ATTACHMENT C

DEFINITIONS

For the purposes of the Medicaid Program and as used in this request, the following terms are defined as follows:

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

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

Ambulette
Ambulette, invalid coach or paratransit vehicle is a special-purpose vehicle designed and equipped to provide non-emergency transport that has either wheelchair-carrying capacity, stretcher-carrying capacity or the ability to carry transit-disabled individuals. A wheelchair-accessible minivan or similar vehicle is not an ambulette.

An ambulette service is an individual, partnership, association, corporation, or any other legal entity which transports the invalid, infirm or disabled by ambulette to or from facilities which provide medical care.

An ambulette service provides the invalid, infirm or disabled with personal assistance.

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

Conditional Liability
Conditional liability is the responsibility of the prior authorization official for making payment only for transportation services which are provided to Medicaid eligible individuals in accordance with the requirements of Title 18 (the regulations of the New York State Department of Social Services).

Day Treatment Program
A day treatment program or continuing treatment program is a planned combination of diagnostic, treatment and rehabilitative services certified by the Office for Persons with Developmental Disabilities or the Office of Mental Health.

Department Staff
Employees of the New York State Department of Health, or designees of the Department of Health, for the purposes of this contract.

Emergency
A medical or mental health condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention could reasonably be expected to result in placing the enrollee's physical or mental health (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, serious impairment to bodily functions, serious dysfunction of any bodily organ or part, serious harm to self or others due to an alcohol or drug abuse emergency, injury to self or bodily harm to others, or with respect to a pregnant woman having contractions: (1) that there is inadequate time to effect a safe transfer to a hospital before delivery, or (2) that transfer may pose a threat to the health or safety of the woman or the unborn child.

Enrollee/Enrollee
An enrollee/enrollee is an individual who is enrolled in the Medicaid Program and is eligible to receive Medicaid services, including transportation.

Fee-for-Service
The payment of a fee by the Department of Health directly to a service provider for a specified direct service.

Medical Escort
A paid or unpaid individual or caregiver accompanying a program eligible enrollee who is physically, mentally, or developmentally disabled and unable to travel or wait without assistance or supervision to receive a Medicaid coverable service. The escort may drive or utilize transportation services with the program eligible enrollee.

Medical Necessity
Health care services are considered medically necessary when those services are:

- Medically appropriate;
- Necessary to meet the basic health needs of the enrollee;
- Rendered in the most cost-efficient manner and type of setting appropriate for the delivery of the covered service;
- Consistent in type, frequency, duration of treatment with scientifically based guidelines of national medical, research, or health care coverage organizations or governmental agencies;
- Consistent with the diagnosis of the condition;
- Required for means other than convenience of the enrollee or his or her physician;
- No more intrusive or restrictive than necessary to provide a proper balance of safety, effectiveness, and efficiency;
- Of demonstrated value; and,
- No more intense level of service than can be safely provided.

Medical Service Provider
An individual, firm, corporation, hospital, nursing facility, or association that is enrolled as a Medicaid provider, or provides a Medicaid coverable service free of charge (for example, a Veterans Administration Hospital, or local county Department of Health.)

Mode
The method used to provide transportation services to enrollees.

Non-Emergency Ambulance Transportation
Non-emergency ambulance transportation is the provision of ambulance transportation for the purpose of obtaining necessary medical care or services by a Medicaid enrollee whose medical condition requires transportation in a recumbent position.

Non-emergency ambulance transportation is transportation of a pre-planned nature where the patient must be transported on a stretcher or requires the administration of life support equipment, such as oxygen, by trained medical personnel.

No-Show
The result of a Department of Health enrollee or transportation service provider not keeping an appointment and failing to cancel the appointment.

Prior Authorization
A determination that payment for transportation is essential in order for a Medicaid enrollee to obtain necessary medical care and services and that the Medicaid Program accepts conditional liability for payment of the Medicaid enrollee's transportation costs.

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

Simple Rotation System
A simple rotation system is a method to identify the next available transportation vendor in the transportation manager's system that can perform the transportation service within the level transportation required. This system is used when an enrollee indicates they have no preference for a specific transportation vendor to perform the service.

Standing Order
Standing orders are requests for prescheduled transportation to recurring Medicaid-covered service appointments at the same location (and often with the same transportation provider). These orders usually occur at the same time(s) and day(s) every week. Dialysis, for example, is considered a regularly recurring service appointment.

Stretcher Van
A vehicle that transports a prone or supine person who does not require medical attention while traveling to services.

Transportation Provider
A transportation provider is a lawfully authorized provider of transportation services who is actively enrolled in the Medicaid Program.

Transportation Services
Transportation services are services by ambulance, ambulette or invalid coach, taxicab, common carrier or other means appropriate to the Medicaid enrollee's medical condition; and transportation attendant to accompany the Medicaid enrollee, if necessary.

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

Urgent Care Transportation
"Urgent care" means that level of care ordered and verified by the individual's physician (online, by phone or fax) to be necessary on the day the request is made. Examples include, but are not limited to, high temperature, persistent rash, vomiting or diarrhea, symptoms which are of sudden or severe onset but which do not require emergency room services. Urgent care is generally determined by the enrollee's medical care provider, but not necessary.

An appointment shall be considered urgent if the medical service provider grants an appointment within forty-eight (48) hours of the enrollee's request.

A hospital discharge shall be considered an Urgent Trip.

ATTACHMENT D

NEW YORK STATE
MEDICAID TRANSPORTATION PROGRAM

TRAVEL REIMBURSEMENT POLICY MANUAL

The purpose of this Travel Reimbursement Policy Manual is to provide guidance to the New York State Department of Health's (Department) Transportation Manager (TM) and eligible Medicaid enrollees to better understand and apply the Department's travel rules and regulations.

The Department sets rules and regulations for reimbursement of prior authorized travel related expenses in accordance to Federally approved guidelines regarding such reimbursement.

When travel arrangements are necessary for an eligible Medicaid enrollee(s) to obtain a Medicaid covered service, such arrangements must be prior authorized by the applicable TM in order for the enrollee to be eligible for reimbursement of allowable expenses incurred. The TM will only reimburse for prior approved travel related expenses. The TM will also reimburse for allowable expenses for an additional person (escort) to accompany an enrollee to their Medicaid covered service and will reimburse expenses per person per day **if** the following criteria is met: (1) it is determined to be medically necessary for the enrollee to travel with an escort, (2) the TM has received the appropriate medical justification signed by the medical provider and (3) if the travel arrangements were prior approved by the TM.

Definition of Travel-Related Expenses

Breakfast: a meal consumed by traveler between the hours of 5:00 am- 10:00 am.

Lunch: a meal consumed by traveler between the hours of 10:01 am and 3:00 pm.

Dinner: a meal consumed by traveler between the hours of 3:01 pm and 10:00 pm.

Incidentals: snacks and/or beverages consumed in addition to breakfast, lunch and dinner; or consumed outside of the defined timeframes defined for meals as noted above.

Non-Compensable Expenses
The non-reimbursable items include, but are not limited to the following:

- SNAP benefits (e.g. food stamps)*
- tobacco products;
- tips;
- meal delivery services;
- shipping expenses;
- alcoholic beverages;
- internet services;
- laundry services;
- additional hotel amenities such as movies and entertainment;
- excessive meal expenses;
- fuel;
- vehicle repairs and supplies;
- rental cars (unless prior authorized by the TM);
- medical supplies;
- over the counter medications, and
- other personal items.

***Note:** Supplemental Nutrition Assistance Program (SNAP) benefits (food stamps) cannot be used while in travel status. Per the Food and Nutrition Act of 2008, SNAP benefits are to be used to purchase food for home consumption.

Meal & Incidental Expense Allowance While in Travel Status

Eligible enrollees may be reimbursed for travel related expenses when an enrollee is considered to be in "travel status." An enrollee is considered to be in "travel status" when traveling from their residence to a Medicaid covered service and during their return trip home following the appointment. Reimbursement for travel related expenses may be considered under the following circumstances:

- When an eligible enrollee is in travel status for at least four hours *and* must travel at least 80 miles one-way to a Medicaid covered service, enrollee may be allowed reimbursement for one meal.
- When an eligible enrollee is in travel status for at least eight hours *and* must travel at least 80 miles one-way to a Medicaid covered service, enrollee may be allowed reimbursement for two meals.
- When an eligible enrollee is in travel status for at least eight hours *and* must travel at least 160 miles one-way to a Medicaid covered service, enrollee may be allowed reimbursement for two or more meals and one-night lodging.

The TM takes into consideration the method of transportation, scheduled appointment time and meals consumed by the enrollee in order to determine if they are appropriate expenses prior to issuing a reimbursement. If an enrollee is traveling less than one full day, the enrollee may not be reimbursed at the federal government's full per diem rate*.

*Visit http://www.gsa.gov to check the most current per diem and standard mileage reimbursement rates for your planning purposes.

"Overnight Travel" is defined as pre-approved travel requiring an overnight stay. This may apply when the enrollee must travel on the day prior to an appointment to arrive on time, prepare for the appointment, or upon completion of the appointment, the return home is excessively burdensome or is not feasible for the enrollee to immediately return home.

The TM will reimburse for up to three (3) meals per day and possible incidentals, based upon location and in accordance with the following guidelines.

The daily maximum reimbursable meal expenses are $51.00 to $74.00 for full day or overnight travel depending on the city where the medical service takes place. The TM will reimburse for reasonable meal expenses according to valid receipts (see below) submitted. Examples of valid and invalid receipts are found at the end of this policy manual.

A reasonable reimbursement guideline for meal expenses is:

- 15% of the daily allowance for breakfast;
- 25% of the daily allowance for lunch;
- 50 % of the daily allowance for dinner; and
- 10% of the daily allowance for incidentals (to include snacks) in accordance with the federal rates and guidelines for per diem meals.

The TM may reimburse approved expenses for one to two reasonable meals per day or one meal and/or reasonable incidentals according to the following guidelines for daily travel where the travel or appointment time is less than one full day.

However, the TM will not reimburse an entire day's meal expense for a single meal. When an enrollee is claiming a meal expense, the following must be provided: an original dated and itemized receipt including the business name and address; date; item(s) purchased; price of each

item, and the total amount of the bill and method of payment, in order to be reimbursed for meal expenses.

Daily Travel

Breakfast

Customarily, a person consumes breakfast at home prior to starting their daily activities. On a day an enrollee or an enrollee and pre-approved attendant is beginning to travel to a Medicaid covered service that has been prior authorized, the TM expects breakfast to be consumed prior to engaging in travel and is therefore not an eligible travel expense.

Lunch

Customarily, a person consumes lunch during the day. On a day an enrollee or an enrollee and pre-approved attendant is traveling to a prior authorized Medicaid covered service, lunch may be consumed and is therefore an eligible travel expense that may be submitted in accordance with these guidelines. Lunch reimbursement shall not exceed the lower of the receipted amount or 25% of the medical location's federal per diem rate. *Please note that travel commencing later in the day does not automatically guarantee lunch expenses to be reimbursed as it is not unreasonable to eat a meal at home prior to traveling.*

Dinner

Customarily, a person consumes dinner in the evening or at the end of the day. On a day an enrollee or an enrollee and pre-approved attendant is beginning to travel to a prior authorized Medicaid covered service where the appointment or travel time will not allow them to consume dinner prior to leaving home, dinner may be consumed prior to returning home, and is therefore an eligible travel expense that may be submitted in accordance with these guidelines. Dinner reimbursement shall not exceed the lower of the receipted amount or 50% of the location's federal per diem rate.

