by the Department when the new owner(s) agree in writing to assume all current Medicaid liabilities and any Medicaid liabilities resulting from claims issued during the seven (7) years prior to the purchase.

Source: *March 2011 Medicaid Update*

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

Ambulettes and Oxygen

An ambulette may transport a person who requires oxygen, as long as the oxygen is individually prescribed and provided, and the passenger self-administers the oxygen.

Ambulette companies may not provide oxygen or oxygen-delivery equipment to riders; and ambulette personnel may not monitor oxygen flow rates.

Source: BEMS Policy Statement 99-08

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.

Source: November 2009 Medicaid Update

Ambulette as Taxi/Livery

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/s 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.

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 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

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

Stretcher Transportation Provided by an Ambulette Service

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

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

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

Lift Policy

Medicaid will pay 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 and other disabilities who are unable to transfer out of the 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 to the examination table is not the responsibility of the transportation driver.

For wheelchair users who need assistance in getting out of their chair, requestors of transportation must coordinate the enrollee's medical care among those practitioners who are able to accommodate the lifting of the enrollee onto the examination table.

It is inappropriate 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.

In these situations, stretcher mode is inappropriate for transportation purposes because the enrollee can be safely transported in a wheelchair.

Transportation vendors should **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

Card Swipe Program

Effective February 2010, the Office of the Medicaid Inspector General (OMIG) expanded the Card Swipe Program to include ambulette transportation providers. Selected providers will receive a letter detailing the new requirements as well as a description of the program. The Card Swipe Program helps providers determine a Medicaid enrollee's current eligibility at the point of service.

This program is regulated at 18 NYCRR §360-6.2(b)(4) which states:

> ***"A[n enrollee] must present the Medicaid identification card or a Department-approved equivalent to the Medicaid provider before receiving medical services or supplies."***

In accordance with 18 NYCRR §514.5(e), providers who participate in the Card Swipe Program are required to use the VeriFone terminal in a significant number of their weekly Medicaid transactions. Minimum compliance with this requirement compels providers to swipe 85% of all eligibility transactions by passing the client benefit identification card through the VeriFone terminal at the beginning **and** end of the service. OMIG will send a letter on a quarterly basis to inform providers of their swipe percentage.

Additional Program information, including device instructions for use, is available online at:

http://www.omig.ny.gov/data/content/view/180/292/.

Source: December 2009 Medicaid Update

Surety Bond Requirement

The Office of the Medicaid Inspector General (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*

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 enrollee'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 enrollee's condition which qualifies use of ambulette transportation.

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

- The Medicaid enrollee needs to be transported in a recumbent position and the ambulette service is able to transport a stretcher as previously described;

- The Medicaid enrollee is wheelchair-bound and is unable to use a taxi, livery, private vehicle or public transportation;

- The Medicaid enrollee has a disabling physical condition which requires the use of a walker or crutches and is unable to use a taxi, livery, private vehicle or public transportation;

- An otherwise ambulatory Medicaid enrollee requires radiation therapy, chemotherapy, or dialysis treatments, which result in a disabling post-treatment physical condition, making the enrollee unable to access transportation without the personal assistance of an ambulette service.

Ambulette transportation may be requested if:

- The Medicaid enrollee has a disabling physical condition other than one described above or a disabling mental condition requiring personal assistance provided by an ambulette service; or

- The ordering practitioner certifies in a manner designated by and submitted to the Department that the Medicaid enrollee 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 §515.3.

Rules for the ordering of transportation services on behalf of New York City Medicaid enrollees are available in the Prior Authorization 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 enrollee uses the means of transportation most appropriate to his medical needs. Orders for taxi/livery services shall be made in advance by either the enrollee or the enrollee'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 enrollee's:

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

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

Please refer to the Prior Authorization Guidelines Manual for more information.

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.

Day Program

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 programs 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 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 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.

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.

