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113.01 **DEFINITIONS**

113.01-1 Department means the Department of Human Services, acting through the Bureau of Medical Services.

Effective 7/1/96

113.01-2 Full Service Transportation Provider (also referred to as a full-service transportation agency) is a Medicaid-enrolled provider who performs transportation services described in this section of the Maine Medical Assistance Manual. Provider owned, contracted or leased vehicles, including vans or buses that operate on fixed or semi-fixed routes, are used in the provision of such services. Paid volunteer drivers must be used at this level as well as paid provider-vehicle drivers.

State agencies may have an agreement with the Department to obtain reimbursement made directly to family members of foster children or adults or for volunteers acting as attendants when providing transportation to Medicaid approved services.

113.01-3 Covered Health Care Service means any health care service for which Medicaid will provide reimbursement.

113.01-4 Transportation Services mean methods of transportation and related travel expenses as described in this Section.

113.01-5 Common Carrier means a bus, train, airplane, taxi cab, or ferry. Buses include commercial carriers such as Trailways or New England Transit.

113.01-6 Related Travel Expenses mean expenses to cover those costs associated with needed transportation services that are other than routine. These expenses may include, but are not limited to, overnight lodging and meals which are paid at the current State rates and with the current State limitations as addressed in Section 40, Manual of Financial Procedures for the State of Maine.

113.01-7 Nearest Health Care Provider means a provider of a covered health care service;

A. selected by and available to the recipient who is generally available to people in that community and located within a reasonable distance from the recipient's residence or point of origin; or

113.01 **DEFINITIONS** (cont.)

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B. who is the recipient's Medicaid authorized managed care primary-care provider or a provider referred by the recipient's Medicaid authorized managed care primary-care provider or when applicable, managed care organization.

113.01-8 Prior Authorization means the approval required prior to the provision of designated services; also referred to as APTP (Authorization Prior To Provision).

113.01-9 Emergency Circumstances means a medical condition of the Medicaid recipient that requires immediate transportation but not by ambulance or police vehicle, in which case, prior authorization may be waived. When emergency circumstances exist, documentation by a medical care provider is required for reimbursement of transportation and related costs. When emergency circumstances exist and the services that are required normally would require prior authorization, documentation of the emergency and all costs must be submitted within thirty (30) calendar days from the date transportation was provided.

113.01-10 Provider Vehicle (also referred to as agency vehicle) means any vehicle owned by, contracted or leased by the transportation provider. Vehicles owned by volunteers or family members are not considered Provider Vehicles regardless of any leasing arrangement. For providers enrolled on or after August 1, 1992, at least one (1) provider vehicle must be equipped with an automatic lift for wheelchairs and in compliance with the Americans with Disabilities Act of 1990.

113.01-11 Family includes the recipient, any member of the recipient's family, or any friend or neighbor who provides transportation services. Family includes a State employee who is required to drive Medicaid recipients to medical services as part of his or her State employment responsibilities.

113.01-12 Own Home means the recipient's residence, foster home, group home, or boarding home; not an institution such as a skilled nursing facility or intermediate care facility, except as noted in Section 113.06-3(A)(4).

113.01-13 Volunteer means a person who contributes personal service to the community through the transportation provider's program but is not an employee of the transportation provider. Volunteers are recruited and

113.01-13 Volunteer (cont.)

designated as volunteer drivers by the transportation provider. A volunteer uses a vehicle other than the provider/agency's vehicle to transport Medicaid clients.

Effective 7/1/96

113.01-14 Passenger miles shall mean the actual number of miles the passenger rides in the vehicle, if the recipient is the only passenger on the vehicle and the vehicle is traveling in the most direct route to the recipient's destination. Vehicle miles driven by provider-owned vehicles on the way to or back from picking up passengers shall not be reported as service being delivered to clients. If there is more than one passenger on a vehicle only that portion of the trip that is the most direct route to the recipient's destination may be billed on behalf of that client as allowable passenger miles. Providers may use MDOT maps or appropriate travel software to help determine the most direct route. If for any reason this most direct mileage calculation cannot be determined or documented, then the provider must bill the recipient's miles using the code for a shared ride on a provider (agency) vehicle.

113.01-15 Wheelchair Van Services mean those medically-necessary transportation services provided to non-ambulatory individuals who do not require the life emergency medical services available aboard an ambulance, but who cannot, due to their disability and to the non-availability of transportation provider facilities, be transported by means of conventional transportation provider services.

113.01-16 Circuitous Trips are those trips run in an indirect or roundabout manner that result in passenger or vehicle miles that are not reimbursable by Medicaid.

113.01-17 Catchment Area is the region in which the provider is authorized by either the Maine Department of Transportation (MDOT) or the Department of Human Services to operate.

113.01-18 Attendants are individuals approved by the transportation provider to accompany children or adults with conditions which preclude their traveling alone. State employees who are required to accompany Medicaid recipients as part of their State employment may be designated as attendants.

113.01-19 Region as used in this document refers to the MDOT Regional Transportation Advisory Committee (RTAC) regions.

Effective 7/1/96

113.01-20 Wheelchair Van Provider is an enrolled Medicaid Transportation Provider that performs Wheelchair-Van Services and is reimbursed only for those limited transportation services in accordance with this policy.

A wheelchair van provider must comply with all applicable requirements of the Americans with Disabilities Act of 1990. A wheelchair van provider is subject to any regional coordination plan governing the region(s) in which it operates.

113.01-21 Pass-through Reimbursement is the amount the provider pays to the recipient or family in compensating them under the friends and family mode, or the amount the provider pays the volunteer in compensating under the volunteer mode, or the amount the provider is reimbursed for providing services under the provider vehicle mode. The rates for the pass-through reimbursement is established by the Bureau.

