# Medical Transportation Policy

**Provider Participation Guidelines**

To participate in the Medicaid Program, providers must have an office and performing services in Rhode Island or in a border community.

Ambulance providers must be licensed through the Department of Health (or other applicable agency for border community providers). Taxi and Public Motor Vehicles must be licensed through the Public Utilities Commission. All license documentation (for companies, vehicles and drivers) must be submitted with the provider application.

**Recertification**

Ambulance providers are annually recertified by the Rhode Island Department of Health (DOH). Once license renewal is obtained, forward a copy of the renewal documentation to Hewlett Packard Enterprise (HPE). HPE should receive this information within thirty days of renewal to avoid interruption of provider eligibility.

Taxi, Public Motor Vehicle Carriers, and Providers in border communities must send in copies of their license or recertification within thirty days of renewal to ensure continuation in the program.

**Claims Billing Guidelines**

Instructions for completing the CMS 1500 claim form are located on the Office of Health and Human Services (OHHS) website at: http://www.eohhs.ri.gov/Portals/0/Uploads/Documents/cms1500_directions.pdf

**Origin/Destination Modifiers**

Claims must include a two-letter origin-destination modifier indicating where the trip begins and ends if billing for mileage, (emergency or non-emergency) non-emergency stretcher and/or emergency (BLS/ALS) transportation services.

**Covered and Non-Covered Services**

The Medicaid Program Covers emergency and non-emergency medical transportation (NEMT) for Medicaid clients to a Medicaid covered service provided by a Medicaid provider. Only ground transportation is covered. The type of trip (emergency/non-emergency) must be consistent with the diagnosis of the patient transported (e.g., a trip billed as emergency transport would not be covered if the patient had a non-emergency diagnosis). Emergency transportation claims for Medicaid clients enrolled in managed care plans should be referred to the appropriate Plan.

**Non-Emergency Medical Transportation**

Non-emergency medical transportation is covered when the recipient has no other means of transportation, no community resource exists and transportation by any other means would endanger the individual's health. Also, the non-emergency medical transportation must be for a Medicaid eligible person, receiving a Medicaid covered service from a Medicaid-participating provider.

**SNF or ICF Resident**

An individual residing in a Skilled Nursing Facility (SNF) or Intermediate Care Facility (ICF) whose condition precludes transportation by the facility automobile to and from physician's office, medical laboratory, hospitals, etc., may be transported subject to the following restrictions.

Non-emergency medical transportation services should only be utilized when the patient cannot be transported by any other means through the facility and when the required medical service cannot be provided within the facility. It is the responsibility of the facility to ensure that the patient is transported by alternative means whenever possible.

Non-emergency transportation services should not be utilized to transport patients to receive services that can be provided within the facility; e.g., portable x-ray services can be provided in a facility setting.
Emergency medical transportation services should only be provided when a patient is severely ill or injured and transportation by any other means would endanger the individual's health.

**Out of State Non-Emergency Medical Transportation**
Non-emergency medical transportation for out-of-state trips will only be considered for payment on the basis of medical necessity. The patient's provider must provide written medical documentation in advance to the State for review. Please allow at least ten business days for the review to be completed. In general, such services are only authorized if the Medicaid covered service is not available in Rhode Island or there are other extenuating medical circumstances. Refer to Section 200-30 of the Provider Manual for authorization guidelines and procedures.

**Round Trips**
Emergency transportation will not be paid for transport back to the point of origin. Emergency round trips are paid only if the patient is transported out of state and back. Non-emergency round trips can be paid if authorization was obtained. Hospital initiated (Emergency Room, Inpatient, Outpatient) non-emergency transports must be billed to the requesting facility.

**Repeat Trips/Extra Attendants**
Up to four (4) one-way non-emergency medical trips may be provided to a patient in one day. All trips must be authorized. Payment for an extra attendant to accompany a patient may be permitted if medically necessary and must be authorized.

**Authorization**
All non-emergency procedure codes (excludes non-emergency stretcher transports) require authorization. In addition, extra attendants also require authorization. When requesting authorization, medical justification must be documented. Authorization should be requested from the transportation scheduler, by calling 401-784-3899.

**Physician's Statement**
Non-emergency medical transportation may require a written statement by the recommending physician. This statement must include the recipient's medical condition that prevents them from taking public transportation and why non-emergency medical transportation is required. If the non- emergency transportation is on-going (such as for kidney dialysis), one statement can be used for a period of up to one year.

**ALS and BLS**
ALS (Advanced Life Support) includes oxygen and heart monitoring devices and is indicated if a condition is life-threatening. BLS (Basic Life Support) does not include oxygen. The level of support is determined by the services that are provided en-route. Additional life support services are not separately payable.

**Mileage**
Mileage is reimbursable for wheelchair, BLS, ALS and out-of-state ambulatory transportation services. There is no mileage reimbursement for in-state ambulatory trips. The maximum mileage allowed for each trip will be predetermined by the State or its designee during the authorization process.

**Waiting Time**
Waiting time is reimbursed for out-of-state trips up to a maximum of two hours. In-state waiting time is included in the base rate.

**Oxygen**
The need for oxygen must bear a reasonable relationship to the medical diagnosis and requirements of the patient. Oxygen will not be allowed on a routine basis.

**Multiple Passengers**
More than one recipient may be transported by the same vehicle on the same trip, provided there are adequate seating and safety restraints for all passengers. Passengers must not have their trip lengthened by more than 30 minutes due to multi-loading of passengers.

**Reimbursement Guidelines**
Providers must bill the Medicaid Program for their usual and customary rate (UCR) as charged to the general public. Rates discounted to specific groups (such as Senior Citizens) must be billed at the same discounted rate to the Medicaid Program. Payments to providers will not exceed the maximum reimbursement rate of the Medicaid Program.

**Medicare/Medicaid Crossover**
The Medicaid Program payment for crossover claims is always capped by the established Medicaid allowed amount, regardless of coinsurance or deductible amounts. The standard calculation for crossover payments is as follows:

**Medicaid will pay the lesser of:**
The difference between the Medicaid allowed amount and the Medicare Payment (Medicaid allowed minus Medicare paid); or The Medicare coinsurance and deductible up to the Medicaid allowed amount, calculated as follows: (Medicare coinsurance/deductible + Medicare paid) - (Medicaid allowed).

**Patient Liability**
The Medicaid Program payment is considered payment in full. The provider is not permitted to seek further payment from the recipient in excess of the Medicaid Program rate.