Prior Authorization

Prior authorization is required for all non-emergency transportation. This includes ambulance, ambulette, livery, taxi and group transports such as day treatment/day program. The prior authorization of non-emergency transportation services is required to ensure that the Medicaid enrollee uses the mode of transportation most appropriate to 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 or applicable prior authorization official (county codes 01-57 and 99);
- The New York State Office of Mental Health (county code 97);
- The New York State Office for Persons with Developmental Disabilities (county code 98); or
- The eMedNY Call Center for non-emergency transportation of NYC Medicaid enrollees (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. A contact list containing each county's designated prior authorization official is available online at:

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

For NYC authorizations, please consult the Prior Authorization Guidelines Manual, available at:

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

In most instances, prior approval of the trip 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, 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 enrollee 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.

DOH-Contracted Prior Authorization Official

The Department of Health (DOH) has contracted with a transportation manager, Medical Answering Services to function as the Prior Authorization Official in the following voluntarily participating counties:

- Albany;
- Broome*;
- Cayuga;
- Columbia;
- Dutchess;
- Fulton;
- Greene;
- Montgomery;
- Oneida;
- Onondaga;
- Orange;
- Putnam;
- Rensselaer;
- Rockland;
- Schenectady;
- Schoharie*;
- Sullivan;
- Ulster;
- Warren;
- Washington; and
- Westchester.

*** Effective March 1, 2012**

MAS has no vehicles and will not provide transportation in competition with existing Medicaid-enrolled transportation vendors. There are **no additional requirements** for Medicaid-enrolled transportation vendors to participate with MAS. Rather, MAS will use all existing transportation vendors to the extent possible. ***Transportation vendors will not need to contract with MAS or complete a new Medicaid enrollment application to receive trip assignments.***

Through this contract with DOH, MAS is primarily tasked with:

- accepting requests for non-emergency Medicaid-funded transportation in their Syracuse-based call center, or via fax, web or email;
- disseminating approvable trips based first upon the medically appropriate mode of transportation, then by enrollee's choice among participating transportation vendors, medical provider's choice among participating vendors, and finally, where no choice is expressed, rotation among participating transportation vendors;
- generating prior authorizations according to the parameters established by the DOH;
- 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 DOH; and
- performing quality assurance surveys.

All participating transportation vendors should obtain access to MAS' web-based system to attest, cancel or request changes to trips, run reports that may help them better manage their trips, and if desired, communicate with MAS. If the transportation vendor would rather communicate with MAS via telephone, fax, email or another method, MAS is flexible and will accommodate the manner prescribed by the vendor.

Transportation vendors in affected counties should consult MAS by calling (800) 850-5340 or visiting their website:

https://www.medanswering.com/.

Inappropriate Prior Authorization Practices

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

Requests for Prior Authorization Submitted After the Trip

The Medicaid Program requires all Medicaid providers to submit a claim within 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.

Many requests submitted greater than 90 days after the date of service are done so because transportation providers cannot confirm an enrollee's Medicaid eligibility because the eligibility determination is pending action by the local department of social services. In these instances, the Medicaid Program considers the request and claim submission to be outside the 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 prior authorizations 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, up to 120 days from the date eligibility is established on the eligibility verification system will be allowed for requests for prior authorization to be submitted.

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

For requests involving changes to existing prior authorizations, the following applies:

- If the request is submitted within 90 days of the date of service, county staff (or their designee) 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, county staff (or their designee) 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, county staff (or their designee) may deny the request for a change in the authorization.

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

- If the request is submitted within 90 days of the date of service, county staff (or their designee) 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, county staff (or their designee) 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, county staff (or their designee) may deny the request for a change in the authorization.

Weekend and Holiday Transportation

When a Medicaid enrollee requires an appointment for a medical service on a weekend or holiday, and the appointment is made on that same weekend or holiday, authorization may not be obtained until the next business day. In such cases, the transportation provider receives the request directly from the ordering practitioner at which the Medicaid enrollee has the medical appointment.