113.02 **ELIGIBILITY FOR SERVICES**

Payment shall be made by the Department only for necessary transportation services provided to individuals who are Medicaid recipients on the date the services are received.

The following Medicaid recipients are eligible for covered transportation services as set forth in this manual:

A. Categorically needy Medicaid recipients, whose eligibility is shown on the Medical Eligibility Card as MM, and

B. Medically needy Medicaid recipients, whose eligibility is shown on the Medical Eligibility Card as MI.

113.03 **DURATION OF SERVICES**

As long as a Title XIX recipient is Medicaid eligible, he or she may obtain covered transportation services which are necessary to assure access to covered health care services and which are provided as set forth in this Section.

The Department reserves the right to request additional information to evaluate the need for transportation services and the appropriateness of the services provided.

113.04 **COVERED TRANSPORTATION SERVICES**

Effective 7/1/96

113.04-1 Regional Requirements. The Maine Department of Transportation (MDOT) or The Department of Human Services (DHS), shall designate a catchment area for Medicaid providers of transportation covered services.

No transportation provider will be authorized to provide covered services which originate outside the assigned catchment area without approval by the Department of Human Services. Exceptions to the regional requirement will be made only to provide increased cost effectiveness of services as determined by the Department of Human Services in consultation with the Maine Department of Transportation.

All full-service Medicaid transportation providers share the State's responsibility to assure necessary transportation of Medicaid recipients whose trips originate in their region to Medicaid covered services.

A covered transportation service is a service for which payment shall be made by the Department. Arrangements for necessary transportation may include a combination of methods for a single trip, for example, ferry services from an off-shore island and the services of a volunteer driver.

A transportation provider shall provide covered transportation services to the nearest health care provider for Medicaid clients residing within, or whose proof of origin is within, the provider's catchment area. In the event a provider is contacted by a recipient outside its catchment area, that provider shall refer the client to the provider which serves that particular catchment area. Recipients may travel to the nearest provider even if that provider is outside of a transportation provider's catchment area.

All Medicaid transportation providers are subject to regional coordination requirements. (To be developed).

113.04-2 Mileage Reimbursement for Provider (Agency) Vehicles Passenger miles (see Definition 113.01-14) are reimbursable for provider controlled vehicles from the recipient's point of origin in the most direct route, to the nearest health care provider of a covered health care service and to his or her own home or point of origin. If a vehicle travels from its point of origin to final destination and returns along that

113.04-2 Mileage Reimbursement... (cont.)

same general route, regardless of the number of stops made, only the most direct route, whether taken or calculated, portion of the trip that is necessary to meet a particular client's medical needs (from the recipient's point of origin in the most direct route to the recipient's point of destination) may be billed on behalf of that client as allowable passenger miles. Circuitous trips shall not be reimbursed. Providers may use MDOT maps or appropriate travel software to help determine the most direct route. If for any reason this most direct route mileage calculation can not be determined or documented, then the provider must bill the recipient's miles using the code for a Shared Ride On A Provider (Agency) Vehicle.

113.04-3 Mileage Reimbursement to a Family. Actual miles traveled are reimbursable by the provider to the family at the amount listed in Chapter III, when the client or family uses their own car or has arranged for the use of a privately-owned vehicle. Reimbursement to a recipient or family, except in an emergency circumstance, will be only for transportation that the provider has authorized prior to the actual trip. The transportation agency must determine that the total mileage for each trip to the nearest health care provider is reasonable. Reimbursement is available only for the number of odometer miles from the recipient's point of origin to the recipient's destination and back to the recipient's point of origin in the most direct route. The recipient must be riding in the vehicle in order to receive any reimbursement.

Effective 3/5/97

The Maine Department of Transportation (DOT) map mileage or actual odometer readings shall be used to calculate mileage reimbursement. If more than one Medicaid family member recipient is transported, the provider must bill the total mileage for the family transportation services under only the name of the recipient traveling the greatest distance.

State employees who are required to drive Medicaid recipients to medical services as part of their State employment responsibilities shall be considered as "Family" and reimbursed directly for mileage and/or related travel expenses by the State or transportation provider at the State rate when driving their own vehicle.

Foster care parents when transporting Medicaid recipients are considered family and cannot enroll as volunteers. Foster care parents are reimbursed at the State Worker Rate in Chapter III.

113.04-4 Mileage Reimbursement to a Volunteer Driver. Vehicle miles are reimbursable to a volunteer driver at no more than the amount listed in Chapter III when prior arranged by the transportation provider.

Volunteers performing round trips for the same recipient are expected to wait for the recipient and/or not record any additional billable mileage, such as to return home, without prior approval by the transportation provider. The Maine Department of Transportation map mileage may be used to calculate mileage reimbursement. Portions of the trip not related to transporting Medicaid recipients to the health care provider shall not be reimbursable. Where more than one Medicaid recipient is transported, total mileage for the volunteer transportation services will be billed under the name of the recipient traveling the greatest distance. The transportation agency must determine that the total mileage for each trip to the nearest health care provider is reasonable.

It is understood that it may not always be practical or economical for a volunteer to wait for a client while at an appointment with a health care provider. Therefore, when arrangements are made to return the client to his or her residence or point of origin, the provider may bill for the shortest route mileage for this second part of the trip.

Effective 3/5/97

113.04-5 Mileage Reimbursement for an Attendant. In the event that transportation is for children, or for adults with conditions which preclude their traveling alone, the client (or responsible person) may make arrangements for one person to accompany the recipient and seek travel reimbursement as an attendant. Attendants are not required to be Medicaid recipients. Attendants who are also State employees are paid at the current State mileage rate per vehicle mile when driving their vehicle. When a State employee is an attendant and travels in a volunteer vehicle with the client, no extra reimbursement is necessary.

When attendants, other than State employees, drive their own vehicles and function as a volunteer driver, they will be reimbursed at the volunteer mile rate.

