

**Attachment**

**MARYLAND MEDICAL ASSISTANCE**  
Guide to the Administration of the  
Transportation Grant Program

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**Fiscal Year 2020**



**MARYLAND**  
Department of Health

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# Introduction

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## Medical Assistance Transportation Manual

Topic: Introduction

Policy #: 10.09.19 INTR

Users: MDH Transportation Staff

Effective Date: 06-30-2017

This manual, titled **MARYLAND MEDICAL ASSISTANCE PROGRAM GUIDE TO THE ADMINISTRATION OF THE TRANSPORTATION GRANT PROGRAM** serves various functions. Primarily, it serves to communicate the Program's regulations and policies governing operation of Grant-funded transportation to local jurisdictions and vendors that operate transportation systems under the Grant. This information is also useful to Medicaid participants who need transportation services, their caregivers, health care providers, and other interested parties. A special section, "Navigating the Medicaid Transportation Grant Program", provides guidance for participants needing to access transportation and those involved in assisting participants in accessing transportation.

It is the mission of the Maryland Medicaid Program (also known as "Medicaid" or "the Program") to improve the health and well-being of low-income citizens of Maryland by ensuring access to medically necessary health care services. Transportation is an essential component to ensuring access to health care for qualified and eligible Medicaid participants.

This guide is designed to serve as a tool to the Grantees for the management of the Non-Emergency Medical Transportation (NEMT) Program. It is not possible to cover each scenario or circumstance that Grantees may experience. Grantees are expected to use this guide, employ critical thinking and evaluate circumstances on a case-by-case review to provide a balanced approach in ensuring participant's access to medical care while following established programmatic requirements.

Four program areas serve the transportation needs of Medicaid participants. Three of these areas, which are described in detail under **BACKGROUND**, play a limited role in the overall provision of transportation services to Medicaid participants. It is the fourth area, **non-emergency medical transportation under the Transportation Grant, which serves to provide access to qualified Medicaid-covered services and is the subject of this manual.**

This manual specifies the scope of services provided under the Grant. It discusses the Program's regulations and policies, as well as limitations, for assuring transportation in detail, with explanations (as appropriate) of the local variations in day- to-day policies and procedures. It provides information on various tools that transportation managers may use to establish the necessity of services. Information on the handling of unique transportation requests is furnished. Finally, guidance on navigating the Grant program is provided for the use of participants and other interested parties.

## Medical Assistance Transportation Manual

Topic: Grantee Accountability

Users: MDH Transportation Staff

Policy #: 10.09.19 45CFR92.36(b) ACCO

Effective Date: 10-31-2018

### ACCOUNTABILITY<sup>1</sup>

- A. The Budget Management Office, Division of Program Cost and Analysis, will reconcile each Human Service Grant-in-Aid (grant) on an annual basis.
- B. The Human Services Agreements Manual shall, by reference, govern this agreement between the MDH and the local jurisdiction and shall address the administrative and fiscal aspects of this budget-based human services funding. All policies required by this manual shall be followed.
- C. Grantee budget submissions must include the submission of the Budget Adjustment Sheets used for the line item posting to FMIS.
- D. Grantees, who want to post budget information to FMIS for locally funded programs, should contact the MDH, General Accounting Division for information on how to complete such an action.
- E. The Local Health Departments will submit a plan for monitoring the performance of their vendors as stipulated in COMAR 10.09.19.03C(4).
- F. All budget modifications and supplements for the current fiscal year will only be accepted up to the close of business on April 1<sup>st</sup>.<sup>1</sup>
- G. Any Grant funded positions that remain vacant for six (6) months, will lose their funding, and shall be reflected in a Budget Reduction submitted no later than April 1<sup>st</sup>.<sup>2</sup>
- H. A signed Memorandum of Understanding (MOU) must be submitted by the local Jurisdiction outlining the responsibilities of Grantee<sup>3</sup>