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

Group Rides and Mileage Reimbursement

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 all Medicaid passengers.

> 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), 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 enrollees 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.

Mileage within New York City

Mileage within urban areas is difficult to control; therefore, the Medicaid Program has established fixed reimbursement amounts for trips occurring within the five (5) boroughs encompassing the City for all modes of transportation. When a trip occurs within any of the five (5) boroughs, i.e., Queens to Manhattan, mileage reimbursement should neither be ordered from nor billed to the Medicaid Program.

NYC Medicaid enrollees are generally expected to obtain their medical care and services within five (5) miles from their residence. This five (5) mile geographic area is considered the common medical marketing area (CMMA). Approval of transportation can be requested for trips greater than five (5) miles from the enrollee'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 (5) 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 an enrollee resides in a borough contiguous with Westchester (Bronx) or Nassau County (Queens), and the enrollee 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 (5) miles from the enrollee's residence. If the one-way trip is greater than five (5) miles, the mileage calculation begins at the NYC/contiguous county border, not the enrollee's residence. For example, an enrollee travels a total of ten (10) miles from Queens to Nassau County. It is two (2) miles from the residence to the county border, and eight (8) miles from the border to the medical site in Nassau County. The one-way mileage is eight (8) miles.

Transports to medical care or services within five (5) miles from the enrollee's residence should never receive a mileage add-on.

Non-Emergency Transportation of Restricted Enrollees

The county and 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 county and 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;
- Podiatrists;
- DME Dealers;
- Dentists; and
- 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, 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.

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.***

Source: May 2008 Medicaid Update

Some counties outside the City of New York have been assigned unique procedure codes for the authorization of toll reimbursement where applicable. For more information please contact the Medicaid Transportation Unit.

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
A0170/CG

E-Z Pass Customers

E-Z Pass customers, who are charged less per toll than those who pay tolls with cash, should bill Medicaid for the ***actual toll amount charged*** to their E-Z Pass account while transporting a Medicaid enrollee or enrollees.

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

Situations Where Medicaid Will Not Provide Reimbursement

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.

Programs and Facilities Certified by the Office for Persons with Developmental Disabilities (OPWDD)

OPWDD Day Treatment and Day Habilitation 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.***

Source: April 2008 Medicaid Update.

Adult Day Health Care (ADHC) Transportation

Most ADHC programs 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 ad hoc medical appointments that take place on the same date as an ADHC visit, will not be granted.

For the remaining programs, the Medicaid Program has assigned specific fee-for-service procedure codes for ADHC transportation. Programs whose transportation providers are paid directly by the State should use the following procedure codes when requesting prior authorization of transportation for Medicaid registrants ***to and/or from the ADHC program***:

Ambulette	**A0130/HC**

The Department will reimburse ambulette transportation providers at the applicable fee approved for ADHC transportation as follows:

County of Recipient Eligibility	One Way Pickup Fee
28 - Nassau 37 - Putnam 39 - Rockland 47 - Suffolk 55 - Westchester	$22.20
66 - NYC	$25.00
Rest of the State	$21.56

Ad hoc medical trips originating from the ADHC program (e.g., trip from the ADHC program to a physician's office) may be requested at the general procedure codes applicable to the county of recipient eligibility.

Source: July 2010 Medicaid Update; Fee-for-Service Changes to Adult Day Health Care Letters

Ambulette – Fee Changes Implemented by the Medicaid Redesign Team

The Medicaid Redesign Team (MRT) has identified ways to provide critical health care services at a lower cost, and recommended a series of proposals to fundamentally restructure and reform the New York State Medicaid program.