Provider reimbursement is not available for attendants traveling on provider vehicles.

Expenses for attendants traveling on public transportation are reimbursed to the provider at the common carrier rate, with the exception of taxis. No reimbursement for attendants is available to the provider when provided on a taxi.

Effective 7/1/96

113.04-6 Public Transportation Fare. Public transportation fare is reimbursable to the recipient when a recipient purchases the minimum required transportation on a fixed route common carrier, such as a bus or ferry. The recipient must submit a minimum of ten (10) or more fixed-route common carrier receipts, such as dated bus transfers, or less than ten

(10) receipts but totaling ten dollars ($10.00) or more in order to receive any reimbursement. In addition, the transfers or similar verification of healthcare appointments, signed or stamped by the healthcare provider, for each corresponding date of healthcare services, must also be submitted to the transportation provider in order to receive any reimbursement. Providers must notify recipients utilizing public transportation of the requirement to submit receipts to the provider so the provider can bill the Department within one year of the date of the first trip receipt. No reimbursement is available to the recipient or the provider unless submitted within one year from the date of the trip. If a recipient uses a volume purchase ticket, no receipt will be issued.

If a recipient uses a volume purchase discount ticket, including a bus pass, to purchase public transportation, he or she must submit proof of the discount ticket, as well as proof of each medical appointment in order to receive any reimbursement. In that event, reimbursement to the recipient will be limited to no more than the volume purchase ticket or the non-discounted cost of the public fare required for transportation to the medical appointment, whichever is less. An attendant traveling with a recipient on a common carrier, other than a taxi, may be reimbursed by the provider whenever the attendant submits a request for reimbursement.

The provider shall receive a provider base rate reimbursement for processing these common carrier receipts only when the recipient submits for reimbursement ten (10) or more receipts, or less than ten (10) receipts totaling ten dollars ($10.00) or more. Providers currently having alternative arrangements with fixed-route common carriers which meet the requirements regarding use of public fixed-route services, may continue to provide service under their existing arrangements, however no base rate will be available to the provider for scheduling these trips.

The provider may receive a provider base rate reimbursement for arranging for a trip that includes the purchase of a single ticket on a common carrier other than a local urban fixed-route bus or local ferry or taxi. For example, a base rate is available for a single ticket on a long distance interstate common carrier or for an international ferry.

113.04-6 Public Transportation Fare (cont.)

Effective 7/1/96

Transportation providers may have written agreements with taxi companies to provide transportation for emergency circumstances, as defined in this section, and when requested outside of the normal business hours of the provider . No provider base rate is available for

transportation arranged on taxis. All taxi reimbursement must be billed using the taxi code.

113.04-7 Wheelchair Van Services. Wheelchair van services are reimbursable for Medicaid recipients only when a full-service Medicaid transportation provider documents the non-availability or unsuitability of conventional transportation services. The full service transportation provider will perform the service if possible or, if unable to perform the service, and all other full-service providers in that region are unable to perform the service, refer the client to a wheelchair van service participating with Medicaid in either that, or the nearest catchment area. The wheelchair van provider must maintain documentation from all full-service providers in the region indicating approval for their services. The wheelchair van service provider must bill Medicaid directly only with the procedure codes assigned to them.

For recipients residing at a nursing facility or boarding home, the facility or home must determine which type of service below is appropriate for the recipient. The following types of services may be provided depending on the client's needs:

A. Curbside Service

At a prearranged time, a client may be picked up at curbside and transported to a specified destination and back. The client must have the mental and physical ability to get from curbside to the door.

B. Door-Through-Door Service

Clients may be provided with whatever assistance is medically necessary over and above curbside service, including: transporting into or out of the residence, transporting up or down stairs and assistance getting into or out of the wheelchair.

113.04-7 Wheelchair Van Services (cont.)

Effective 7/1/96

For residents of nursing facilities or boarding homes, all transportation providers must request prior authorization for required repetitive transportation or wheelchair van services from the Bureau of Medical Services (BMS) whenever the nursing facility is unable to provide transportation services to required ongoing medical services, such as dialysis, radiation or chemotherapy. The only exceptions to this prior authorization requirement is when the nursing facility or boarding home maintains documentation, medically justifying, that the patient cannot transfer from the wheelchair to the facility car or van and, therefore, cannot be transported by the facility vehicle.

These medical transportation services are normally provided for by means of separate funding and reimbursed on a per diem basis to the nursing facility or boarding home. The nursing facility or boarding home must document why their vehicle was not used.

For reimbursement purposes the wheelchair van shall be considered a provider vehicle and passenger miles are determined and billed in accordance with 113.01-14, Passenger Miles, and 113.04-2, Mileage Reimbursement for Provider Vehicles.

Wheelchair van providers are responsible for: determining necessity, the nearest health care provider, emergency transportation, regional coordination, and prior authorization provisions, in accordance with this policy.

Wheelchair van providers cannot bill for attendant services or any other full-service provider codes allowed in Chapter III.

113.04-8 Highway Tolls and Parking Fees. Highway tolls and parking fees are reimbursable when a private family vehicle or volunteer vehicle is used to transport a recipient to a covered health care service. Receipts must be submitted with the request for mileage reimbursement. Please refer to Section 113.06-3 for out-of-state travel requirements.

113.04-9 Related Travel Expenses. Related travel expenses require prior authorization and are reimbursable at the current State rates and the current state limitations when travel time or distance necessitate recipients staying overnight in order to receive medically necessary health care services. Related travel expenses coverage shall not apply to expenses for meals and lodging while awaiting transplant services.

113.04-10 Seven-Day Clinics Services. Transportation reimbursement will be available for transportation to freestanding clinics, such as Methadone Clinics, which generally require the provision of services to recipients seven days per week regardless of the limits on transportation imposed by the service limits in other sections of the Maine Medical Assistance Manual and until such time as these services are covered by the Department under a Home and Community Based Waiver program.