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<sup>1</sup> <https://www.gpo.gov/fdsys/pkg/CFR-2010-title45-vol1/pdf/CFR-2010-title45-vol1-sec92-36.pdf>

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<sup>1</sup> Added 04/14/2017

<sup>2</sup> New 10/23/2018

<sup>3</sup> New 5/10/19

## Medical Assistance Transportation Manual

Topic: Background

Users: MDH Transportation Staff

Policy#: 10.09.19 42CFR431.53 BACK

Effective Date: 6-30-2017

Federal regulations (42CFR §431.53) require states to have a plan to ensure that Medicaid participants have transportation to and from Medicaid covered services. The State of Maryland has elected to provide transportation to covered services through four Program areas:

- Emergency transportation – reimbursement for 911 ambulance service from the scene of an incident (COMAR 10.09.31);
- Medicare covered transportation services – copayment and deductible payments for Medicare-approved services to Maryland Medical Assistance participants. (COMAR 10.09.13.04);
- Transportation to services under the Individuals with Disabilities Education Act (IDEA) – reimbursement for transportation to receive Medicaid-covered school-based services included in the participant’s Individualized Education Plan (IEP) (COMAR 10.09.25); and
- **Non-emergency medical transportation (NEMT) under the Transportation Grant – The administration of grants to counties, municipal corporations, and nonprofit organizations for the provision of safety-net transportation services to Medical Assistance Program participants :**  
[http://www.dsd.state.md.us/comar/SubtitleSearch.aspx?search=10.09.19.\\*](http://www.dsd.state.md.us/comar/SubtitleSearch.aspx?search=10.09.19.*)

Under the Transportation Grant (hereafter known as “Grant”), Maryland has elected to ensure transportation to non-emergency medical services as an administrative service by providing grant funding to local jurisdictions (hereafter known as “grantees”). The funds are to be used to:

- Screen participants’ requests for transportation to ensure participant eligibility and necessity of transportation;
- Arrange for, or provide and document, the most efficient means of transportation where no other transportation is available to the participant and, without the provision of transportation, the participant would not be able to access medical care; and
- Ensure that Medicaid-funded transportation is used in a manner consistent with the requirements of COMAR 10.09.19.

Grantees are required to operate the NEMT program in accordance with federal and State regulations governing the administration of the Grant. These regulations specify screening criteria to ensure that participants who have no other transportation resource can access needed medical care. The regulations also specify the minimum documentation required for various

## **Medical Assistance Transportation Manual**

**Topic: Background**

**Users: MDH Transportation Staff**

**Policy#: 10.09.19 42CFR431.53 BACK**

**Effective Date: 6-30-2017**

modes of mobility and eligibility criteria. Finally, the regulations exclude coverage for transportation to specific services covered elsewhere.

The transportation benefit is uniform for all eligible and qualified Maryland Medicaid participants; however, from county to county, the otherwise available transportation resources vary. The Baltimore and Washington D.C. metropolitan areas are rich in public, taxi, and other transportation resources, while in rural counties these resources may be sparse. These and other factors, unique to each jurisdiction, have a significant impact on the manner in which grantees operate their transportation programs to meet their participants' needs. For these reasons, while grantees are expected to ensure that participants have necessary transportation in accordance with COMAR 10.09.19, grantees are afforded flexibility in implementing methods and procedures for day to day operations.

# Medical Assistance Transportation Manual

**Topic: Definitions**

**Users: MDH Transportation Staff**

**Policy#: 10.09.19.02**

**Effective Date: 6-30-2017**

For purposes of this manual, the following terms have the meanings specified:

“Ambulance” means a specially designed vehicle used for transporting the sick or injured, which has necessary patient care equipment including a stretcher, clean linens, first aid supplies, oxygen equipment, and, in addition, other safety and lifesaving equipment which may be required by State or local laws to classify the vehicle as an ambulance.

“Attendant” means an individual needed to accompany a participant who is unable to travel alone.