MRT proposal #29 concerning Medicaid transportation program initiatives contains targeted fee actions that include a reduction of the amount paid for **ambulette transportation.** The new fees, depicted in the chart below, are **effective July 1, 2011:**

County/ies	One Way Trip	July 1, 2011 Fee
New York City	**Dialysis** transportation: 5 miles or less	$27.00
New York City	**Dialysis** transportation: over 5 miles	$30.00
New York City	**All other** ambulette transportation: 5 miles or less	$29.00
New York City	**All other** ambulette transportation: over 5 miles	$34.70
Nassau & Suffolk	**Dialysis** transportation	$40.00
Nassau & Suffolk	**All other** ambulette transportation	$48.50
All Other Counties Statewide	**All** ambulette transportation	All trip unit ambulette fees reduced by $1.50
Statewide	Ambulette **mileage** fee	No Change

The table below illustrates the **new procedure codes** for **dialysis transportation in New York City.** Ordering practitioners must submit new orders for ambulette transportation of New York City Medicaid enrollees for dates of service or after **July 1, 2011.**

County	One Way Trip	Procedure Code	Modifier	Description
66-New York City	$27.00	A0130	AX	All trips to **dialysis** within 5 miles
66-New York City	$30.00	A0130	SC	All trips to **dialysis** over 5 miles

Source: May 2011 Medicaid Update

Ambulance Services - Use of Claim Modifier

All ambulance providers are required to include procedure code modifiers on submitted ambulance (category of service 0601) claims that include one of the following procedure codes:

Procedure Code	Description
A0426	Advanced Life Support, Non-emergency, Level 1
A0427	Advanced Life Support, Emergency, Level 1
A0428	Basic Life Support, Non-emergency (BLS)
A0429	Basic Life Support, Emergency, (BLS Emergency)

The 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

Acceptable Claim Modifiers

Origination/Destination	Modifier
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 ORIGIN CDS/RESIDENCE	DR
DIAG THERA SITE NOT P OR H ORIG/DEST INTERM STOP	DX
RES, DOM, CUST FAC(NOT 1819)/DIAG THERA NOT P OR H	ED
RES, DOM, CUST FAC(NOT 1819)/HOSP BASE DIALYSIS	EG
RES, DOM, CUST FACILTY(NOT 1819)/HOSPITAL	EH
RES, DOM, CUST FAC /SITE TRANS BETWEEN AMBUL MODES	EI
RES, DOM, CUST FAC(NOT 1819)/ NON-HOSP DIALYSIS	EJ
RES, DOM, CUST FAC(NOT 1819)/ SNF 1819 FACILITY	EN
RES, DOM, CUST FAC(NOT 1819)/ RESIDENCE	ER
RES,DOM,CUST FAC(NOT 1819)/DEST CD INTR STP	EX
HOSP DIALYSIS FAC/ORIG DIAG THER SITE NOT P OR H	GD
HOSP DIALYSIS FAC/RES, DOM, CUST FAC (NOT 1819)	GE
HOSP DIALYSIS FACILITY (HOSP RELATED)/ HOSPITAL	GH
HOSP DIALYSIS FAC/SITE OR TRANS BETW AMBUL MODES	GI
MULTIPLE PATIENT TRANSPORT	GM
HOSP DIALYSIS FAC(HOSP RELATED)/SNF (1819 FAC)	GN
HOSP DIALYSIS FAC(HOSP RELATED)/PHYSICIANS OFFICE	GP
HOSP DIALYSIS FAC(HOSP RELATED)/RESIDENCE	GR
HOSP DIALYSIS FAC(HOSP RELATED)/DEST INTERM STOP	GX
HOSP/DIAG THERA SITE NOT P OR H USED AS ORIGIN CDS	HD
HOSP/RES, DOM, CUST FACILITY OTHER THAN 1819 FAC	HE
HOSPITAL/HOSP DIALYSIS FACILITY(HOSP OR HOSP RELAT)	HG
HOSPITAL/HOSPITAL	HH
HOSPITAL/SITE OF TRANS BETW MODES OF AMBUL TRANSP	HI
HOSPITAL/NON-HOSPITAL BASED DIALYSIS FACILITY	HJ
HOSPITAL/SKILLED NURSING FACILITY SNF (1819 FAC)	HN
HOSPITAL/PHYSICIAN'S OFFICE	HP
HOSPITAL/RESIDENCE	HR
HOSPITAL/DEST CD INTERM STOP AT PHYS OFC TO HOSP	HX
SITE OF TRAN BETW MODE OF AMB/DIAG THER NOT P OR H	ID
SITE OF TRANS BETW MODE OF AMB/HOSP BASED DIALYSIS	IG
SITE OF TRANS BETWEEN MODES OF AMBULANCE/HOSPITAL	IH
SITE OF TRANS BETW MODES OF AMB/NON-HOSP DIALYSIS	IJ
SITE OF TRANS BETW MODES OF AMB/SNF (1819 FACILITY)	IN
SITE OF TRANS BETW MODES OF AMB TRANS/PHYS OFFICE	IP
SITE OF TRANS BETW MODES OF AMB/DEST INTERM STOP	IX
NON-HOSP DIALYSIS FAC/DIAG THERA ORIGIN	JD