Please note that travel commencing later in the day does not automatically guarantee dinner expenses to be reimbursed as it is not unreasonable to eat a meal at home prior to traveling or returning home.

Incidentals

Incidental expenditures, including snacks and beverages, may be incurred throughout the trip and reimbursement may be submitted in accordance with these guidelines. Reimbursement for incidentals shall not exceed the lower of the receipted amount or 10% of the medical location's federal per diem rate.

Overnight Travel

Breakfast

On a day an enrollee or an enrollee and pre-approved escort has travelled to a prior authorized Medicaid covered service, or must return home the morning after the appointment, accrued breakfast travel expenses may be submitted in accordance with these guidelines and additional breakfast expenses may be submitted on each subsequent travel day prior to returning home. Breakfast reimbursement shall not exceed the lower of the receipted amount or 15% of the medical location's federal per diem rate. *Reimbursement for breakfast is not available after the traveler(s) have returned home.*

Lunch

On a day an enrollee or an enrollee and pre-approved escort is traveling to and from a prior authorized Medicaid covered service, lunch may be consumed and is an eligible travel expense that may be submitted in accordance with these guidelines. Lunch reimbursement shall not exceed the lower of the receipted amount or 25% of the location's federal per diem rate. *Reimbursement for lunch is not available after the travelers have returned home.*

Dinner

Customarily, a person consumes dinner in the evening (typically anywhere between 5:00pm-7:00pm). On a day an enrollee or an enrollee and pre-approved escort has travelled to a prior authorized Medicaid covered service and the enrollee's appointment or travel time will not allow them to consume dinner prior to leaving home, dinner may be consumed during travel to their destination or after the Medicaid covered service, and is therefore an eligible travel expense that may be submitted in accordance with these guidelines. Dinner reimbursement shall not exceed the lower of the receipted amount or 50% of the location's federal per diem rate. *Reimbursement for dinner is not available after the travelers have returned home.*

Hotel Selection

The TM will select value rated, reasonably priced hotels using the federally established lodging expense as a guideline, or select hotels with reduced medical rates associated with a medical facility, if more cost effective. Current per diem rates can be found on the General Service Administration (GSA) website: https://www.gsa.gov/portal/content/104877

The TM will attempt to secure hotel arrangements with the closest, most appropriate hotel in approximation to the enrollee's Medicaid covered service to minimize additional expenses. Any expenses incurred are to be within the specified allowable guidelines in order to be considered for reimbursement.

Unreceipted Stay

This method provides for flat rate allowances for meals, lodging and incidental expenses regardless of where lodging is obtained, as well as circumstances where an official receipt cannot be generated, such as when lodging with relatives or friends. Rates are established based on the county where lodging is obtained or the location to which the enrollee was traveling (whichever rate is less), and such location must be indicated. No receipts are required when using this method. Please note that if the enrollee has a hotel receipt and no meal receipts, this method cannot be used for reimbursement. Current rates as of October 26, 2016 are as follows:

- New York City, Nassau, Suffolk, Rockland and Westchester Counties $50.00
- Albany, Broome, Erie, Monroe and Onondaga Counties $40.00
- All other Counties within New York State $35.00
- Out of State $50.00

Exclusions & Additional Information

Many hotels include a continental breakfast. When a continental breakfast is included, the TM will not reimburse for incurred breakfast expenses.

The TM will consider providing reimbursement for receipted parking, tolls, and additional local travel expenses directly related the enrollee receiving a Medicaid-covered service.

The TM will consider providing reimbursement of a prior approved rental vehicle secured by an enrollee on a case by case basis when such use is directly related to the provision of the necessary Medicaid-covered service, has a medical justification provided by the enrollee's physician and is deemed the most cost effective mode of transportation. Note that, when prior approved, the rental vehicle may not exceed the size or accommodation needs of the enrollee and/or his/her attendant. For example, the TM will not reimburse for a luxury car when a compact or mid-size vehicle is more appropriate.

Personal Vehicle Mileage Reimbursement

The following information relates to reimbursement for the use of a personal vehicle to travel to and from prior-approved Medicaid covered service appointments.

Requesting Prior Approval for a Trip

For the TM to consider reimbursement of transportation and travel related expenses, the following steps are required:

Step 1: Obtain prior approval for all trips by calling the TM. Trip requests can be made by telephone or online, and must be made no less than 72 hours prior to the Medicaid covered service appointment.

You must provide:

1. The enrollee's Medicaid number;
2. The enrollee's date of birth;
3. The enrollee's current address;
4. The enrollee's current telephone number;
5. The name and telephone number of the person scheduling the trip;
6. The date of appointment;
7. The enrollee's primary care physician or physician ordering the trip;
8. The exact address of the destination, including zip code;
9. If someone other than the enrollee is driving; and
10. Any additional information required by the TM.

Step 2: Request an invoice number for every trip for your records and proof of prior approval.

Step 3: Request the operator mail the reimbursement forms to you prior to the Medicaid covered service, or you may obtain the forms directly from the TM's website.

Requesting Reimbursement

Step 1: Complete the mileage/travel reimbursement form found on the TM's website. If someone other than the enrollee is driving, the form must be signed by the driver when the form is completed. Please note, the driver's social security number is required for the first reimbursement, but subsequent claims do not require social security numbers.

Step 2: On the day of the Medicaid covered service, request the physician or staff member within the facility to sign the designated area of the reimbursement form to confirm attendance.

Step 3: Save and attach all ORIGINAL receipts pertaining to parking/toll expenses and/or meal receipts, if applicable, and write amounts in the appropriate fields. Save copies of all information submitted to the TM for your personal record.

Step 4: Mail completed form with any original receipts to the TM within 90 days of the trip.

Claim Certification Statement

By submitting a claim, the claimant certifies that:

I am a qualified to provide such services for which I am submitting for reimbursement.

I have reviewed the form.

I have furnished or caused to be furnished the care, services and supplies itemized in accordance with applicable federal and state laws and regulations.

The amounts listed are due and, except as noted, no part thereof has been paid by, or to the best of my knowledge is payable from any source other than, the Medicaid Program.

Payment of fees made in accordance with established schedules is accepted as payment in full; other than a claim rejected or denied or one for adjustment, no previous claim for the care, services and supplies itemized has been submitted or paid.

All statements made hereon are true, accurate and complete to the best of my knowledge.

No material fact has been omitted from this form.

I understand that payment and satisfaction of this claim will be from federal, state and local public funds and that I may be prosecuted under applicable federal and state laws for any false claims, statements or documents or concealment of a material fact.

Taxes from which the State is exempt are excluded.

All records pertaining to the care, services and supplies provided including all records which are necessary to disclose fully the extent of care, services and supplies provided to individuals under the New York State Medicaid Program will be kept for a period of six years from the date of payment, and such records and information regarding this claim and payment therefore shall

be promptly furnished upon request to the Health Department, the State Medicaid Fraud Control Unit of the New York State Office of Attorney General or the Secretary of the Department of Health and Human Services.

There has been compliance with the Federal Civil Rights Act of 1964 and with section 504 of the Federal Rehabilitation Act of 1973, as amended, which forbid discrimination on the basis of race, color, national origin, handicap, age, sex and religion.

I agree to comply with the requirements of 42 CFR Part 455 relating to disclosures by providers; the State of New York through its fiscal agent or otherwise is hereby authorized to:

(1) make administrative corrections to this claim to enable its automated processing subject to reversal by provider, and

(2) accept the claim data on this form as original evidence of care, services and supplies furnished.

By making this claim I understand and agree that I shall be subject to and bound by all rules, regulations, policies, standards, rates and procedures of the Health Department as set forth in Title 18 of the New York Official Compilation of Codes, Rules and Regulations of New York State and other Department publications.

I understand and agree that I shall be subject to and shall accept, subject to due process of law, any determinations pursuant to said rules, regulations, policies, standards, fee codes and procedures, including, but not limited to, any duly made determination affecting my (or the entity's) past, present or future status in the Medicaid Program and/or imposing any duly considered sanction or penalty.

I understand that my signature on the claim form incorporates the above certifications and attests to their truth.

Customer Service
Contact the TM if you have any questions.

Frequently Asked Questions

1. What are the current reimbursement rates?

- Enrollee self-drive ----------IRS medical mileage rate.
- In-home relative/partner or spouse/caregiver/friend----------IRS medical mileage rate.
- Out-of-home family member/neighbor/friend/volunteer------IRS standard mileage rate.

Mileage rates are established annually by the Internal Revenue Service (IRS) and can be found on the U.S. General Services Administration (GSA) website of: https://www.gsa.gov/portal/category/26429 .

2. Do I need to track my miles?

You do not need to report miles on the claim form, since mileage is automatically calculated using the TM's mileage calculation system. Mileage is calculated using the shortest distance route as determined by the system. Mileage/Travel reimbursement is available for loaded mileage only, i.e., mileage incurred while actively transporting the enrollee.

3. What mileage expenses are considered reimbursable?

The TM will reimburse for round-trip loaded miles to and from an approved Medicaid covered service. Loaded miles are the miles traveled in which the enrollee having an appointment is transported to and from their home address/approved pickup location to the appointment location/approved drop off location.

The TM considers reimbursement of expenses for tolls, parking and bridge fare, if accompanied by an original receipt or EZ Pass account statement.

4. How long after my appointment do I have to submit my claim for reimbursement?

The claimant has 90 days from the appointment date to submit a claim for reimbursement.

5. I submitted a claim, but it was returned to me unprocessed. What happened?

Incomplete claim forms or those that contain unauthorized trips/expenses are returned unprocessed to the claimant.

6. Why does the amount on my check not match the amount I requested?

The TM audits your claim and may make adjustments as needed. Please call the TM for an explanation.

7. What is an itemized receipt?

An itemized receipt (see example on page 10) has ALL of the following pieces of information on it:

1) Business Name
2) Date
3) Item(s) Purchased
4) Price of Each Item
5) Amount of Bill
6) Method of Payment

Questions?

Questions concerning this Travel Reimbursement Policy may be directed to Department's Medicaid Transportation Policy Unit via email to MedTrans@health.ny.gov or telephone to (518) 473-2160.

Examples of Invalid Receipts

Welcome to Mel's

Check #: 0001 12/20/16
Server: Josh F 4:38PM
Table: 7/1 Guests: 2

2 Beef Burger (@9.95/ea) 19.90
SIDE: Fries
1 Bud Light 3.79
1 Bud 4.50

Sub-total 28.19
Sales Tax 2.50
TOTAL 30.69

Balance Due 30.69

Thank you for your patronage!

This receipt does not show how the bill was paid. Notice how it still shows "balance due"?

This receipt shows alcohol was purchased. Per NYSDOH policy, the purchase of alcohol is a non-compensable item and will not be reimbursed. The Bud and Bud Light along with the taxes associated would be deducted from the amount to be reimbursed.