The transportation provider may receive a provider base rate for the arrangement of these transportation services. The base rate is limited to once every seven (7) round trips for the most cost effective means to the Department, and billed in accordance with this Chapter and the Seven-Day Clinics Services listed in Chapter III. Effective with services provided on or after 11/25/96, when no other means of transportation exist, taxis are a reimbursable mode f or the provision of Seven-day clinic services. Providers must notify recipients utilizing seven day clinic services of the requirement to submit requests of reimbursement to the provider so the provider can bill the Department within one year of the date of the first trip receipt. No reimbursement is available to the recipient or the provider unless submitted within one year from the date of the trip.

Effective 11/25/96

113.05 **NONCOVERED SERVICES**

Providers may establish a policy for billing recipients for non-covered services providing recipients are informed in advanced of their policy and their policy pertains to all persons they transport, not just Medicaid recipients.

113.05-1 No Show

When a recipient fails to keep a prior arranged transportation appointment with a volunteer, a provider vehicle, or taxi, (referred to as a “no show”,) no Medicaid reimbursement is available.

113.06 **POLICIES AND PROCEDURES**

Effective 7/1/96

Prior to the provision of covered health care services, transportation may be arranged or provided to covered health care services by the transportation provider only when transportation is not otherwise available. When transportation is arranged or provided, the transportation provider must be able to document it is the least expensive means available, to the Medicaid program, that is suitable to the recipient's medical needs. There are a variety of alternatives available to meet clients needs including, but not limited to, free sources, car pooling, fixed route buses or ferries, trains, planes, family members, volunteer drivers, or provider controlled vehicles.

113.06-1 Determining Necessity. Transportation providers will receive requests for transportation and evaluate them for necessity prior to arranging or providing actual transportation.

In arranging or providing transportation, providers have an obligation to assure that payment is made only where free transportation is not otherwise available. Reimbursement is available for the least expensive, to the Department, means suitable to the recipient's medical needs.

A. If a recipient, family member, neighbor, friend or voluntary organization has been providing a recipient with transportation for health care services, the Department will expect those sources to continue providing such transportation unless the recipient indicates that such transportation is no longer available because of evident hardship or a significant change in circumstances. The transportation provider shall normally rely upon the Medicaid recipient's representation that they have no other means of transportation available.

Recipients do not have a choice of the mode of transportation. Those recipients currently arranging their own means of transportation and being reimbursed under the friends and family mode are expected to continue to do so. A reduction in the Medicaid reimbursement for the friends and family mode is, by itself, not considered a hardship, or a significant change in circumstances and will not qualify as having no other means available. Additional demonstration of recipient change of circumstances or hardship will be necessary, otherwise recipients will be required to continue to utilize their own vehicles. When

113.06-1 Determining Necessity (cont.)

requested, prior to provision of services, the Department's Bureau of Medical Services shall assist recipients in establishing their need for transportation services.

Effective 7/1/96

Factors in making this determination must include each individual's circumstances including but not limited to the following:

- the recipient has a current Medicaid eligibility card;
- whether the recipient or family can provide or arrange its own transportation, or has in the past;
- availability and cost of public transportation;
- the individual's age and physical abilities;
- geographic location;
- type of transportation service required; and
- location of a nearest health care provider (113.01-7).

B. The requested service must be for a future scheduled time. Payment will not be made for previously-incurred transportation or related travel expenses. Except in emergency circumstances as defined in 113.01-9, the future scheduled time requirement may be waived provided written documentation by the medical care provider of the emergency circumstances is submitted to the transportation agency by either the recipient or the health care provider.

C. The recipient must reside in his or her own home unless the recipient meets the exceptions outlined in Section 113.06-3(A)(4).

D. Transportation shall be to a covered health care service, as identified in the table of contents of the Maine Medical Assistance Manual (MMAM). The transportation to a service listed in the table of contents will not be subject to the limits described in those pertinent sections of the MMAM.

E. Transportation must be to the nearest health care provider as defined in Section 113.01-7.

The transportation provider determines whether or not the client's choice of health care provider meets the definition of nearest health care provider.

113.06-1 Determining Necessity (cont.)

Effective

7/1/96 If a recipient requests services to a health care provider and that provider is not the nearest health care provider, then the recipient must show good cause. Examples of good cause, include, but are not limited to:

1. The nearest health care provider refuses to treat the recipient;

2. The nearest health care provider cannot provide the specific service; or

3. The Department will also consider granting good cause exceptions to recipients who can satisfactorily establish that it is necessary to be treated by a provider who is not the nearest provider. In most cases such an exception will only be granted when the recipient can provide evidence of a valid medical reason that it is in the recipient's best interest not to be treated by the nearest provider.

   The recipient may receive reimbursement for transportation to a provider who is not the nearest health care provider when the cost of the health care, transportation, or a combination of the two is less costly to the Department than the nearest provider.

F. Transportation for medications will be reimbursed only when the medications are for immediate medical necessity. Separate trips to obtain medication refills will not be reimbursed.

113.06-2 Arranging or Providing Cost Effective Transportation. After a provider has determined that a recipient qualifies for transportation services, it shall arrange or provide transportation in the least expensive, to the Department, manner suitable to meet the recipient's medical needs. Unless prior approval is required, the provider shall make every effort to provide transportation services even if they fall outside the provider's routine practice for advance notice.

In seeking to arrange the least expensive, to the Department, means, providers shall first seek all sources of free transportation assistance available in its region, such as arrangements with local and voluntary

113.06-2 Arranging or Providing Cost Effective Transportation (cont.)

Effective 7/1/96 organizations such as the American Red Cross, church groups, and senior citizen groups. If a provider finds it difficult to arrange for free

services in its region, maintaining documentation, such as a semi-annual letter from its identified possible sources of free services, regarding the lack of availability of free services, shall satisfy the requirement to first seek all sources of free transportation assistance.