“Appropriate” means a provider that meets the following requirements:

- a. An enrolled provider who participates in the Maryland Medicaid Program, either through a Managed Care Organization or direct fee-for-service;
- b. Has the training and skills necessary to provide the needed care (includes but is not limited to applicable licensure and/or certification) at the determined level of need; and
- c. Is willing to accept the participant as a patient.

“Curb-to-Curb” means a service in which the participant is transported from curbside to curbside and manages without assistance from the vehicle operator.

“Department” has the meaning stated in COMAR 10.09.36.01.

“Door-through-Door” means a service in which the participant is transported, due to the participant’s medical condition or disability, from inside their point of origin and taken into the destination. Door-through-door service is covered only for ambulance transport.

“Door-to-Door” means a transportation service in which, due to the participant’s medical condition or disability, it is necessary for the driver to assist the participant between the vehicle and the building, but the driver does not enter the building.

“Emergency” means a situation requiring prompt diagnosis and treatment of conditions having the potential of causing imminent disability or death.

“Emergency services” means services provided in hospital emergency facilities after the onset of a medical condition manifesting itself by symptoms of sufficient severity that the absence of immediate medical attention could reasonably be expected by a prudent layperson, possessing an average knowledge of health and medicine, to result in:

- a. Placing health in jeopardy;
- b. Serious impairment to bodily functions;
- c. Serious dysfunction of any bodily organ or part: or

## Medical Assistance Transportation Manual

Topic: Definitions

Users: MDH Transportation Staff

Policy#: 10.09.19.02

Effective Date: 6-30-2017

- d. Development or continuance of severe pain.

“Frequent trips” means the participant attends the same prescribed subscription service 3 or more times per week. The significance of frequent trips for compassionate consideration to participants ineligible for NEMT services due to public transportation.<sup>1</sup>

“Grantee” means the entity in receipt of grant funds from the Department pursuant to COMAR 10.09.19.

“Maryland Department of Health” means MDH formerly known as Department of Health and Mental Hygiene, DHMH

“Medical Assistance Program” means a program of comprehensive medical and other health-related care for indigent and medically indigent individuals.

“Medicare” has the meaning stated in COMAR 10.09.36.01.

“Medically Fragile Children” means children whose complex medical conditions require professional nursing monitoring and supervision on a 24-hour basis to prevent life-threatening complications, prevent deterioration of health status, and/or maintain health status. A medically fragile condition is defined as a chronic physical condition which results in a prolonged dependency on medical care for which daily skilled nursing intervention is medically necessary

“Necessary” has the meaning stated in COMAR 10.09.36.01.

“Non-Ambulatory” means a condition which renders, as attested to by a licensed medical doctor, a recipient physically unable to use a bus, taxicab, or private automobile for transit to or from a hospital to receive medical treatment.

“Program” has the meaning stated in COMAR 10.09.36.01.

“Participant” means an individual who is certified as eligible for, and is receiving, Medical Assistance benefits.

“Third Party Liability” means coverage through an individual, entity, insurance, or program that is liable to pay for health care services.

“Urgent” means services provided in instances which require prompt attention after the onset of a medical condition or incident resulting in bodily dysfunction or extreme discomfort.

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<sup>1</sup> FY19 updated for clarity

## **Medical Assistance Transportation Manual**

**Topic: Definitions**

**Users: MDH Transportation Staff**

**Policy#: 10.09.19.02**

**Effective Date: 6-30-2017**

“Wheelchair van” means a vehicle equipped with either a lift tailgate or side lift which is used for loading patients who are non-ambulatory but who do not require the use of equipment found in an ambulance.