KINGSGATE MARRIOTT
CONFERENCE CENTER AT THE
UNIVERSITY OF CINCIANNATI
151 Goodman Dr.
Cincinnati, OH 45219
(513) 487-3800
CHECK 2520

REF: 0888
CD TYPE: VISA
TR TYPE: PURCHASE
DATE: MAY 19, 2016

TOTAL $8.50
ACCT: 9806 EXP: **/**
AP: 012315
NAME: DAVID M ROE

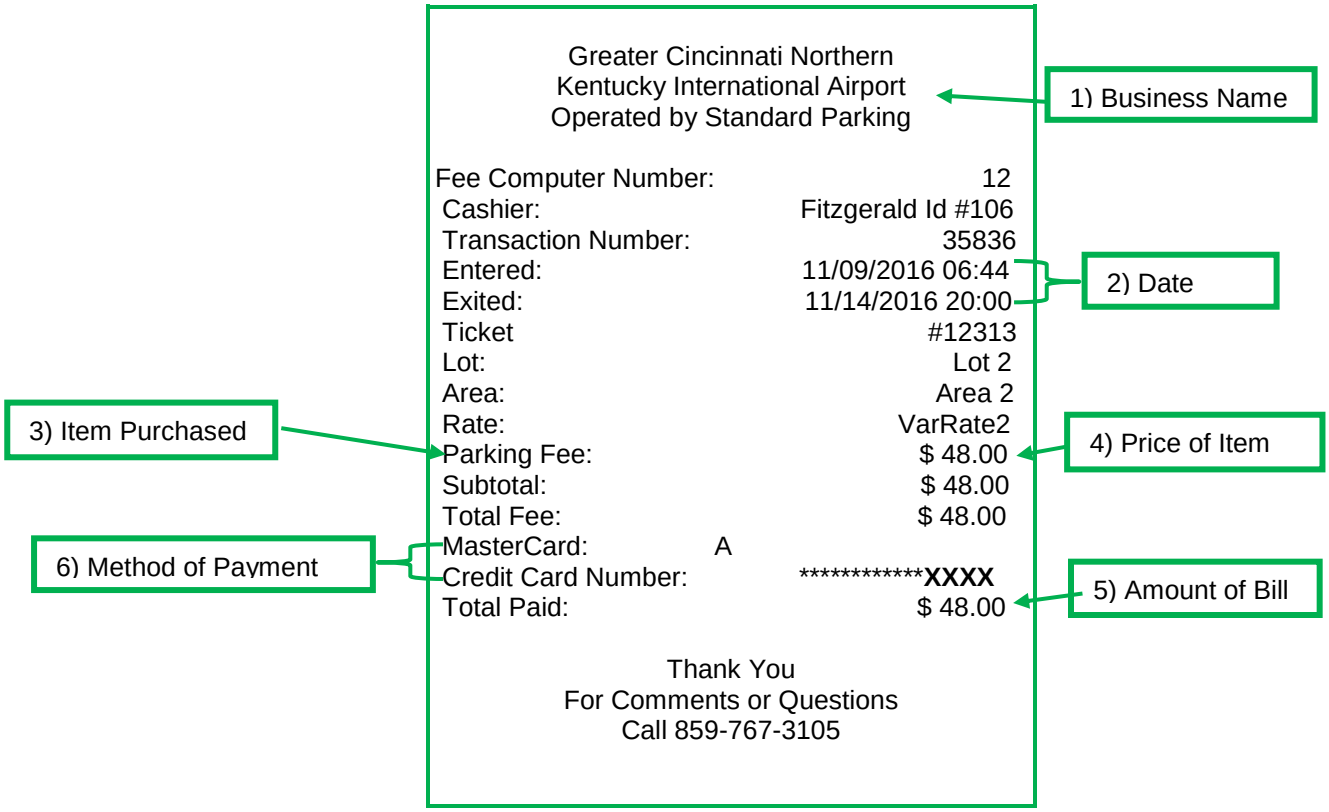
CARDMEMBER ACKNOWLEDGES RECEIPT OF GOODS
AND/OR SERVICES IN THE AMOUNT OF THE
TOTAL SHOWN HERON AND AGREES TO PERFORM
THE OBLIGATIONS SET FORTH BY THE
CARDMEMBER'S AGREEMENT WITH THE ISSUER

THANK YOU

CUSTOMER COPY

This receipt does not show what was purchased.

Example of a Valid Receipt



ATTACHMENT E

TRANSPORTATION MANAGEMENT LAW

Section 365-h of the Social Services Law, as added by Chapter 8 of the Laws of 1995 and Subdivision 3 as amended by Section 26 of Part B of Chapter 1 of the Laws of 2002, amended by 2018-19 Budget, to read as follows:

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* § 365-h. Provision and reimbursement of transportation costs.

1. The local social services official and, subject to the provisions of subdivision four of this section, the commissioner of health shall have responsibility for prior authorizing transportation of eligible persons and for limiting the provision of such transportation to those recipients and circumstances where such transportation is essential, medically necessary and appropriate to obtain medical care, services or supplies otherwise available under this title.

2. In exercising this responsibility, the local social services official and, as appropriate, the commissioner of health shall:

   (a) make appropriate and economical use of transportation resources available in the district in meeting the anticipated demand for transportation within the district, including, but not limited to: transportation generally available free-of-charge to the general public or specific segments of the general public, public transportation, promotion of group rides, county vehicles, coordinated transportation, and direct purchase of services; and

   (b) maintain quality assurance mechanisms in order to ensure that

      (i) only such transportation as is essential, medically necessary and appropriate to obtain medical care, services or supplies otherwise available under this title is provided;

      (ii) no expenditures for taxi or livery transportation are made when public transportation or lower cost transportation is reasonably available to eligible persons; and

      (iii) transportation services are provided in a safe, timely, and reliable manner by providers that comply with state and local regulatory requirements and meet consumer satisfaction criteria approved by the commissioner of health.

3. In the event that coordination or other such cost savings measures are implemented, the commissioner shall assure compliance with applicable standards governing the safety and quality of transportation of the population served.

4. The commissioner of health is authorized to assume responsibility from a local social services official for the provision and reimbursement of transportation costs under this section. If the commissioner elects to assume such responsibility, the commissioner shall notify the local social services official in writing as to the election, the date upon which the election shall be effective and such information as to transition of responsibilities as the commissioner deems prudent. The commissioner is authorized to contract with a transportation manager or managers to manage transportation services in any local social services district, other than transportation services provided or arranged for enrollees of managed long term care plans issued certificates of authority under section forty-four hundred three-f of the public health law. Any transportation manager or managers selected by the commissioner to manage transportation services shall have proven experience in coordinating transportation services in a geographic and demographic area similar to the area in New York state within which the contractor would manage the provision of services under this section. Such a contract or contracts may include responsibility for: review, approval and processing of transportation orders; management of the appropriate level of

transportation based on documented patient medical need; and development of new technologies leading to efficient transportation services. If the commissioner elects to assume such responsibility from a local social services district, the commissioner shall examine and, if appropriate, adopt quality assurance measures that may include, but are not limited to, global positioning tracking system reporting requirements and service verification mechanisms. Any and all reimbursement rates developed by transportation managers under this subdivision shall be subject to the review and approval of the commissioner.

* NB Repealed 8 years after the contract entered into pursuant to this section 365-h is executed

* § 365-h. Provision and reimbursement of transportation costs.

1. The local social services official shall have responsibility for prior authorizing transportation of eligible persons and for limiting the provision of such transportation to those recipients and circumstances where such transportation is essential, medically necessary and appropriate to obtain medical care, services or supplies otherwise available under this title.

2. In exercising this responsibility, the local social services official shall:

   (a) make appropriate and economical use of transportation resources available in the district in meeting the anticipated demand for transportation within the district, including, but not limited to: transportation generally available free-of-charge to the general public or specific segments of the general public, public transportation, promotion of group rides, county vehicles, coordinated transportation, and direct purchase of services; and

   (b) maintain quality assurance mechanisms in order to ensure that

   (i) only such transportation as is essential, medically necessary and appropriate to obtain medical care, services or supplies otherwise available under this title is provided and

   (ii) no expenditures for taxi or livery transportation are made when public transportation or lower cost transportation is reasonably available to eligible persons.

3. In the event that coordination or other such cost savings measures are implemented, the commissioner shall assure compliance with applicable standards governing the safety and quality of transportation of the population served.

* NB Effective 8 years after the contract entered into pursuant to this section 365-h has been executed

ATTACHMENT F

Title 18 of the New York Code of Rules and Regulation (NYCRR) §505.10

Transportation for Medical Care and Services

Effective Date: 04/29/98

(a) Scope and purpose.

This section describes the department's policy concerning payment for transportation services provided to Medical Assistance (MA) recipients, the standards to be used in determining when the MA program will pay for transportation, and the prior authorization process required for obtaining such payment.

Generally, payment will be made only upon prior authorization for transportation services provided to an eligible MA recipient. Prior authorization will be granted by the prior authorization official only when payment for transportation expenses is essential in order for an eligible MA recipient to obtain necessary medical care and services which may be paid for under the MA program.

(b) Definitions.

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

(2) Ambulance service means any entity, as defined in section 3001 of the Public Health Law, which is engaged in the provision of emergency medical services and the transportation of sick, disabled or injured persons by motor vehicle, aircraft, boat or other form of transportation to or from facilities providing hospital services and which is currently certified or registered by the Department of Health as an ambulance service.

(3) Ambulette or invalid coach means a special-purpose vehicle, designed and equipped to provide non-emergency transport that has wheelchair-carrying capacity, stretcher-carrying capacity, or the ability to carry disabled individuals.

(4) Ambulette service means an individual, partnership, association, corporation, or any other legal entity, which transports the invalid, infirm or disabled by ambulette to or from facilities which provide medical care. An ambulette service provides the invalid, infirm or disabled with personal assistance as defined in this subdivision.

(5) Common medical marketing area means the geographic area from which a community customarily obtains its medical care and services.

(6) Community means either the State, a portion of the State, a city or a particular classification of the population, such as all persons 65 years of age and older.

(7) Conditional liability means that the prior authorization official is responsible for making payment only for transportation services which are provided to MA-eligible individuals in accordance with the requirements of this Title.

(8) Day treatment program or continuing treatment program means a planned combination of diagnostic, treatment, and rehabilitative services certified by the Office of People with Developmental Disabilities or the Office of Mental Health.

(9) Department established rate means the rate for any given mode of transportation which the department has determined will ensure the efficient provision of appropriate transportation to MA recipients in order for the recipients to obtain necessary medical care or services.

(10) Emergency ambulance transportation means the provision of ambulance transportation for the purpose of obtaining hospital services for an MA recipient who suffers from severe, life-threatening or potentially disabling conditions which require the provision of emergency medical services while the recipient is being transported.

(11) Emergency medical services means the provision of initial urgent medical care including, but not limited to, the treatment of trauma, burns, and respiratory, circulatory and obstetrical emergencies.

(12) Locally prevailing rate means a rate for a given mode of transportation which is established by a transit or transportation authority or commission empowered to establish rates for public transportation, a municipality, or a third-party payor, and which is charged to all persons using that mode of transportation in a given community.

(13) Locally established rate means the rate for any given mode of transportation which the social services official has determined will ensure the efficient provision of appropriate transportation for MA recipients in order for the recipients to obtain necessary medical care or services.

(14) Non-emergency ambulance transportation means the provision of ambulance transportation for obtaining necessary medical care or services to an MA recipient whose medical condition requires transportation by an ambulance service.

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

(16) Personal assistance means the provision of physical assistance by a provider of ambulette services or the provider's employee to an MA recipient for the purpose of assuring safe access to and from the recipient's place of residence, ambulette vehicle and MA covered health service provider's place of business.

Personal assistance is the rendering of physical assistance to the recipient in:

- walking, climbing or descending stairs, ramps, curbs or other obstacles;
- opening or closing doors;
- accessing an ambulette vehicle; and
- the moving of wheelchairs or other items of medical equipment and the removal of obstacles as necessary to assure the safe movement of the recipient.

In providing personal assistance, the provider or the provider's employee will physically assist the recipient which shall include touching, or, if the recipient prefers not to be touched, guiding the recipient 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 recipient who can walk to and from a vehicle, his or her home, and a place of medical services without such assistance is deemed not to require personal assistance.