Origination/Destination	Modifier
NOT P OR H	
NON-HOSP DIALYSIS FAC/RES, DOM, CUS FAC (NOT 1819)	JE
NON-HOSPITAL BASED DIALYSIS FACILITY/HOSPITAL	JH
NON-HOSP DIALYSIS FAC/SITE OF TRANS BETW MODES AMB	JI
NON-HOSP BASED DIALYSIS FAC/SNF (1819 FACILITY)	JN
NON-HSP-BASED DIALYSIS FACILITY/PHYS OFC	JP
NON-HOSPITAL BASED DIALYSIS FACILITY/RESIDENCE	JR
NON-HOSP DIALYSIS FAC/DEST CD INTERM STOP AT PHYS	JX
SNF (1819 FACILITY)/DIAG THERA ORIGIN(NOT P OR H)	ND
SNF (1819 FACILITY)/HOSP BASED DIALYSIS(HOSP RELAT	NG
SNF (1819 FACILITY)/HOSPITAL	NH
SNF (1819 FACILITY)/TRANS BETWEEN MODES OF AMBUL	NI
SNF (1819 FACILITY)/NON-HOSP BASED DIALYSIS FACIL	NJ
SNF (1819 FACILITY)/SNF (1819 FACILITY)	NN
SNF (1819 FACILITY)/PHYSICIAN'S OFFICE	NP
SNF (1819 FACILITY)/RESIDENCE	NR
SNF (1819 FACILITY)/DEST CD INTERM STOP PHYS OFFIC	NX
PHYS OFFICE/DIAG THERA SITE ORIGIN CDS NOT P OR H	PD
PHYS OFFICE/RES, DOM, CUS FACILITY(NOT 1819 FACIL)	PE
PHYS OFFICE/HOSP BASED DIALYSIS FACILITY	PG
PHYSICIAN'S OFFICE/HOSPITAL	PH
PHYS OFC/SITE OF TRANS BETWE MODES OF AMBUL TRANSP	PI
PHYS OFFICE/NON-HOSPITAL BASED DIALYSIS	PJ