A. Car pooling with another recipient(s) where appropriate. When carpooling is utilized, only the recipient utilizing his/her vehicle shall receive reimbursement. The recipient shall receive reimbursement at the family rate when car pooling.

B. Fixed-route bus or ferry. When the distance to and/or from public transportation, such as fixed route buses or ferries, as a link between origin and destination does not exceed 1/4 mile and public transportation is available and an appropriate level of service, then public transportation will be utilized. Where available and appropriate, public fixed-route bus transportation is considered less costly than the friends and family mode. Recipients who qualify for public fixed-route bus but wish instead to drive their own vehicle, may do so, however the reimbursement will be as if they had taken the fixed route bus, except their odometer mileage replaces the need for a bus transfer or pass.

C. Arranging shared rides with other recipients utilizing a volunteer driver.

113.06-3 Prior Authorization

A. Prior authorization for reimbursement is required in the following circumstances:

1. transportation or wheelchair van service to out-of-state covered health care services;

2. when related travel expenses have been requested;

3. when unusual requests have been made by recipients or providers. In such instances, the State agency staff will assist the transportation provider in making decisions;

113.06-3 Prior Authorization (cont.)

Effective 7/1/96

4. when repetitive transportation or wheelchair van service is requested for clients residing in a nursing facility (NF) or boarding home.

   Transportation to Day Habilitation Services does not require prior authorization.

In the event that the nursing facility cannot provide transportation services, i.e., when transportation services are not reimbursed under their per diem, the transportation provider must request prior authorization for routine transportation for required repetitive medical services, such as but not limited to: dialysis, chemotherapy, and radiation therapy. The Bureau of Medical Services will notify the nursing facility, recipient, and transportation provider of the decision regarding authorization for transportation services.

The wheelchair van service may be provided without prior authorization only when the nursing facility patient cannot transfer from the wheelchair to a car or van and medical documentation to support this is on file at the nursing facility. A direct call to a wheelchair van provider for wheelchair van services must first be referred to the nearest full-service transportation provider in their region for the determination of the least costly appropriate means of meeting the recipient's needs. After such approval, the full service provider may agree in writing to have the nursing facility and the wheelchair van provider arrange for services directly.

Prior authorization must be requested before services are provided. In emergency circumstances, as defined in 113.01-9, prior authorization may be waived provided documentation by a medical care provider is submitted to the transportation agency in writing by either the Medicaid recipient or the medical care provider.

B. Prior authorization must be requested in writing. The request must include the recipient's name, ID number, and birth date, as well as the following pertinent information regarding the request:

   1. Method of transportation;

   2. State the necessity when a person is to accompany the recipient;

3. Charge for transportation method;

4. Date(s) of service(s); and

5. Specific related travel expenses.

C. Procedure to Request Prior Authorization. Requests for prior authorization must e made on form MA-56R, "Request for Prior Authorization". The MA-56R form must be completed in accordance with procedures set forth in Appendix 1 of this Section.

Effective 7/1/96

The MA-56R form may be faxed to the Department. The white copy of the completed form must be mailed to:

Professional Claims Review Unit
Division of Benefits Management
DHS/Bureau of Medical Services
#11 State House Station/249 Western Ave.
Augusta, Maine 04333-0011

The Professional Review Unit staff will notify the providers of approval or denial of the request. If approved, a prior authorization number will be designated in the approval letter.

113.06-4 Records

Agencies must maintain for a minimum of three (3) years appropriate recipient and fiscal records that document: 1) the transportation services provided each recipient, 2) the basis for decisions rendered by the agency concerning those services, and 3) the costs and charges to provide those services. Appropriate records include copies of correspondence, receipts, and vouchers.

A. Recipient Records. Recipient records must include, but are not limited to, the following information:

1. Name, address, and telephone number of the recipient;

2. Birth date;

3. Medicaid identification number;

113.06-4 Records (cont.)

4. If an attendant is needed for a child or an incapacitated adult, the name of the attendant;

5. A brief description of the factors used to determine that the recipient qualified for Medicaid reimbursement of transportation services;

6. The method(s) of transportation provided and the cost(s) of each;

7. Date(s) transportation provided;

8. Departure and destination points for each transportation service; and

9. Name and location of the health care provider.

Effective 3/5/97

10. Name of the family or volunteer driver.

B. Fiscal Records

The agency must maintain accurate and auditable financial records which are in sufficient detail to substantiate charges for a period of not less than three (3) years following the date of service.

If an audit is initiated within the required retention period, the records must be retained until the audit is completed and any settlement made.

The agency will maintain documentation in sufficient detail to substantiate services billed to the Department. Documentation must include receipts and records of mileage, including odometer mileage for every trip billed when the DOT mileage map is not used. Mileage is to be rounded up or down to the nearest whole mile.

C. Recipient and fiscal records, or copies thereof, shall be made available to authorized state and federal representatives at no cost to the Department.

113.06-5 Surveillance and Utilization Review

Effective 7/1/96

A. Medicaid Surveillance and Utilization Review, Bureau of Medical Services, monitors the medical services provided and determines the appropriateness and necessity of the services.

B. The Department and its professional advisors regard the maintenance of adequate client records as essential for the delivery of quality care. In addition, providers should be aware that the transportation provider's records are key documents for post-payment audit. In the absence of proper and complete client records, no payment will be made and payments previously made may be recovered in accordance with Chapter I of this Manual.

C. The Department requires that copies of client records and other pertinent information will be transferred, upon request and with the client's signed release of information, to other providers involved in the client's care.

D. Upon request, the provider must furnish to the Department, without additional charge, the records, or copies thereof, corresponding to and substantiating services billed by the provider.