(17) Prior authorization means a prior authorization official's determination that payment for a specific mode of transportation is essential in order for an MA recipient to obtain necessary medical care and services and that the prior authorization official accepts conditional liability for payment of the recipient's transportation costs.

(18) Prior authorization official means the department, a social services district, or their designated agents.

(19) Transportation attendant means any individual authorized by the prior authorization official to assist the MA recipient in receiving safe transportation.

(20) Transportation expenses means:

(i) the costs of transportation services; and

(ii) the costs of outside meals and lodging incurred when going to and returning from a provider of medical care and services when distance and travel time require these costs.

(21) Transportation services means:

(i) transportation by ambulance, ambulette or invalid coach, taxicab, common carrier or other means appropriate to the recipient's medical condition; and

(ii) a transportation attendant to accompany the MA recipient, 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 MA recipient's family.

(22) Undue financial hardship means transportation expenses which the MA recipient cannot be expected to meet from monthly income or from available resources. Such transportation expenses may include those of a recurring nature or major one-time costs.

(23) Vendor means a lawfully authorized provider of transportation services who is either enrolled in the MA program pursuant to Part 504 of this Title or authorized to receive payment for transportation services directly from a social services district or other agent designated by the department. The term vendor does not mean an MA recipient or other individual who transports an MA recipient by means of a private vehicle.

(c) Ambulette and non-emergency ambulance transportation.

(1) Who may order:

Only those practitioners, facilities, or programs listed in paragraph (4) of subdivision (d) of this section may order or submit an order on behalf of a practitioner for ambulette or non-emergency ambulance transportation services.

(2) Criteria for ordering ambulette transportation.

Ambulette transportation may be ordered if any one of the following conditions exist:

(i) The recipient needs to be transported in a recumbent position and the ambulette service ordered has stretcher-carrying capacity; or

(ii) The recipient is wheelchair bound and is unable to use a taxi, livery service, bus or private vehicle; or

(iii) The recipient has a disabling physical condition which requires the use of a walker or crutches and is unable to use a taxi, livery service, bus or private vehicle; or

(iv) The recipient has a disabling physical condition other than one described in subparagraph (iii) of this paragraph or a disabling mental condition, either of which requires the personal assistance provided by an ambulette service, and the ordering practitioner certifies, in a manner designated by the department, that the recipient cannot be transported by a taxi, livery service, bus or private vehicle and requires transportation by ambulette service; or

(v) An otherwise ambulatory recipient requires radiation therapy, chemotherapy, or dialysis treatment which results in a disabling physical condition after treatment and renders the recipient unable to access transportation without the person assistance provided by an ambulette service.

(3) Criteria for ordering non-emergency ambulance transportation.

Non-emergency ambulance transportation may be ordered when the recipient is in need of services while being transported to a provider of medical services which can only be administered by an ambulance service.

(4) Recordkeeping.
The ordering practitioner must note in the recipient's patient record the condition which justifies the practitioner's ordering of ambulette or non-emergency ambulance services.

(5) Audit and claim review.

An ordering practitioner or a facility or program submitting an order on the practitioner's behalf, which does not comply with this subdivision may be subjected to monetary claims and/or program sanctions as provided in section 504.8(a) of this Title.

(d) Prior authorization.

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

(2) Requests for prior authorization may be made by the MA recipient, his or her representative, or an ordering practitioner.

(3) The recipient, his or her representative, or ordering practitioner must make the request in the manner required by the prior authorization official.

(4) A request for prior authorization for non-emergency ambulance transportation must be supported by the order of an ordering practitioner who is the MA recipient's attending physician, physician's assistant, or nurse practitioner. A request for prior authorization for transportation by ambulette or invalid coach must be supported by the order of an ordering practitioner who is the MA recipient's attending physician, physician’s assistant, nurse practitioner, dentist, optometrist, podiatrist or other type of medical practitioner designated by the district and approved by the department. A diagnostic and treatment center, hospital, nursing home, intermediate care facility, long term home health care program, home and community-based services waiver program, or managed care program may submit an order for ambulette or non-emergency ambulance transportation services on behalf of the ordering practitioner.

(5) Each social services district must inform applicants for and recipients of MA of the need for prior authorization in order for transportation expenses to be paid under the MA program and of the procedures for obtaining such prior authorization.

(6) The prior authorization official may approve or deny a request for prior authorization, or require the ordering practitioner to submit additional information before the request is approved or denied.

(7) The prior authorization official must use the following criteria in determining whether to authorize payment of transportation expenses in accordance with subdivision (d) of this section:

(i) When the MA recipient can be transported to necessary medical care or services by use of private vehicle or by means of mass transportation which are used by the MA recipient for the usual activities of daily living, prior authorization for payment for such transportation expenses may be denied;

(ii) when the MA recipient needs multiple visits or treatments within a short period of time and the MA recipient would suffer undue financial hardship if required to make payment for the transportation to such visits or treatments, prior authorization for payment for such transportation expenses may be granted for a means of transportation ordinarily used by the MA recipient for the usual activities of daily living;

(iii) when the nature and severity of the MA recipient's illness necessitates a of transportation other than that ordinarily used by the MA recipient, prior authorization for such a mode of transportation may be granted;

(iv) when the geographic locations of the MA recipient and the provider of medical care and services are such that the usual mode of transportation is inappropriate, prior authorization for another mode of transportation may be granted;

(v) when the distance to be traveled necessitates a large transportation expense and undue financial hardship to the MA recipient, prior authorization for payment for the MA recipient's usual mode of transportation may be granted;

(vi) when the medical care and services needed are available within the common medical marketing area of the MA recipient's community, prior authorization for payment of transportation expenses to such medical care and services outside the common medical marketing area may be denied;

(vii) when the need to continue a regimen of medical care or service with a specific provider necessitates travel which is outside the MA recipient's common medical

marketing area, notwithstanding the fact that the medical care or service is available within the common medical marketing area, prior authorization for payment of transportation expenses to such medical care and services outside the common medical marketing area may be granted; and

(viii) when there are any other circumstances which are unique to the MA recipient and which the prior authorization official determines have an effect on the need for payment of transportation expenses, prior authorization for payment for such transportation expenses may be granted.

(e) Payment.

(1) Payment for transportation expenses will be made only when transportation expenses have been prior authorized except for emergency ambulance transportation or Medicare approved transportation by an ambulance service provided to an MA-eligible person who is also eligible for Medicare Part B payments.

(2) Payment for transportation expenses will be made only to the vendor of transportation services, to the MA recipient or to an individual providing transportation services on behalf of the MA recipient.
(3) Payment will be made only for the least expensive available mode of transportation suitable to the MA recipient's needs, as determined by the prior authorization official.

(4) Payment to vendors for transportation services must not exceed the lower of the department established rate, the local established rate, the locally prevailing rate, or the rate charged to the public, by the most direct route for the mode of transportation used. However, payment may be made in excess of the locally prevailing rate or the rate charged to the public when federal financial participation in the MA payment for transportation services is available and such payment is necessary to assure the transportation service.

(5) Payment to vendors will be made only where an MA recipient is actually being transported in the vehicle.

(6) In order to receive payment for services provided to an MA recipient, a vendor must be lawfully authorized to provide transportation services on the date the services are rendered. A vendor of transportation services is lawfully authorized to provide such services if it meets the following standards:

(i) ambulance services must be certified or registered by the Department of Health and comply with all requirements of that department.

(ii) ambulette services must be authorized by the Department of Transportation. Ambulette drivers must be qualified under Article 19-A of the Vehicle and Traffic Law. Ambulette services and their drivers must comply with all requirements of the Department of Transportation and the Department of Motor Vehicles or have a statement in writing from the appropriate department or departments verifying that the ambulette services or their drivers are exempt from such requirements. In addition, ambulette services operating in New York City must be licensed by the New York City Taxi and Limousine Commission.

(iii) taxicab or livery services must comply with all requirements of the local municipality concerning the operation of taxicab or livery service in that municipality and with all requirements of the Department of Motor Vehicles; and

(iv) Vendors which provide transportation to day treatment or continuing treatment programs must be authorized by the Department of Transportation. Drivers for such vendors must be qualified under Article 19-A of the Vehicle and Traffic Law. Such vendors and their drivers

must comply with all requirements of the Department of Transportation and the Department of Motor Vehicles or have a statement in writing from the appropriate department or departments verifying that the vendors or their drivers are exempt from such requirements.

(7) Payment is available for transportation services provided in order for the recipient to receive an MA covered service is the recipient receives such service (other than transportation services) at school or off of the school premises and both the covered service and transportation service are included in the recipient's individualized education plan. Payment is available for transportation services provided in order for the recipient, or the recipient's family member or significant other to receive an MA covered service if both the covered service and transportation service are included in the recipient's interim or final individualized family services plan. For purposes of this section, a significant other is a person who substitutes for the recipient's family, interacts regularly with the recipient, and affects directly the recipient's developmental status. Reimbursement for such services must be made in accordance with the provider agreement.

(8) Payment to a provider of ambulette services will only be made for services documented in contemporaneous records in accordance with section 504.3 of this Title. Documentation must include:

(i) the recipient's name and MA identification number;
(ii) the origination of the trip;
(iii) the destination of the trip;
(iv) the date and time of service; and,
(v) the name of the driver transporting the recipient.

(9) Payment will not be made for transportation services when:

(i) the transportation services are ordinarily made available to other persons in the community without charge; however, payment may be made under such circumstances when federal financial participation in the MA payment for transportation services is available;
(ii) the transportation services are provided by a medical facility and the costs are included in the facility's MA rate;
(iii) a vendor is not actually transporting an MA recipient;
(iv) the MA recipient has access to and can make use of transportation, such as a private vehicle or mass transportation, which the recipient ordinarily uses for the usual activities of daily living unless prior authorization has been granted by the prior authorization official.

(f) Medical transportation plans and rate schedules.

(1) The department may either establish rate schedules at which transportation services can be assured or delegate such authority to the social services districts.

(2) As directed by the department, each social services district must prepare and submit for department approval a medical transportation plan which provides for essential transportation of MA recipients to and from medical care and services which may be paid for under the MA program and the rate schedules to be used by the district. The department will approve a transportation plan if it finds that the plan satisfactorily demonstrates that appropriate modes of transportation are available to MA recipients in the social services district and that the rates of payment for transportation are adequate to ensure the availability of transportation to and from medically necessary care and services which can be paid for under the MA program.

(i) Amendments to transportation plans or changes to rate schedules must be submitted at least 60 days prior to the effective date of the amendment. The department may permit a shorter notification period in circumstances where the department has adequate time to

review the proposed amendment prior to its effective date. Factors which will be considered in determining whether to shorten the notification period include, but are not limited to, the complexity of the proposed amendment and the number and complexity of any other proposed amendments which the department is reviewing when the request is made. The department may also waive the notification period at the request of the social services district where a waiver would permit more efficient and effective administration of the MA program.

(ii) Plans, rate schedules or amendments may not be implemented without departmental approval.

(iii) The transportation rate schedules submitted for approval must be complete and contain the current department established rates, the locally established rates, or the locally prevailing rates for each transportation service for which the district is required to pay.

(3) Failure to obtain the approval required by this subdivision may result in the social services district being denied federal and state reimbursement for the expenses related to transporting MA recipients to providers of medical care or services.

(4) On request, a vendor of transportation services must submit pertinent cost data, which is available to the vendor, to the department or the social services district. The department or the social services district may not require a certified cost document if providing such certification will result in additional expense to the vendor. Failure to comply with the requirements of this paragraph may result in the vendor's termination from participation in the MA program.