Origination/Destination	Modifier
FACILITY	
PHYSICIAN'S OFFICE/SNF (1819 FACILITY)	PN
PHYSICIAN'S OFFICE/RESIDENCE	PR
PATIENT PRNCD DEAD AFTER AMBLNCE CALLED	QL
AMBULANCE SERVICES UNDER ARRANGEMENT BY A HOSPITAL	QM
AMBULANCE SERVICES FURNISHED DIRECTLY BY A HOSPITAL	QN
RESIDENCE/DIAG THERA SITE ORIGIN CDS NOT P OR H	RD
RESIDENCE/HOSPITAL BASED DIALYSIS FACILITY	RG
RESIDENCE/HOSPITAL	RH
RESIDENCE/SITE OF TRANS BETWE MODES OF AMBUL TRANS	RI
RESIDENCE/NON-HOSPITAL BASED DIALYSIS FACILITY	RJ
RESIDENCE/SKILLED NURSINC FACILITY (SNF)(1819 FAC)	RN
RESIDENCE/PHYSICIAN'S OFFICE	RP
RESIDENCE/DEST CD INTERM STOP AT PHYS OFF TO HOSP	RX
SCENE OF ACCIDENT ACUTE/DIAG THER ORIG NOT P OR H	SD
SCENE OF ACCIDENT ACUTE EVENT/HOSP BASED DIALYSIS	SG
SCENE OF ACCIDENT ACUTE EVENT/HOSPITAL	SH
SCENE OF ACCIDENT ACUTE/TRANS BETW MODES AMBUL TRA	SI
SCENE OF ACCIDENT OR ACUTE/NON-HOSP BASED DIALYSIS	SJ
SCENE OF ACCIDENT OR ACUTE EVENT/SNF (1819 FAC)	SN
SCENE OF ACCIDENT OR ACUTE EVENT/PHYSICIAN'S OFFIC	SP
DEST CD INTERM STOP AT PHYS OFC ON WAY TO HOSP	SX

Source: May 2010 Medicaid Update

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.

Nursing homes are prohibited from seeking monetary compensation from Medicaid residents or their family members. The fee-for-service reimbursement paid by Medicaid to transportation and medical providers is considered payment in full for all services rendered to the enrollee both during transit and at the medical appointment. No additional compensation should be sought or accepted.

Source: *October 2010 Medicaid Update*

Contracted Billing Agents

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

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

Additionally, these billing companies must enroll as a "Service Bureau" with the New York State Medicaid Program. Even if the billing company is enrolled as a service provider, they must separately enroll as a Service Bureau in order to submit claims on behalf of another provider.

Source: February 2010 Medicaid Update

Transportation Rosters

Both transportation providers who render transportation services and ordering providers listed as requesting the service for Medicaid enrollees 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 fiscal agent (for New York City Medicaid enrollees). These prior authorizations will only appear on the roster when they are first entered into the system or if any subsequent changes are made. In the majority of cases, especially for New York City enrollees, 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 enrollee 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 enrollee's last name.

DATE OF BIRTH
This is the Medicaid enrollee'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 enrollee. 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.

MOD
This is the modifier authorized for the trip, if applicable.

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 enrollee.

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 enrollee. 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.

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.

Additionally, claim edit 700 - PA UNITS OR PAYMENT AMOUNT EXCEEDED - will deny claims which contain more daily units than allowed by a prior authorization.

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

Source: July 2009 Medicaid Update

Procedure Codes Changes Effective April 2011

Medicaid implemented new transportation procedure codes contained in the federal Healthcare Common Procedure Code System (HCPCS). ***Effective for dates of service on or after April 27, 2011***, transportation claims require new procedure codes and modifiers in order to be processed. Claims with dates of service on or after April 27, 2011 that list the current transportation procedure codes that begin with the prefix "NYxxx" will be denied. Instead, the new procedure codes and modifiers, as described on the following page, must be submitted.

Claims *submitted* on or after April 27, 2011, for dates of service up to and including April 26, 2011, should continue to reflect the authorized "NYxxx" codes.

Some authorized transports may use only a solitary HCPCS code, while other transportation services will have a two-letter modifier attached to the same or another HCPCS code. While a solitary HCPCS code will reimburse one amount, the same HCPCS code authorized with a modifier will reimburse a different amount.

Department staff, in collaboration with staff of the department of social services in each county, have reassigned the current "NYxxx" procedure codes to the new HCPCS/modifier structure.