# Medical Assistance Transportation Manual

Topic: Limitations

Users: MDH Transportation Staff

Policy #: 10.09.19.05 LIM1

Effective Date: 6-30-2017

## Limitations

Some transportation services are not covered under the Grant because they are covered under another Program area. For example, emergency (911) transportation service is paid directly by the Program outside the Grant. Ambulance service that is covered by Medicare Part B is paid directly by Medicare as primary payer with the coinsurance being paid by the Program, also outside the Grant. If a participant is covered under Medicare Part A, then the nursing home is responsible for the transport as cited in the Medicare Learning Network Matters Number SE0433 ( <https://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnmattersarticles/downloads/se0433.pdf> ). Additionally, certain Medicaid-covered services provide transportation between home and the service included in the rate for that service. These services include medical day care, day habilitation services, and psychiatric rehabilitation services.

As noted in COMAR 10.09.19.05

Monies from a grant provided under these regulations may not be used to pay for the following:

- A. Emergency transportation services;
- B. Medicare ambulance services;
- C. Transportation to or from Veterans Administration hospitals unless it is to receive treatment for a non-military-related condition;
- D. Transportation to or from any correctional institutions;
- E. Transportation of participants committed by the courts to mental institutions;
- F. Transportation between a nursing facility and a hospital, for routine diagnostic tests, nursing services, or physical therapy which can be performed at the nursing facility;
- G. Transportation services from a facility for treatment when the treatment is provided by the facility in which the participant is located;
- H. Transportation to receive nonmedical services;
- I. Gratuities of any kind;
- J. Transportation between a medical day care facility and the participant's home;
- K. Transportation to or from a State facility while the patient is a resident of that facility;
- L. Transportation of non-Medical Assistance participants;
- M. Trips for purposes related to education, recreational activities, or employment;
- N. Transportation of anyone other than the participant, except for an attendant accompanying a minor or when an attendant is medically necessary;
- O. Wheelchair van service for ambulatory participants;
- P. Ambulance service for a participant who does not need to be transported in a prone position;
- Q. Transportation between a community rehabilitation program (CRP) and the participant's home;
- R. Transportation between a day habilitation program and the participant's home;
- S. Transportation to or from services that are not medically necessary.

## **Medical Assistance Transportation Manual**

**Topic: Scope of Services**

**Users: MDH Transportation Staff**

**Policy#: 10.09.19.04 SCOPE**

**Effective Date: 6-30-2017**

The Transportation Grant covers the least expensive, most appropriate mode of transportation of last resort for Maryland Medicaid participants who *do not* have restricted eligibility such as Qualified Medicare Beneficiary (QMB). Both community-based participants and participants living in care facilities are potentially eligible for transportation. The Grant encompasses both HealthChoice and full fee-for-service participants.

### **SERVICES COVERED BY MARYLAND MEDICAL ASSISTANCE (MEDICAID) FOR WHICH NEMT CAN BE UTILIZED**

**The following services are generally covered by Maryland's Medicaid Program. This list is provided as a guide to acknowledge Medicaid covered services to which a qualified and eligible Medicaid participant may be transported. If you need clarification of covered services for HealthChoice participants, contact your Administrative Care Coordination Unit. If you need clarification of covered services for fee-for-service participants, contact Participant Relations at 410-767-5800.**

- Ambulatory surgical center services
- Chiropractic care for beneficiaries under age 21 and REM participants.
- Clinic services
- Dental services and dentures for beneficiaries under age 21, pregnant women up to delivery, and REM participants. Implant services can be covered after approval on a case-by-case review. Contact the Program for verification of coverage.
- Diabetes care services (covered under Health Choice)
- Early and Periodic Screening, Diagnosis and Treatment (EPSDT) for beneficiaries under age 21
- Eye glasses for beneficiaries under age 21
- Family planning services and supplies for Medical Assistance and Health Choice participants. **\*\*Medical Assistance transportation not provided to those participants in the Family Planning Program.**
- **Hearing aids and Cochlear Implants.**
- Hospital inpatient and outpatient services (acute, chronic, psychiatric, rehabilitation, specialty)
- Kidney dialysis services
- Laboratory and x-ray services
- Medical Day Care services. Transportation of participants between the home and the facility to receive medical day care services is the responsibility of the center. Transportation to and from Medicaid covered services while attending the Medical Day Care facility may be provided after participants are properly screened (Medical Day Care Transmittal No 30). (attachment 1)