(5) The department or each social services district for which payment of transportation services is made through the Medicaid Management Information System (MMIS) must adhere to the following requirements in establishing payment rates with vendors of transportation services:

(i) The department or the social services district must select at least one of the following:

(a) a flat rate for all transportation services provided;
(b) a base rate for all transportation services provided, plus a mileage charge;
(c) a flat rate for transportation services within specified areas; or
(d) a mileage rate based on distance.

(ii) The department or the social services district may establish with vendors a reduced rate for any of the following:

(a) transportation of additional persons;

(b) transportation of persons traveling to and from day treatment or continuing treatment programs; and

(c) transportation of persons for purposes of obtaining regularly recurring medical care and services.

(iii) The department or the social services district may establish an additional rate for any of the following:

(a) other transportation costs, limited to the costs of meals, lodging and transportation attendants. Such costs must be approved by the department before the social services district may establish the additional rate; and

(b) bridge and road tolls.

(6) Rates established by the department will be deemed part of all applicable social services district medical transportation plans.

Volume: C

ATTACHMENT G

Medicaid Enrollee Fair Hearing Rights

Fair Hearings

A Fair Hearing is a chance for you to tell an Administrative Law Judge from the New York State Office of Temporary and Disability Assistance, Office of Administrative Hearings, why you think a decision about your case made by a local social services agency is wrong. The Office of Temporary and Disability Assistance will then issue a written decision which will state whether the local agency's decision was right or wrong. The written decision may order the local agency to correct your case.

- **Request a Fair Hearing** - Requests for Hearings can be completed online, by US Mail, by telephone or by fax.
- **Request an Adjournment or Reopening** - If you cannot appear at a hearing that has been scheduled but hasn't been held yet, you may request that it be adjourned (postponed) to another date. You may submit your request for an adjournment online, by US Mail, by telephone or by fax. If the hearing date has already passed and you didn't attend the hearing, under some limited circumstances, you may be able to have the hearing rescheduled.
- **Cancel a Fair Hearing** - If you no longer need a hearing that you have requested, you may let us know online, by US Mail, by telephone or by fax.
- **Request Compliance with a Fair Hearing Decision** - If you have received a fair hearing decision that says that your local agency should do something and you believe that they haven't done it, you may submit a Compliance Complaint to us. You may do this online, by US Mail, by telephone or by fax.
- **Search the Fair Hearing Decision Archive** - The Office of Administrative Hearings publishes all of its Fair Hearing Decisions on the Internet. These decisions have all personal and confidential information removed. If you want to look at old decisions or find other decisions whose facts are similar to yours, you may search this archive.

Contact Fair Hearings

For all other issues, including inquiries or complaints regarding a specific fair hearing decision, obtaining an additional copy of a decision, or requests to amend a decision and/or reopen a hearing, you may contact the Office of Administrative Hearings at:

Office of Temporary and Disability Assistance
Office of Administrative Hearings
PO BOX 1930
Albany, N.Y. 12201-1930

Fax: 518-473-6735
Phone: 1 (518) 474-8781 or 1 (800) 342-3334 (toll free)

Speech or Hearing Impaired Individuals

Please contact the New York Relay Service at 711 and request that the operator call us at 1 (877) 502-6155. Service at this number will *only* be provided to callers using TDD equipment.
Source: http://otda.ny.gov/hearings/.

Attachment I

92 ADM-21, Transportation for Medical Care and Services: 18 NYCRR 505.10

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¦ ADMINISTRATIVE DIRECTIVE ¦
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TRANSMITTAL: 92 ADM-21

DIVISION: Medical Assistance

TO: Commissioners of Social Services

DATE: June 2, 1992

SUBJECT: Transportation for Medical Care and Services: 18 NYCRR 505.10

SUGGESTED DISTRIBUTION:
- Medical Assistance Staff
- Child/Teen Health Plan Staff
- Transportation Unit Staff
- Staff Development Coordinators

CONTACT PERSON: For additional information contact Loretta Grose at 1-800-342-3715, extension 35873 (OA USERID AW0680).

ATTACHMENTS: There are no attachments to this Administrative Directive.

FILING REFERENCES

Previous ADMs/INFs	Releases Cancelled	Dept. Regs.	Soc. Serv. Law & Other Legal Ref.	Manual Ref.	Misc. Ref.
81 INF-27		505.10	20.3 (d)		89 LCM-193
82 ADM-40		360-7.7	34.3 (f)		89 LCM-42
82 INF-28			365-a.2 (j)		89 LCM-43
86 INF-16			365-b, 368-a		90 LCM-51
87 ADM-39			14 NYCRR		90 LCM-88
87 INF-50,67			579.5(a)(1);		
90 ADM-1			585.10, .13a		

DSS-296EL (REV. 9/89)

I. Purpose

This Directive informs social services district staff of revisions to Title 18 of the Official Compilation of Codes, Rules and Regulations of the State of New York (18 NYCRR) 505.10, "Transportation for Medical Care and Services".

This ADM outlines the programmatic implications of the revisions as follows:

A. Definition of Terminology;

B. Clarification of Existing Medical Assistance Transportation Policy;

C. Conformity of State Regulation with Federal Policy;

D. Licensure Requirements of Transportation Providers;

E. Prior Authorization of Ambulance Transportation Involving Persons Covered Under Medicare Part B;

F. Qualified Orderers of Ambulance and Ambulette Transportation;

G. Changes Requested by Social Services Districts and Other Sources; and,

H. Medical Transportation Expenditure Claiming Procedures

II. Background

The previous version of 18 NYCRR 505.10 was last amended in 1981. Since that time, changes in the Medical Assistance (MA) program, as well as new licensure requirements for transportation vendors, resulted in various departmental policy statements which clarified the scope and intent of this regulation. Additionally, several court cases have broadened the effect of this regulation beyond its original intent. The revised regulation clearly defines the purpose and range of transportation under the MA program.

III. Program Implications

A. Definition of Terminology

Certain terms which are commonly used in the MA transportation program are now defined in 18 NYCRR 505.10, as follows:

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

2. Ambulance Service. A certified ambulance service means any entity, as defined in section 3001 of the Public Health Law, which is engaged in the provision of emergency medical services and the transportation of sick, disabled or injured persons by motor vehicle, aircraft, boat or other form of transportation to or from facilities providing hospital services and which is

currently certified or registered by the Department of Health as an ambulance service.

3. Emergency Ambulance Transportation. Emergency ambulance transportation means the provision of ambulance transportation for the purpose of obtaining hospital services for an MA recipient who suffers from severe, life-threatening, or potentially disabling conditions which require the provision of emergency medical services while the recipient is being transported.

4. Non-Emergency Ambulance Transportation. Non-emergency ambulance transportation means the provision of ambulance transportation for the purpose of obtaining necessary medical care or services to an MA recipient whose medical condition requires transportation in a recumbent position.

5. Emergency Medical Services. Emergency medical services means the provision of initial urgent medical care including, but not limited to, the treatment of trauma, burns, and respiratory, circulatory and obstetrical emergencies.

6. Ambulette. An ambulette, or invalid coach, means a special-purpose vehicle, designed and equipped to provide non-emergency care, that has either wheel chair carrying capacity or the ability to carry disabled individuals.

7. Ambulette Service. An ambulette service means an individual, partnership, association, corporation, or any other legal entity which transports the invalid, infirm or disabled by ambulette to or from facilities which provide medical care. An ambulette service provides the invalid, infirm or disabled with personal assistance entering and exiting their residences, the ambulette, and a facility which provides medical care.

8. Prior Authorization. Prior authorization means a prior authorization official's determination that payment for a specific mode of transportation is essential in order for an MA recipient to obtain necessary medical care and services and that the prior authorization official accepts conditional liability for payment of the recipient's transportation costs.

9. Prior Authorization Official. Prior authorization official means the department, a social services district, or their designated agents.

10. Conditional Liability. Conditional liability means that the prior authorization official is responsible for making payment only for transportation services which are provided to MA-eligible individuals in accordance with the requirements of this Title.

11. Common Medical Marketing Area. Common medical marketing area means the geographic area from which a community customarily obtains its medical care and services.

12. Community. Community means either the State, a portion of the State, a city or a particular classification of the population, such as all persons 65 years of age and older.

13. Locally Established Rate. Locally established rate means the rate for any given mode of transportation which the social services official has determined will ensure the efficient provision of appropriate transportation for MA recipients in order for the recipients to obtain necessary medical care or services.

14. Locally Prevailing Rate. Locally prevailing rate means a rate for a given mode of transportation which is established by a transit or transportation authority or commission empowered to establish rates for public transportation, a municipality, or a third- party payor, and which is charged to all persons using that mode of transportation in a given community.

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

16. Day Treatment Program or Continuing Treatment Program.
Day treatment program or continuing treatment program means a planned combination of diagnostic, treatment and rehabilitative services certified by the Office of Mental Retardation and Developmental Disabilities or the Office of Mental Health.

17. Transportation Attendant. Transportation attendant means any individual authorized by the prior authorization official to assist the MA recipient in receiving safe transportation.

18. Transportation Expenses. Transportation expenses means:

i. the costs of transportation services; and

ii. the costs of outside meals and lodging incurred when going to and returning from a provider of medical care and services when distance and travel time require these costs.

19. Transportation Services. Transportation services means:

i. transportation by ambulance, ambulette or invalid coach, taxicab, common carrier or other means appropriate to the recipient's medical condition; and

ii. a transportation attendant to accompany the MA recipient, 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 MA recipient's family.

20. Vendor. Vendor means a lawfully authorized provider of transportation services who is either enrolled in the MA program pursuant to Part 504 of this Title or authorized to receive payment for transportation services directly from a social services district or other agent designated by the department. The term vendor does not mean an MA recipient or other individual who transports an MA recipient by means of a private vehicle.

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

B. Clarification of Existing Medical Assistance Transportation Policy

Section 505.10 provides clarification of current policy for the authorization and payment of MA transportation as follows:

1. The transportation must be provided to an MA recipient.

   Example 1: The parent of a hospitalized child, who is receiving MA, is required to go to the hospital for periodic consultations regarding the scope of the child's on-going medical care. The parent's transportation expenses for these medical consultations may be reimbursable under the MA program (based on medical necessity) only if the parent is an MA recipient. If the parent is not a recipient of MA, the transportation expenses are not covered. (However, when a child travels to medical care and services, an attendant is required. It is expected that the parent or guardian of the child will act as attendant. In these situations, the costs of transportation, lodging and meals of the parent or guardian may be reimbursable regardless of the parent or guardian's MA eligibility.)

2. The transportation must be made to or from a necessary care or service which may be paid for under the MA program.

   Example 1: An MA recipient requests reimbursement for transportation expenses to an Alcoholics Anonymous meeting or some other self-help group. Reimbursement for transportation expenses should not be authorized as these programs are not paid for under the MA program.

   Example 2: A physician has ordered that it is medically necessary for a 55 year old developmentally disabled MA recipient to attend a sheltered workshop program in order for the recipient to maintain physical and mental health. The physician has further ordered that it is medically necessary for the MA recipient to travel by ambulette. Even though a physician has ordered this program and specified the mode of transportation, transportation should not be authorized since a sheltered workshop program is not a service covered under the MA program.

   Example 3: A young, chronically-ill mother of two children is residing in a long-term-care facility. This MA recipient's attending physician has approved a home visit for the recipient and included this order in the recipient's therapeutic plan of care. This transportation home should not be authorized since the recipient is not being transported to an MA covered service.

Example 4: A 25 year old developmentally disabled Intermediate Care Facility (ICF) resident is ordered by the ICF's attending physician to participate in a summer camp program. This transportation should not be authorized since a summer camp program is not a service covered under Medicaid.