113.06-6 Recipient Notice and Hearing Rights

A. If a qualified Medicaid recipient requests transportation services to a provider who is not the nearest health care provider, then that request shall be referred to the Bureau for prior authorization. Any denial shall inform the recipient that they may be reimbursed up to the amount which would be allowed for services to the nearest health care provider.

For example, Presque Isle recipient seeks services in Portland when nearest provider is in Bangor and no good cause exists. Recipient can obtain services in Portland but only obtain reimbursement for costs of transportation from Presque Isle to Bangor.

B. In all other cases, if transportation to qualified Medicaid recipients to covered services, as identified in the table of contents of the Maine Medical Assistance Manual is denied, reduced, or terminated, notices to recipients must be provided and such notices shall be in writing and must apprise recipients of the

113.06-6 Recipient Notice and Hearing Rights (cont.)

Effective 7/1/96

reasons for the action and their appeal rights. A copy of this correspondence must be retained in the recipient's records. The form of the notice which must be provided to the recipient is attached hereto as Appendix 2.

C. Examples of circumstances requiring notice and appeal rights include when:

1. The recipient requests transportation to covered services, as identified in the table of contents of the Maine Medical Assistance Manual but is denied, reduced, or terminated;

2. The recipient is not eligible for transportation to refill a prescription;

3. The recipient requests reimbursement for previously incurred (non-emergency) transportation not authorized by policy.

113.06-7 Provider Performance Requirements

Providers must:

1. upon request, to the satisfaction of the Department, provide evidence that all volunteer and provider owned or leased vehicle drivers have:

A. a valid, current driver's license, appropriate to the vehicle driven;

B. not been denied, if previously applied for, a State agency approval as a driver for transportation services;

C. undergone at initial hiring and then at two year intervals, a State Bureau Investigation (SBI) check;

D. undergone at initial hiring and then at two year intervals a Department of Motor Vehicle record check, and have no Operating Under the Influence (O.U.I.) convictions within the last 3 years; and

E. complied with all state seat belt and child-seat safety laws;

113.06-7 Provider Performance Requirements (cont.)

2. upon request, to the satisfaction of the Department, provide evidence that all volunteer and provider owned or leased vehicles are:

   A. currently registered;

   B. currently inspected;

   C. insured with at least the minimum State required insurance; and

   D. in compliance with all state seat belt and child-seat safety laws;

3. ensure all provider owned or leased vehicles used for Medicaid reimbursable transportation services participate in a regular preventative maintenance program;

4. have a program for drug testing sufficient to meet State and/or federal requirements;

5. have an information system with the capacity to meet the data collection requirements required by the Department;

6. meet all applicable Federal Transit Administration (FTA) standards and have all applicable FTA assurances on file;

7. fully participate and comply with an ongoing regional coordination process as defined and required in the policy to a achieve maximum cost efficient provision of transportation services.

8. upon request, to the satisfaction of the Department, provide evidence that all provider owned or leased vehicle drivers used by the provider have within the first six months of employment:

   A. undergone at initial hiring and at two year intervals, a physical examination;

   B. received training in the care and movement of disabled persons, such as “Passenger Assistant Techniques” (PAT) or its equivalent;

113.06-7 Provider Performance Requirements (cont.)

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   C. received First Aid and CPR training; or have previously received training within the past three years;

D. received in-house driver training, including at a minimum: emergency evacuation, accident prevention, record keeping, and communications; and

E. successfully completed the National Safety Council Defensive Driving Course or an equivalent;

9. complete requests for reimbursement as specified by the Department;

10. maintain a complaint resolution system and address all complaints within thirty (30) days;

11. utilize backup drivers to provide consistent, reliable service;

12. perform an annual audit in compliance with the Maine Auditing and Accounting Procedures (MAAP) or its equivalent;

13. upon request, to the satisfaction of the Department, demonstrate that transportation services have been provided on a cost-efficient basis in accordance with this policy as well as on a least unit cost basis. For example, a provider must maintain records that they regularly seek to utilize all regional sources of free transportation available to them, and recipient trips are scheduled in the least costly mode to the Department.

14. maintain written policies and procedures for, at a minimum, dispatching, complaints, scheduling, no show policy, vehicle maintenance, and emergency procedures;

15. maintain records for those measurable standards contained in this Section; Providers' measurable standards are expected to include their provision of trips, modes, and mileage used to transport Medicaid recipients. This information, including passenger miles, trips provided, and all or at least an accurate sampling of deadhead miles, is to be available to the Bureau.

113.06-7 Provider Performance Requirements (cont.)

16. utilize a customer satisfaction survey measuring: on time performance, effectiveness and efficiency, courtesy of drivers and staff, vehicle cleanliness and comfort of vehicles;

17. utilize a written annual staff evaluation process;

18. maintain normal business hours of operation to meet the needs of the client;

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19. maintain a list of current Medicaid covered services for which transportation is available;

20. at least quarterly, review a 5% sample of their recipients receiving family reimbursement or volunteers receiving reimbursement for the appropriateness of their services and compliance with this Section. At a minimum, the review must include vehicle mileage checks and documentation of the health care visits. Any discrepancy must be reported to the Department immediately;

21. notify all recipients of the provider's no show policy and charge if any, for no show violations;

22. open all provider/agency vehicle routes, including fixed-transit routes separately funded by the MDOT, to Medicaid recipients; and

23. track all or by reliable sample, billable volunteer deadhead miles, total volunteer miles, and make this information available to the Bureau. Effective July 1, 1996 all providers shall reduce by 10% over current year's billable miles per trip and then maintain in subsequent years this reduction to their Medicaid billable volunteer miles per trip.

113.07 **REIMBURSEMENT**

Reimbursement for covered services shall be as listed in Chapter III, Section 113.

In accordance with Chapter I of the Maine Medical Assistance Manual, it is the responsibility of the provider to seek payment from any other resources that are available for payment of a rendered service prior to billing the Medical Assistance Program.