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Topic: Scope of Services

Users: MDH Transportation Staff

Policy#: 10.09.19.04 SCOPE

Effective Date: 6-30-2017

- Medical equipment and supplies and Oxygen services, as well as related respiratory equipment services (services are normally delivered to the participant's home. A grantee should verify that a participant has an appointment)
- Mental health treatment, case management and rehabilitation services
- Nurse anesthetist, nurse midwife, and nurse practitioner services
- Nursing facility services
- Physician services (some dental surgery may be included)
- Podiatry services
- School based health-related services for beneficiaries under age 21 (Contact the Program to clarify coverage; these transportation services are usually covered under the IDEA Program)
- Substance abuse treatment services -- closest appropriate facility
- Vision care services (routine eye examinations every two years)

Grants are provided to each of Maryland's 24 local jurisdictions (23 counties and Baltimore City). At their discretion, the grantees may arrange to provide transportation service either directly or through subcontractors. Subcontractors hired to perform transportation services may not also perform screening services.

The Grant covers round trip transportation to qualified and eligible Maryland Medical Assistance participants via shared ride to scheduled medical services which are covered by Medical Assistance. Additionally, the grant covers return trips from hospital emergency visits, return trips from hospital stays, and medically necessary inter-facility hospital transfers. All modes of transport are available (ambulance, wheelchair van, sedan/van, air transport) as appropriate with proper clinical documentation. The participant will be transported by the most economic and most appropriate form of transportation based on clinical diagnosis or documented disability.

Medicaid transportation is a scheduled, shared-ride program operating generally Monday through Friday during normal business hours. Exceptions are made as needed for special circumstances such as dialysis, out of town transports, and hospital discharges. Curb-to-curb or door-to-door service is provided as medically necessary (door through door service is covered only for ambulance transport) as noted on the Physician Certification Form.

24 hours advance notice to appropriate scheduling contact is required to secure transportation. For trips outside the local area or region, for example from Western Maryland or the Eastern Shore to Baltimore, three (3) to five (5) business days advance notice may be required. Grantees will, however, make every effort to accommodate transportation requests

## **Medical Assistance Transportation Manual**

**Topic: Scope of Services**

**Users: MDH Transportation Staff**

**Policy#: 10.09.19.04 SCOPE**

**Effective Date: 6-30-2017**

with less than 24 hours' notice for hospital discharges and urgent (NOT emergency) medical services. Examples of urgent medical services include: 1) same-day doctor appointments for acutely ill participants for whom delay may put the participant's health at risk, and 2) trips to hospital emergency rooms for nursing home residents for re-insertion of catheters or feeding tubes that cannot be replaced safely by facility nursing staff.

# Arranging Transportation Services

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## **Medical Assistance Transportation Manual**

**Topic: Ambulance Screening - Dual Eligible**

**Users: MDH Transportation Staff**

**Policy #: 10.09.19.04A(2) DUAL**

**Effective Date: 06-30-2017**

### **AMBULANCE SERVICES NOT COVERED BY THE MEDICARE PART A SKILLED NURSING BENEFIT**

**If a nursing facility/hospital calls about ambulance service for a Part A Skilled Nursing Patient; the following trips can be performed by MA Transportation, subject to our standard screening:**

1. The ambulance trip is to the SNF (Skilled Nursing Facility) for admission.
2. The ambulance trip is from the SNF to home.
3. The ambulance trip is to a hospital based or nonhospital based ESRD (End State Renal Disease) Facility along with the return trip to the SNF.
4. The ambulance trip is for the following services:
  - a) Cardiac catheterization
  - b) Computerized axial tomography (CT) scans
  - c) Magnetic resonance imaging (MRI)
  - d) Ambulatory surgery that involves the use of an operating room
  - e) Angiography
  - f) Lymphatic and venous procedures
  - g) Radiology therapy
  - h) Removal, replacement and insertion of PEG tubes.