Example 5: An MA recipient has an appointment with a physician who has not been excluded from enrollment in the MA program, but who has voluntarily chosen not to enroll as an MA provider. Transportation to this appointment can be authorized since physician services are covered under the MA program.

3. Payment will be made only for the least expensive available mode of transportation. The least expensive available mode of transportation must be suitable to the MA recipient's needs as determined by the prior authorization official.

   Example 1: An MA recipient has access to a bus line and is physically able to use a bus to travel to necessary medical care and services. The prior authorization official has determined that a bus token(s) is less expensive than private vehicle mileage reimbursement. However, the MA recipient wishes to use a private vehicle. Even though the recipient prefers to use a private car the local social services district can limit reimbursement to a bus token(s). No reimbursement should be made if the bus is not used.

4. Payment will be made to a vendor only for services provided where an MA recipient is actually being transported in the vehicle. Payment will not be available for non-passenger occupied time.

   Example 1: An ambulette arrives at a recipient's home for a scheduled appointment. The recipient is not at home; therefore, no trip is made. The vendor should not be reimbursed for this service since the MA recipient was not transported in the vehicle.

   Example 2: An ambulette arrives at a physician's office to pick up a recipient and return the recipient to the recipient's home. The pick-up is scheduled for 1:00 P.M. The recipient does not leave the physician's office until 1:20 P.M. The ambulette company should not be reimbursed an extra amount for this additional 20 minutes waiting time since the MA recipient was not in the vehicle.

During some long-distance trips, it may be appropriate for the vendor to wait for the recipient rather than return to the vendor's base of operation. Social services districts may choose to establish an enhanced base rate for this type of trip, but no specific fee should be designated for waiting time.

5. Transportation should take place within the common medical marketing area, which means the geographic area from which a community customarily obtains its medical care and services. While recipients may exercise freedom of choice in the selection of medical care and service providers, this does not mean that the local social services district must pay for transportation to medical care and service outside the common medical marketing area when the same care and service is available locally.

   When authorizing long-distance transportation social services districts must ensure that the medical care and services required by the recipient are not readily available within the recipient's common medical marketing area. The appropriateness of reimbursement for long-distance transportation should be decided by the prior authorization official after a careful consideration of relevant factors such as location of service and recipient, medical need, recipient's personal circumstances and continuity of medical care.

   Example 1: An MA recipient residing in Albany wishes to consult a medical provider located in Syracuse, which is outside the recipient's common medical marketing area. If this same type of provider is available within the Albany area, the prior authorization official may, after consideration of all criteria set forth in section 505.10(d)(7), deny reimbursement for transportation to the medical provider located in Syracuse. In this instance, medical care and services are available within the recipient's common medical marketing area; therefore, payment for transportation outside the area is not essential in order for the recipient to obtain needed medical care. If the recipient chooses to go to the out of area medical provider, no transportation reimbursement should be provided as appropriate medical care within the common medical marketing area has been assured.

   Example 2: A pregnant woman, who changes residence from one social services district to another, may need to consult with her original physician in her former district of residence for a period of time before an adequate transfer of care to a new local provider can be accomplished. Reimbursement for transportation to the out of area physician could be provided for as long a period as consultation with this physician is medically necessary.

C. Conformity of State Regulation with Federal Policy

The Code of Federal Regulations (42 CFR 431.53) requires states participating in the Medicaid program to assure necessary transportation to and from providers of medical care and services which are covered under the states' Medicaid programs. Assuring transportation does not necessarily mean payment for transportation. This federal requirement to assure necessary transportation can be met in a variety of ways, including:

1. The use of transportation services which are ordinarily made available to other persons in the community without charge;

2. The use of volunteer services;

3. Payment to a vendor of transportation services; or,

4. Reimbursement to MA recipients for the use of a private vehicle or mass transportation.

Social services districts can reasonably assume that recipients have some form of transportation available to them for their usual activities of daily living. If a recipient has access to and can make use of the mode of transportation generally used for the usual activities of daily living (such as shopping, recreation, worship services), the recipient should use this mode of transportation to travel to medical appointments. Reimbursement for this mode of transportation does not have to be made. The prior authorization official may authorize payment, however, where the failure to do so would cause the recipient undue financial hardship. If the recipient's normal mode of transportation is available, reimbursement is not necessary for transportation to occasional medical treatment.

Example 1: A rural county resident regularly travels 25 miles one way in her personal vehicle to the county seat in order to shop for food, clothes, and other household items. Reimbursement for occasional transportation to the same city for medical appointments can be denied.

Example 2: An ambulatory individual living in a city resides five blocks from a bus route which interconnects with other bus routes throughout the city. When the individual must travel to the site of a medical practitioner which is in the catchment area of the bus routes, the district can reasonably expect the individual to use the bus and can deny reimbursement for the cost of the token.

Example 3: A department in a rural county provides van transportation of recipients to a major medical center in a neighboring county on Tuesdays and Fridays of each week. For non-urgent medical appointments to the center, the department can expect recipients to schedule appointments for and use the van on Tuesdays or Fridays. Reimbursement for personal vehicle mileage to the van pickup site can be denied.

An MA recipient may use a private vehicle or mass transit for the usual activities of daily living. Reimbursement may be made for these modes of transportation when the use of these modes without reimbursement would constitute an undue financial hardship for the MA recipient. The prior authorization official must decide whether or not to reimburse for these situations on a case by case basis. Reimbursement for mileage in a private vehicle, when authorized, is assumed to be round-trip even if the MA recipient does not return with the driver to the origin point but remains in a medical facility.

Example 4: An MA recipient, diagnosed with a short-term illness requires multiple medical visits within a short period of time. The frequency of these visits may provide a reason for the social services district to reimburse the MA recipient for transportation expenses.

Example 5: A child with an unusual heart problem, residing in the city of Buffalo, may need to access medical services at a New York City hospital specializing in children's diseases. Although located outside the recipient's common medical marketing area, the social services district should reimburse for this long-distance transportation if it is necessary to assure appropriate medical care. In this type of circumstance it may be necessary for the MA recipient to access medical care and services located outside the common medical marketing area. When long distance travel is required, the social services district should provide reimbursement as the cost of transportation is excessive. While a recipient may, in general circumstances, access medical care and services through use of a private vehicle or mass transit, a severe illness may necessitate the use of a higher mode of transport. If a higher mode of transport is required, the recipient would not be expected to assume this cost.

Example 6: An MA recipient is generally able to use the mass transit system for medical appointments and other daily activities. Reimbursement for this MA recipient's transportation is not being paid by the social services district. This recipient suffers a sprained ankle and cannot use the mass transit system. A higher mode of transport, in this case a taxi, is required. The social services district may wish to reimburse for transportation expenses in this situation as the cost of this higher mode of

transport, without reimbursement, may be an undue financial hardship to the recipient.

An elderly recipient, generally driven to medical appointments by a family member, breaks a leg and is now unable to utilize a private vehicle for transportation to necessary medical appointments. An ambulette is necessary and is ordered by the attending physician. The recipient would not be expected to assume the cost of this higher mode of transport. In these cases, social services districts should provide payment for transportation expenses.

Example 7: A mother and her small children who normally take a bus to medical appointments cannot use mass transit due to icy or snowy weather. Reimbursement to this recipient for a safer and more accessible method of transportation (private vehicle or taxi) may be appropriate.

Procedures for denial of transportation reimbursement should be included as part of the social services district's transportation plan.

Recipients who request reimbursement and are denied reimbursement for transportation expenses must be informed of their right to a fair hearing.

The prior authorization official should consider a number of factors when deciding whether or not to authorize reimbursement for a recipient's private transportation expenses. These factors include but are not limited to:

1. Frequency of medical appointments;
2. Distance to be traveled;
3. Continuity of medical care;
4. Medical condition of the recipient;
5. Weather conditions;
6. Availability of the recipient's usual mode of transportation;
7. Undue financial hardship to the recipient if reimbursement is not authorized; and,
8. Any other circumstance which may affect the recipient's ability to access needed medical care and services.

D. Licensure Requirements of Transportation Providers

Section 505.10(d)(6) establishes licensure requirements for transportation providers, as follows:

1. Ambulance services must be certified or registered by the Department of Health and comply with all requirements of that department.

2. Ambulette services must be authorized by the Department of Transportation. Ambulette drivers must be qualified under Article 19-A of the Vehicle and Traffic Law. Ambulette services and their drivers must comply with all requirements of the Department of Transportation and the Department of Motor Vehicles or have a statement in writing from the appropriate department or departments verifying that the ambulette services or their drivers are exempt from such requirements.

In addition, ambulette services operating in New York City must be licensed by the New York City Taxi and Limousine Commission.

3. Taxicab or livery services must comply with all requirements of the local municipality concerning the operation of taxicab or livery service in that municipality.

4. Vendors which provide transportation to day treatment or continuing treatment programs must be authorized by the Department of Transportation. Drivers for such vendors must be qualified under Article 19-A of the Vehicle and Traffic Law. Such vendors and their drivers must comply with all requirements of the Department of Transportation and the Department of Motor Vehicles or have a statement in writing from the appropriate department or departments verifying that the vendors or their drivers are exempt from such requirements. Payment to vendors will be made only when they meet the above requirements on the date the services are rendered.

E. Prior Authorization of Ambulance Transportation Involving Persons Covered Under Medicare Part B

Chapter 763 of the Laws of 1989 mandated that ambulance providers be paid the full deductible and coinsurance amounts of an approved Medicare Part B claim for the transportation of MA eligible persons who are covered under Medicare Part B. Section 505.10(c)(1) now reflects this legislation. Prior authorization of non-emergency ambulance transportation is not required for ambulance claims in which there is a Medicare Part B approved amount. Approval by Medicare of an ambulance transport will be deemed appropriate approval for MA purposes.

Prior authorization will still be required for non-emergency ambulance transportation for which there is no Medicare Part B coverage.

F. Qualified Orderers of Ambulance and Ambulette Transportation

Section 505.10(c)(4) allows an ordering practitioner who is the MA recipient's attending physician, physician's assistant or nurse practitioner to order non-emergency ambulance transportation. Ambulette transportation may be ordered by an ordering practitioner who is the MA recipient's attending physician, physician's assistant, nurse practitioner, dentist, optometrist, podiatrist or other type of medical practitioner designated by the social services district and approved by the Department. If a social services district wishes to include additional ordering provider groups the district must submit such request to the Division of Medical Assistance for approval as part of their social services district's Title XIX Medical Transportation Plan.

G. Changes Requested by Social Services Districts and Other Sources

1. Vendors of transportation services must provide pertinent cost data to a social services district upon request. The request should be for any pertinent cost data which would aid the social services district in containing expenditures or establishing rates. Social services districts may request this data as long as the request does not place an additional financial cost on the vendor. An example of an additional financial cost would be a request for a certified cost document when such a certified cost document does not exist. Additional financial cost does not mean the cost of photocopying financial documents or computer generated printouts of financial documents. These procedures should be readily and inexpensively available to the vendor. Failure to comply with the social services district request may result in the vendor's termination from the MA program.

   This provision is not intended to encourage the development of cost-based rates. A variety of factors should be included in the rate setting process.

2. Social services districts must notify applicants for and recipients of MA of the procedures for obtaining prior authorization of transportation services. Several recent court decisions granted recipients retroactive reimbursement for private vehicle transportation costs because these recipients were never notified by the social services district that the potential for MA transportation reimbursement existed. Information regarding the availability of reimbursement for prior authorized private medical transportation expenses is included in the revised client information booklets DSS-4148A and DSS-4148B.