Specific guidelines for orderers of New York City transportation services appear in the Prior Authorization Guidelines Manual, online at:

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

The following lists available codes and modifiers, as well as the definition of each, available in each county. Please note that each county may have been assigned different codes based upon the county's individual transportation needs; and not every HCPCS code or modifier will be used in every county.

Source: December 2010 Medicaid Update

April 27, 2011 Procedure Coding System with Modifiers

HCPCS Code	Definition
A0100	Taxi: local trip or trip within the common medical marketing area
S0215	Taxi/livery/van mileage
A0110	Van transportation by county-based provider (e.g., public transit)
A0120	Van transportation by private vendor

Modifier	Definition
AX	Dialysis transportation
CG	Unassigned – available for extraordinary transports
HA	Transport to a child/adolescent program
HC	Transport to a non-geriatric program

A0130	Ambulette: local trip or trip within the common medical marketing area
T2004	Ambulette: One Way Trip
S0209	Ambulette mileage
T2005	Ambulette Stretcher transportation
T2049	Ambulette Stretcher mileage
A0170	Parking fees & Thruway/Bridge/Tunnel Tolls

HE	Transport to a mental health program
HF	Transport to a substance abuse program
HG	Transport to an addiction program
HH	Transport to an integrated mental health/substance abuse program
HI	Transport to an integrated mental health/developmental disabilities program
HK	Transport to specialized programs for high-risk populations
SC	Transportation service not otherwise defined
TF	Intermediate level of care
TG	Complex/high level of care
TJ	Group Ride of children/adolescents
TK	Extra passenger
TN	Transport outside the common medical marketing area
TU	After-hours transportation
TV	Holiday/weekend transportation

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/Paramedic ALS 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.

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

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

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 for People With Developmental Disabilities or the Office of Mental Health.

Department-Established Reimbursement Fee

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

Emergency Ambulance Transportation

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.

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.

Local Departments of Social Services

The local department of social services (LDSS) is the locality that authorizes the Medicaid enrollee’s eligibility for Medicaid. There are sixty (60) LDSS in New York State, including the five (5) 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 for Persons with 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 enrollees in order for the Medicaid enrollees 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 for Persons 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. These agencies are responsible for the prior authorization of both emergency and non-emergency transportation services for enrollees assigned to 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 enrollee 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 enrollee's attending physician or other medical practitioner who has not been excluded from or denied enrollment in the Medicaid Program and who is requesting transportation on behalf of the enrollee in order for the enrollee 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 enrollees for the purpose of assuring safe access to and from the Medicaid enrollee's place of residence, ambulette vehicle or Medicaid-covered health service provider's place of business.

Personal assistance is the rendering of physical assistance to a Medicaid enrollee 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 enrollee.

In providing personal assistance, the provider or provider's employee will physically assist the enrollee which shall include touching, or, if the enrollee prefers not to be touched, guiding ("shadowing") 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.

A Medicaid enrollee 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 enrollee 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 enrollee's transportation costs.

Prior Authorization Official

A prior authorization official is an official from:

- The local department of social services or their designated agent (county codes 01-57 and 99);
- the Office of Mental Health (county code 97); or
- the Office for Persons with Developmental Disabilities (county code 98).

Transportation Attendant

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

Transportation Expenses

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

Transportation Services

Transportation services are services by ambulance, ambulette, taxi, common carrier or other means of appropriate to the Medicaid enrollee's medical condition; and the transportation attendant to accompany the enrollee 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 enrollee's family.

Vendor

A vendor is a lawfully authorized provider of transportation services who is either enrolled in the Medicaid Program pursuant to 18 NYCRR §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 enrollee or other individual who transports an enrollee by means of privately owned vehicle.

Section V – Modifications

This section details the changes made to this manual since its last online posting.

Page #	Description of Modification
24	Added Medicaid policy regarding requests for stretcher transportation of wheelchair-bound enrollees, and the transportation vendor's responsibility in such circumstances.
31	Added counties under State-procured transportation management.