113.07-1 Provider Pass-through rates

Transportation rates are established by the Bureau of Medical Services for each transportation provider except for day habilitation rates which are determined by the Division of Mental Retardation and approved by the Bureau of Medical Services. For this reason, the changes to a base rate and pass-through reimbursement methodology contained in this rule do not apply to the Division of Mental Retardation (DMR) day habilitation transportation. DMR transportation will

continue to be provided and reimbursed at the DMR set rates per mile. All other provisions of this rule, including the new definition of a passenger mile on a provider/agency vehicle, do apply.

Providers shall receive reimbursement for their pass-through costs for each mode: free services, common carrier-bus or ferry, common carrier-other, family or friends, volunteer driver, or provider vehicle, as listed in Chapter III and at rates determined by the Department.

Volunteer pass-through rates shall be at the provider's current pass-through rate, (the most used rate in calendar year 1995) not to exceed the amount listed in Chapter III.

113.07-2 Provider Base Rates

Providers shall receive, in addition to their pass-through costs for each mode described in this section, an administrative provider base rate for arranging or providing trips subject to the limitations contained in this Section. A trip is considered to be one arranged or provided transport per recipient per day to one health care appointment/destination and return, unless the recipient receives transportation to different health care appointments/destinations during the same day. In that event, additional trips are billable for each qualified health care visit/destination for which the provider has made separate, additional arrangements. No provider base rate is available for scheduling transportation for attendants accompanying recipients to their appointments.

Effective 3/5/97

Providers are eligible to receive a split base rate when transportation is arranged with another full-service Medicaid transportation provider that is more cost effective to the Department than arranging or providing the service themselves. Examples include: scheduling a recipient on another provider's controlled vehicle instead of using a volunteer driver, or scheduling a shared ride with a volunteer already scheduled by another provider.

113.07-2 Provider Base Rates (cont.)

Effective 3/5/97

In addition to the administrative provider base rate, providers shall receive split base rate when transportation is arranged using more than one mode of transportation that would normally not be used, and that is more cost effective to the Department than arranging or providing the service using just one mode. Examples include scheduling a recipient with a volunteer to take the recipient to a fixed route bus stop instead of having the volunteer take the recipient the total distance.

All reimbursement for split base rates must be carefully documented by the provider, and show the cost of the service provided, including the split base rate, is less expensive to the Department than would otherwise occur. Providers must bill these services using the Provider Split Base Rate.

The second provider receiving the recipient as a result of this split trip may receive a regular base rate, as if they had arranged the trip entirely by themselves.

Provider base rates for Seven Day Clinic Services

The transportation provider may receive a provider base rate for the arrangement of these transportation services. The reimbursement is limited to once every seven (7) round trips, on the most cost effective means available to the Department and billed in accordance with this Section and the Seven-Day Clinics Services listed in Chapter III. When a recipient utilizes more than one mode during any seven days, including free sources of transportation, the provider can bill for a base rate providing they can document that seven round trips were made. No reimbursement is available when a recipient fails to utilize a minimum of seven round trips to a Seven Day Clinic Service.

113.07-3 Provider Reimbursement by Mode

A. Reimbursement for a trip arranged by the provider on a free source of transportation.

Providers shall receive a base rate for each round trip provided per day per recipient scheduled on a free source of transportation, examples include: trips arranged through church groups, public service groups or car pooling.

113.07-3 Provider Reimbursement by Mode (cont.)

Providers who bill a base rate for free sources are responsible for being able to verify the trip occurred If there is no round trip on that day, the provider may bill a base rate for the single one way trip.

B. Reimbursement for common carrier fixed-route bus or ferry services.

Providers may receive a provider base rate for the arrangement of fixed route bus or ferry services. However, since recipients can normally arrange these services themselves, the provider base rate reimbursement is limited to a maximum of once for each ten (10) documented recipient one way trips or for less than ten trips whose receipts total more than ten dollars ($10.00) and billed in accordance with Chapter III.

C. Reimbursement for Common Carrier fixed-route transportation services other than a bus, a ferry or a taxi.

Providers shall receive a base rate for each round trip provided per day per recipient scheduled on a common carrier other than a fixed-route local urban bus, local ferry or a taxi. If there is no round trip on that day, the provider may bill a base rate for each single one way trip.

There is no provider base rate reimbursement available for scheduling recipients on taxis.

D. Reimbursement for a trip on a provider vehicle.

Providers shall receive a provider base rate for each round trip provided per day per recipient scheduled on a provider vehicle. If there is no round trip on that day, the provider may bill a Provider Base Rate (one way trip.) Providers wishing to bill for each one way trip instead of a round trip shall use the Provider Base Rate (one way) code for each one way part of the trip.

Effective 3/5/97

E. Reimbursement for trips provided by recipients or their family.

Providers shall receive a base rate for each round trip arranged per day to a covered health care service. If there is no round trip on that day, the provider shall bill a base rate for the single one

113.07-3 Provider Reimbursement by Mode (cont.)

Effective 7/1/96

way trip. An additional base rate may be billed for each additional recipient with a different point of origin or destination, that is transported to a health care appointment in a family vehicle. In that event, total round trip mileage associated with the health care visit shall be billed as one trip to the recipient traveling the greatest distance.

F. Reimbursement for trips provided by a volunteer driver.

Providers shall receive a provider base rate for each round trip arranged per day per recipient to a covered health care service with a volunteer driver. Appropriate round trip mileage associated with the health care visit shall be billed as one trip. If there is no round trip on that day, the provider may bill a base rate for the single one way trip.

If a provider is able to schedule more than one recipient with one volunteer, the provider shall receive as many base rates as recipients traveling, providing all transportation is provided in the most cost effective means available to the Department. For example, sending a volunteer across a county to pick up multiple recipients must be more cost effective to the Department than sending two individual volunteers.