3. A court found that the previous version of Section 505.10 required social services districts to negotiate with vendors in the rate setting process. The use of the term "negotiate" has been eliminated from the language of the regulation. Section 505.10 now permits rates to be established by the local social services official at a level which assures transportation for MA recipients to necessary medical care and services. Negotiation may be included as part of the rate-setting process if the social services district so desires, but negotiation is not required.

H. Medical Transportation Expenditures Claiming Procedures

1. All medical transportation services furnished by an entity to which a direct vendor payment can be made are claimable for reimbursement as program assistance costs.

2. All non-vendor medical transportation payments should be claimed for reimbursement as administrative costs. These non-vendor payments include, but are not limited to, the following:

   a. reimbursement to recipients for approved medical transportation;

   b. costs of meals or lodging enroute to and from medical care;

   c. cost of a transportation attendant to accompany the recipient, if necessary, and the costs of 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 MA recipient's family;

   d. cost of bus and subway tokens purchased by the social services district for distribution to recipients;

   e. payments to a party which is not the provider of the transportation services.

IV. Required Action

Social services district staff must follow the provisions of this release in authorizing and making payment for transportation services for MA eligible persons.

If any changes in social services district's procedures occur, the social services district must submit these changes in writing to the department for approval and amendment of the social services district's transportation plan.

V. System Implications

None.

VI. Effective Date

The Directive is effective July 1, 1992 retroactive to April 1, 1992.

_____
Jo-Ann A. Costantino
Deputy Commissioner
Division of Medical Assistance

NEW YORK STATE
MEDICAID TRANSPORTATION

ORDERING GUIDELINES MANUAL

EFFECTIVE JULY 15, 2010

Introduction

When the Medicaid Program was established in the 1960s, the federal government recognized that unless needy individuals could actually get to and from providers of services, the entire goal of the Medicaid Program is inhibited at the start. As a result, States are required under federal regulations to ensure necessary transportation for Medicaid enrollees to and from medical services. The federal government also provided authority for States to ensure the provision of this transportation to Medicaid enrollees with federal financial participation in the cost of these services under the Medicaid Program. For the Medicaid population, getting to and from services can be a struggle. If the enrollee cannot get to services, then the Program fails from the start; so New York State made the decision to cover a series of optional services under the Medicaid Program, including medical transportation.

In order to maintain enough flexibility to sufficiently meet the transportation needs of Medicaid enrollees in a significantly culturally and geographically diverse State, the responsibility of managing the New York State Medicaid Transportation Program was delegated to each county's local departments of social services. The New York City Medicaid Transportation Program is administered by the City of New York Human Resources Administration, which encompasses the five boroughs of the City of New York, with oversight by the New York State Department of Health.

Medicaid covers the transportation of eligible, enrolled persons who need transportation to and from Medicaid-covered services. All transportation must be prior authorized for payment.

For questions, comments and more information, please contact the Medicaid Program's Transportation Unit:

Telephone: (518) 473-2160
Fax: (518) 486-2495
Email: MedTrans@health.ny.gov

Section I – Covered Transportation Services

Medicaid covers the transportation of eligible, enrolled persons who need transportation to and from Medicaid-covered services. When traveling to medical appointments, a Medicaid enrollee is to use the same mode of transportation as used to carry out the activities of daily life. Medicaid will pay for the **least costly, most medically appropriate** level of transportation to and from services covered by the Medicaid Program.

Covered non-emergency transportation services include:

- Personal vehicle;
- Public transportation (bus/subway);
- Livery;
- Ambulette; and
- Ambulance.

Section II – Rules for Ordering

As an ordering practitioner, you are responsible for ordering medically necessary transportation within the common medical marketing area (CMMA).

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

Enrollees who have reasonable access to a mode of transportation used for the normal activities of daily living; such as shopping and recreational events; are expected to use this same mode to travel to and from medical appointments when that mode is available to them.
Medicaid may restrict payment for transportation if it is determined that:

- the enrollee chose to go to a medical provider outside the CMMA when services were available within the CMMA, and
- the enrollee could have taken a less expensive form of transportation but opted to take the more costly transportation.

In either case above, if the enrollee or his/her medical practitioner can demonstrate circumstances justifying payment, then reimbursement can be **considered**.

Responsibility of the Ordering Practitioner

As the medical practitioner requesting taxi, ambulette, or non-emergency ambulance services, you are responsible for ordering the **medically appropriate** mode of transportation for the Medicaid enrollee. A basic consideration for this should be the enrollee's current level of mobility and functional independence.

The transportation ordered should be the least specialized mode required based upon the enrollee's **current** medical condition. For example, if you feel the enrollee does not require personal assistance, but cannot walk to public transportation, you should authorize taxi service, not ambulette service.

Any ordering practitioner or entity ordering transportation on the practitioner's behalf that orders transportation which is deemed not to meet the above rules may be sanctioned according to 18 NYCRR Section 515.3, available online at: http://www.health.ny.gov/regulations/

Acceptable Orderers of Transportation

If you are enrolled as a Medicaid provider and the category of service in which you have enrolled reflected in the table below, then you may request prior authorization of transportation services on behalf of Medicaid enrollees.

Provider Type	Provider Type
Shared Health Facility	Long Term Care Health Related Facility
Dental Group	Long Term Care Day Care
Physician Group	ICF for Developmentally Disabled
Midwife Group	Mental Retardation: Outpatient Services
Clinical Psychologist Group	Nursing Home Sponsored HHA Professional Svcs
Free-Standing Diagnostic & Treatment Ctr	Long Term Home Health Care
Ordered Ambulatory (Other than Labs)	Salaried Optometrist
Hospice	LTC: Ordered Ambulatory (Other than Labs)
Dental School	Self-Employed Optometrist
Dental Service	Salaried Optician
Prepaid Capitation Plan	Physician
Free-Standing Home Health Ag Professional Svc	Self-Employed Optician
Assisted Living Program	Physician: CHAP Practitioner
OMH-Certified Rehabilitation Facility	Registered Physician's Assistant
HHAS: OMR/DD Waiver Services	Physician
Hos Svc: Ordered Ambulatory (Other than Labs)	Nurse Practitioner
Hos Svc: Home Care Program	Podiatrist
Inpatient Facility	Midwife
Skilled Nursing Facility	Clinical Psychologist
Hos Svc: Hospital Base Outpatient Services	Occupational Therapist
Hos Svc: Health Related Facility	Physical Therapist
Audiologist	Speech Therapist
Long Term Care Skilled Nursing Facility	Respiratory Therapist
	Respiratory Therapist Technician

If you have any questions regarding the category of service in which you are enrolled, please contact eMedNY Provider Services at (800) 343-9000.

Non-Emergency Ambulance
Generally, ambulance service is requested when a Medicaid enrollee needs to be transported in a recumbent position (lying down) or is in need of medical attention while en route to their medical appointments.

A request for prior authorization **must** be supported by the order of a practitioner who is the Medicaid enrollee's:

- Attending physician;
- Physician's assistant; or
- Nurse practitioner.

Ambulette

Ambulette service is door-to-door; from the enrollee's home through the door of the medical appointment. Personal assistance by the staff of the ambulette company is required by the Medicaid Program in order to bill the Program for the provision of ambulette service. 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.

If personal assistance is not necessary and/or not provided, then taxi service should be ordered.

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.

Ambulettes may also provide taxi (curb-to-curb) service and will transport taxi-eligible enrollees in the same vehicle as ambulette-eligible enrollees. The Medicaid Program does not require the ambulette service to be licensed as a taxi service; the only requirement that ambulettes need to meet for this service is the proper authority and license to operate as an ambulette.

A request for prior authorization of ambulette transportation 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 designated by the district and approved by the Department.

A diagnostic and treatment clinic, hospital, nursing home, intermediate care facility, long term home health care program, home and community based services waiver program, or managed care program may order non-emergency ambulance transportation services on behalf of the ordering practitioner.

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

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

- The Medicaid enrollee needs to be transported in a recumbent position and the ambulette service is able to accommodate a stretcher;
- The Medicaid enrollee is wheelchair-bound and is unable to use a taxi, taxi service, bus or private vehicle;
- The Medicaid enrollee has a disabling physical condition which requires the use of a walker or crutches and is unable to use a taxi, bus or private vehicle;
- An otherwise ambulatory Medicaid enrollee requires radiation therapy, chemotherapy, or dialysis treatments which result in a disabling physical condition after treatment, making the enrollee unable to access transportation without personal assistance provided by an ambulette service;
- 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 services; and,
- The ordering practitioner certifies in a manner designated by and submitted to the Department that the Medicaid enrollee cannot be transported by taxi, bus or private vehicle and there is a need for ambulette service.

Taxi Transportation

A request for prior authorization for transportation by New York City livery services 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 designated by the district and approved by the Department.

A diagnostic and treatment clinic, hospital, nursing home, intermediate care facility, long term home health care program, home and community based services waiver program, or managed care program may order 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 an ambulette transport.

Day Program Transportation
Day program transportation is unique in that this transportation can be provided by an ambulance, ambulette or taxi 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 day treatment/day program must adhere to the same requirements for their specific provider category.

Form 2015 (2/2017)

ATTACHMENT K

Enrollee Name: _____

NEW YORK STATE | Department of Health | Office of Health Insurance Programs

Patient Information: Enrollee's Name: Date of Birth: Medicaid Client ID:
Address: City: State: Zip:

Please use the space below to indicate what mode of transportation this enrollee uses for activities of daily living such as attending school, worship, shopping, social visits, family, etc.?

Can the enrollee utilize mass/public transportation? ☐ Yes ☐ No. *If Yes, please stop here and proceed to the Medical Provider section of this Form.*

Does the enrollee have any medically documented reason that he/she cannot be transported in a group ride capacity? ☐ Yes ☐ No
If you checked Yes, please provide the medical reason.

Mode of Transport: Please check the box below that indicates the most medically appropriate mode of transportation for this enrollee.

☐ **Taxi/Livery** - Requires no assistance curb to curb.
☐ **Ambulette Ambulatory** - Door through door assistance.
☐ **Ambulette Wheelchair** - Enrollee uses wheelchair.
☐ **Stretcher Van** - Enrollee is confined to bed.
☐ **Basic Life Support Ambulance (BLS)** – Enrollee is confined to a bed, cannot sit in a wheelchair, **and requires** medical attention/monitoring during transport for reasons such as isolation precautions, oxygen not self-administered, sedated, etc.
☐ **Advance Life Support Ambulance (ALS)** – Enrollee is confined to a bed, cannot sit in a wheelchair, **and requires** medical attention/monitoring during transport for reasons such as IV requiring monitoring, cardiac monitoring and tracheotomy.

1. Is the above Mode of Transportation required for the enrollee's behavioral, emotional and/or mental health diagnosis? ☐ Yes ☐ No
   a) *If you checked YES, please use the space provided to indicate the relevant condition and how it impacts the patient's ability to access public transportation.*
   b) Is the patient receiving any type of treatment to reduce the acute symptoms that are resulting in the need for a higher mode of transportation?
      ☐ Yes ☐ No. *If you checked YES, please use the space provided to enter the type of treatment.*
   c) What is the expected outcome of the treatment?

2. Is the above Mode of Transportation required for a mobility related issue? ☐ Yes ☐ No. *If you checked YES, please use the space below to enter relevant medical and /or physical conditions this patient has which justifies the enrollee requiring a higher mode of transportation*.

Form 2015 (2/2017)

ATTACHMENT K

Enrollee Name: _____

NEW YORK STATE | Department of Health | Office of Health Insurance Programs

3. Please use the space below to indicate any other health related reason that justifies the request for a mode of transportation higher than public transportation.

4. Please indicate below the anticipated length of time this enrollee will require a higher mode of transportation:
☐ Temporarily until __/__/____ ☐ Long Term (9-12 months) __/__/____ ☐ Permanent (subject to periodic review)

5. Please use the space below to provide any relative information that is unique to the patient that will impact any medical transportation request. This may include but is not limited to morbidities such as: bariatric requirements, unique housing situations, and requirements for an escort, etc.

CERTIFICATION STATEMENT: *I (or the entity making the request) understand that orders for Medicaid-funded travel may result from the completion of this form. I (or the entity making the request) understand and agree to be subject to and bound by all rules, regulations, policies, standards and procedures of the New York State Department of Health, as set forth in Title 18 of the Official Compilation of Rules and Regulations of New York State, Provider Manuals and other official bulletins of the Department, including Regulation 504.8(2) which requires providers to pay restitution for any direct or indirect monetary damage to the program resulting from improperly or inappropriately ordering services. I (or the entity making the request) certify that the statements made hereon are true, accurate and complete to the best of my knowledge; no material fact has been omitted from this form.*

Medical Provider Information:
A medical provider is defined as a Physician, Physician's Assistant, Nurse Practitioner, Licensed Social Worker, Dentist or Registered Nurse who has provided direct medical care to the Medicaid enrollee.

Medical Provider's Name NPI # Date of Request

Clinic/Facility/Office Name Clinic/Facility/Office Address City State Zip

Telephone # Fax #

Name of person completing this form Title

Signature

This form **must** be completed in its entirety or it will not be processed nor approved.

Fax to: TBD (Pending Award)

ALL INFORMATION CONTAINED IN THIS FORM IS DEEMED CONFIDENTIAL AND SAFEGUARDED BY THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (HIPAA).

Attachment L

Call Center Telephone Compliance Report

Instructions:

1) The purpose of this tool is to standardize telephony reporting requirements for all Medicaid Transportation Management contracts.

2) There are four (4) additional worksheets within this file. Please populate those cells that are gray-filled, within the worksheets labeled *"General Phone Data"* and *"Hold Times"*, with data exported directly from your phone system.

3) Reports should be submitted to the Department each month, no later than the 15th day the following month.

4) If a Transportation Manager has contracts for more than one (1) Contract Region, a separate report must be submitted for each Contract Region

5) The intent of this reporting tool, as well as other requests that will be forthcoming, is to not only ensure that the Bureau can demonstrate transportation management contract compliance and accountability, but to increase our ability to identify areas for improvement, assess quality performance standards, and highlight areas of continued success. We firmly believe that a partnership with your company in achieving the agreed upon standardized reporting protocols will help us to better explain the important role and scope of the Department's Medicaid transportation program, and the valuable contribution of our management contractors. As always, we look forward to the opportunity to work with you. If you have any questions, please contact us.

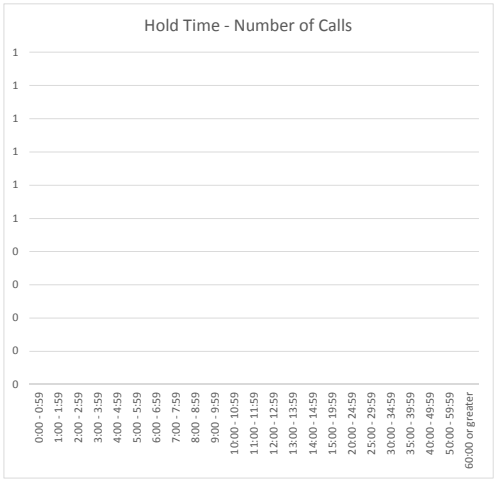
Operational Definitions

Worksheet	Line	Column(s)	Instructions
General Phone Data	1	D - K (merged	Upload the name of the Contract Region (free text field)
General Phone Data	1	N - O (merged)	Upload the calendar year (YYYY)
General Phone Data	3	B - M	Upload the total number of incoming phone calls
General Phone Data	4	B - M	Upload the total number of incoming phone calls, reaching the AVR is 3-minutes or less
General Phone Data	7	B - M	Upload the total number of calls routed to a call center operator
General Phone Data	8	B - M	Upload the total number of calls abandoned in queue - Between AVR pick-up & call center operator pick-up
General Phone Data	14	B - M	Upload the number of calls answered by a call center operator in 3-minutes or less
General Phone Data	17	B - M	Upload the number of calls placed on hold by a call center operator
General Phone Data	18	B - M	Upload the number of calls abandoned, after being placed on hold by a call center operator
General Phone Data	21	B - M	Upload the mean (average) call handle time - From operator pick-up until call completion, including hold time(s)
General Phone Data	22	B - M	Upload the median * call handle time - From operator pick-up until call completion, including hold time(s)
General Phone Data	23	B - M	Upload the maximum call handle time - From operator pick-up until call completion, including hold time(s)
Hold Times	2	B - M	Upload the number of calls placed on hold (minutes-seconds) 0:00 - 0:59
Hold Times	3	B - M	Upload the number of calls placed on hold (minutes-seconds) 1:00 - 1:59
Hold Times	4	B - M	Upload the number of calls placed on hold (minutes-seconds) 2:00 - 2:59
Hold Times	5	B - M	Upload the number of calls placed on hold (minutes-seconds) 3:00 - 3:59
Hold Times	6	B - M	Upload the number of calls placed on hold (minutes-seconds) 4:00 - 4:59
Hold Times	7	B - M	Upload the number of calls placed on hold (minutes-seconds) 5:00 - 5:59
Hold Times	8	B - M	Upload the number of calls placed on hold (minutes-seconds) 6:00 - 6:59
Hold Times	9	B - M	Upload the number of calls placed on hold (minutes-seconds) 7:00 - 7:59
Hold Times	10	B - M	Upload the number of calls placed on hold (minutes-seconds) 8:00 - 8:59
Hold Times	11	B - M	Upload the number of calls placed on hold (minutes-seconds) 9:00 - 9:59
Hold Times	12	B - M	Upload the number of calls placed on hold (minutes-seconds) 10:00 - 10:59
Hold Times	13	B - M	Upload the number of calls placed on hold (minutes-seconds) 11:00 - 11:59
Hold Times	14	B - M	Upload the number of calls placed on hold (minutes-seconds) 12:00 - 12:59
Hold Times	15	B - M	Upload the number of calls placed on hold (minutes-seconds) 13:00 - 13:59
Hold Times	16	B - M	Upload the number of calls placed on hold (minutes-seconds) 14:00 - 14:59
Hold Times	17	B - M	Upload the number of calls placed on hold (minutes-seconds) 15:00 - 19:59
Hold Times	18	B - M	Upload the number of calls placed on hold (minutes-seconds) 20:00 - 24:59
Hold Times	19	B - M	Upload the number of calls placed on hold (minutes-seconds) 25:00 - 29:59
Hold Times	20	B - M	Upload the number of calls placed on hold (minutes-seconds) 30:00 - 34:59
Hold Times		B - M	Upload the number of calls placed on hold (minutes-seconds) 35:00 - 39:59
Hold Times	22	B - M	Upload the number of calls placed on hold (minutes-seconds) 40:00 - 49:59
Hold Times	23	B - M	Upload the number of calls placed on hold (minutes-seconds) 50:00 - 59:59
Hold Times	24	B - M	Upload the number of calls placed on hold (minutes-seconds) 60:00 or greater

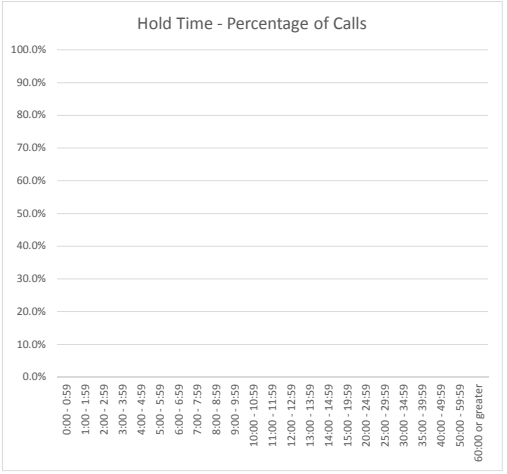
* The median is the exact middle point in a range of values that are arranged from smallest to largest. Half (50%) of all values will be less than the median and half (50%) will be greater than the median. If the range contains an even number of values, the median is the average of the middle two values.

	Contract Region:										Calendar Year:			
	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	YTD Total	YTD Mean
Total number of incoming calls													0	
Number of calls reaching AVR - 3-rings or less													0	
- Percentage of calls reaching AVR - 3-rings or less	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!		#DIV/0!
Number of calls routed to a call center operator													0	
Number of calls abandoned while in waiting queue													0	
- Percentage of calls abandoned while in waiting queue	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!		#DIV/0!
Number of calls reaching a call center operator	0	0	0	0	0	0	0	0	0	0	0	0	0	
- Percentage of calls reaching a call center operator	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!		#DIV/0!
Number of calls answered by call center operator <3 mins													0	
- Percentage of calls answered by call center operator <3 mins	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!		#DIV/0!
Number of calls placed on hold by call center operator													0	
Number of calls abandoned while on hold													0	
- Percentage of calls abandoned while on hold	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!		#DIV/0!
Mean handle time (seconds)														#DIV/0!
Median handle time (seconds)														#DIV/0!
Maximum handle time (seconds)														#DIV/0!

Hold Time - Number of Calls	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	YTD Total
0:00 - 0:59													0
1:00 - 1:59													0
2:00 - 2:59													0
3:00 - 3:59													0
4:00 - 4:59													0
5:00 - 5:59													0
6:00 - 6:59													0
7:00 - 7:59													0
8:00 - 8:59													0
9:00 - 9:59													0
10:00 - 10:59													0
11:00 - 11:59													0
12:00 - 12:59													0
13:00 - 13:59													0
14:00 - 14:59													0
15:00 - 19:59													0
20:00 - 24:59													0
25:00 - 29:59													0
30:00 - 34:59													0
35:00 - 39:59													0
40:00 - 49:59													0
50:00 - 59:59													0
60:00 or greater													0
	0	0	0	0	0	0	0	0	0	0	0	0	0
	0	0	0	0	0	0	0	0	0	0	0	0	0



Hold Time - Percentage of Calls	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	YTD Mean
0:00 - 0:59	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
1:00 - 1:59	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
2:00 - 2:59	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
3:00 - 3:59	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
4:00 - 4:59	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
5:00 - 5:59	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
6:00 - 6:59	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
7:00 - 7:59	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
8:00 - 8:59	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
9:00 - 9:59	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
10:00 - 10:59	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
11:00 - 11:59	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
12:00 - 12:59	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
13:00 - 13:59	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
14:00 - 14:59	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
15:00 - 19:59	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#VALUE!	#DIV/0!	#DIV/0!	#DIV/0!	#VALUE!
20:00 - 24:59	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
25:00 - 29:59	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
30:00 - 34:59	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
35:00 - 39:59	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
40:00 - 49:59	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
50:00 - 59:59	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
60:00 or greater	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!



Hold Times													
Fractile Analysis	Mean	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
< 1 minute	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
< 2 minutes	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
< 3 minutes	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
< 4 minutes	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
< 5 minutes	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
< 6 minues	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
< 7 minutes	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
< 8 minutes	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
< 9 minutes	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
< 10 minutes	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
< 11 minutes	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
< 12 minutes	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
< 13 minutes	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
< 14 minutes	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
< 15 minutes	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
< 20 minutes	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
< 25 minutes	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
< 30 minutes	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
< 35 minutes	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
< 40 minutes	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
< 50 Minutes	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
< 60 Minutes	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
≥ 60 Minutes	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!