G. Reimbursement for related transportation costs are made in accordance with Chapter III.

113.08 **PROVIDER ENROLLMENT AND TERMINATION**

113.08-1 Enrollment Procedure

Transportation providers, other than State Agencies or Wheelchair Van providers, wishing to enroll as a full-service Medicaid transportation provider must follow the enrollment procedure below. Full-service transportation providers cannot also be wheelchair van providers. A Medicaid provider billing number will not be assigned until all steps are met.

1. Providers must complete a Medicaid Provider Enrollment Information Form and sign a Medicaid Provider/Supplier Agreement.

113.08-1 Enrollment Procedure (cont.)

2. Providers must sign an additional agreement with the Department indicating their agreement to operate within their established regional catchment area, compliance with the regional coordination requirements, and acceptance of their Medicaid rate of reimbursement.

3. Providers must submit cost data, projections, financial statements, and any other reports as required by the Department to establish reimbursement rates.

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4. Upon request, providers must demonstrate to the satisfaction of the Department that they meet and will maintain all the applicable provisions of this Section.

5. Certain providers may wish to provide specialized transportation services, such as transportation to day habilitation services, or Early Intervention Services in addition to the regular Medicaid covered services. In order to be reimbursed for these transportation services, providers must furnish to the Department a letter of approval from the State agency providing the State share of Medicaid funding for this specialized transportation. A contract with such agencies will meet this requirement.

6. Applicants wishing to enroll as Medicaid Full Service Providers must, to the satisfaction of the Department, provide proof of their safe and cost effective prior experience in the management of Maine Medicaid non-emergency transportation services.

113.08-2 Enrollment for Wheelchair Van Providers

Applicants wishing to enroll as Medicaid Wheelchair van providers must follow the procedures listed below. Wheelchair van providers cannot also be full-service transportation providers.

1. Providers must complete a Medicaid Provider Enrollment Information form and sign a Medicaid Provider/Supplier Agreement.

113.08-2 Enrollment for Wheelchair Van Providers (cont.)

2. Providers must sign an additional agreement with the Department indicating their agreement to operate within their established regional catchment area, compliance with the regional coordination requirements, and acceptance of their Medicaid rate of reimbursement.

3. Providers must submit cost data, projections, financial statements, and any other reports as required by the Department to establish reimbursement rates.

4. Upon request, providers must demonstrate to the satisfaction of the Department, that they meet and will maintain all the applicable provisions of this Section.

5. Applicants wishing to enroll as Wheelchair Van providers must, to the satisfaction of the Department, provide proof of their safe and cost-effective prior experience in the management of Maine Medicaid non-emergency wheelchair van transportation services.

113.08-3 Termination of Provider enrollment

Providers who are found out of compliance with this Section of the Maine Medical Assistance manual, their Departmental agreements, including the regional catchment area requirement, regional coordination requirement or the qualifying and performance standards will have their provider enrollment terminated. Termination procedures would follow in accordance with the Medicaid Provider/Supplier Agreement.

113.09 **BILLING INSTRUCTIONS**

Billing must be accomplished in accordance with the Department's "Maine Medicaid Billing Instructions for Transportation Services" or by electronic format acceptable to the Bureau.

Effective 3/5/97

The code for Provider Base Rate (one way trip) is to be used to bill a base rate for a one way trip. For round trips, providers can bill either the Provider Base Rate (round trip) code or the one way code twice; once for each one-way part of the round trip.

Appendix 1

INSTRUCTIONS FOR
REQUEST FOR PRIOR AUTHORIZATION

The MA-56R should be completed as follows:

1. Name: Recipient's name as shown on the Medical Eligibility Card.

2. Patient's Own ID Number: As shown on the Medical Eligibility Card.

3. Birth date: As shown on the Medical Eligibility Card.

4. Sex: Male/Female

5. Program: As shown on the Medical Eligibility Card, as MM or MI.

6. N/A

7. Medicare Number or Other Insurance (if applicable): As shown on the recipient's red, white and blue Medicare ID card or other insurance card.

8. Type of residence: Check appropriate box. Home, Boarding Home or Other.

9. Patient's address: Recipient's current address.

10. Services or Supplies requested: Indicate the service requested.

    A. Units: enter the unit(s) of service.

    B. Procedure Code: Enter the procedure code from the billing instructions.

    C. & D. To-From Dates: Enter the dates of service.

    E. Enter the actual cost of the service or the allowance for the agency's service.

    F. Usual and customary fee: Enter the agency's usual and customary charge.

    G. Name and location of the provider of the client's choice.

    H. N/A

Appendix 1 (cont.)

INSTRUCTIONS FOR
REQUEST FOR PRIOR AUTHORIZATION

I. N/A

11. Services, supplies, equipment to be provided by: Name, address, telephone number, and provider number of the transportation agency must be typed in full.

12. Signed by: The form must be signed by an authorized person and dated.

13. Physician's Statement: Enter a notation in this block that authorization, if for out-of-state health care services, has been verified.

Appendix 2

SAMPLE NOTICE OF FAIR HEARING RIGHTS

(Agency Letterhead)

DATE

Dear (recipient or responsible person):

Your request for transportation to _____ has been denied for the following reason(s):

Effective 7/1/96

__ You are not eligible for transportation to refill a prescription.

__ You did not get approval for the transportation before your trip and no emergency existed.

__ Other: (Explanation)

----------NOTICE OF RIGHT TO FAIR HEARING----------

If you do not agree with this decision, you have the right to request a fair hearing. Any request for a hearing must be made within thirty (30) calendar days of the date of this letter. To request a hearing, contact the Director, Bureau of Medical Services the Department of Human Services, 11 State House Station, Augusta, Maine 04333-0011.

If you have additional questions please call consumer relations at 1-800-321-5557.