# Medical Assistance Transportation Manual

Topic: Ambulance Screening – Dual Eligible Crossover Claims

Users: MDH Transportation Staff

Policy #: 10.09.19.04A(2) XOVER

Effective Date: 06-01-2018

| Coverage Type   | Aeromedical Claim  | 9-1-1 Ambulance Claim   | NEMT Ambulance Claim  |
|---|--|---|---|
| <p><u>Medicare - Crossover</u></p> <p>****There is no NEMT method of oversight to avoid dual payment, nor to track via the Grant.</p> | <p>Processed as a crossover claim via Provider Relations. If the claim does not automatically cross over (ie 60 days have passed and provider has not received payment) or if insurance is a Medicare Advantage Plan, the claim must be manually processed (electronically or via paper claim)</p>   | <p>Processed as a crossover claim via Provider Relations. If the claim does not automatically cross over (ie 60 days have passed and provider has not received payment) or if insurance is a Medicare Advantage Plan, the claim must be manually processed (electronically or via paper claim)</p> <p><sup>1</sup>As of 3/2018, any Medicare Deductible &gt;\$183, the claim will be denied.</p>          | <p>Processed as a crossover claim via Provider Relations. If the claim does not automatically cross over (ie 60 days have passed and provider has not received payment) or if insurance is a Medicare Advantage Plan, the claim must be manually processed (electronically or via paper claim)</p>  |
| <p><u>QMB</u></p>   | <p><b>EOMB</b> – we pay the Part B and Coinsurance. However, if Medicare already paid more than MA would have paid, we pay \$0. Issue approval for a payment of \$0.<sup>1</sup></p> <p><b>EOMD</b> – We deny payment as well.</p> <p>**** supposed to be processed as a crossover claim via Provider Relations. There is no NEMT method of oversight to avoid dual payment, nor to track via the Grant.</p> | <p><b>EOMB</b> – we pay the Coinsurance and deductible. However, if Medicare already paid more than the \$100 MA would have paid, we pay \$0. Not a denial, rather issue a payment of \$0.</p> <p><b>EOMD</b> – We deny payment as well.</p> <p>**** supposed to be processed as a crossover claim via Provider Relations. As of 3/2018, any Medicare Deductible &gt;\$183, the claim will be denied.</p> | <p>If the bill comes from the contracted NEMT provider for that county:<br/><b>EOMB</b> – we pay the Part B and Coinsurance. However, if Medicare already paid more than MA would have paid, we pay \$0. Not a denial, rather issue a payment of \$0.<br/><b>EOMD</b> – We deny payment as well.</p> <p>Non Contracted NEMT Provider – No Mechanism to Pay.</p> |
| <p><u>SLMB - S07, S14</u></p>   | <p>We do not pay anything because we already paid the premium. <b>Denial based on SLMB Coverage Type</b></p>   | <p>We do not pay anything because we already paid the premium. <b>Denial based on SLMB Coverage Type</b></p>  | <p>We do not pay anything because we already paid the premium. <b>Denial based on SLMB Coverage Type</b></p>  |
| <p><u>X02" - Undocumented or ineligible alien</u></p>   | <p>Approved emergency services on approved dates only.<br/><b>Denial based on Coverage Type</b></p>  | <p>Not Eligible.<br/><b>Denial based on Coverage Type</b></p>   | <p>Determine service type. If transport is for dialysis, continue screening; NEMT may be approved. If transport request is to any other service, stop screening; Not Eligible.</p>  |
| <p><u>Commercial Insurance or TPL</u></p>   | <p>Primary insurance payment is not an automatic approval for Medicaid. Full Review of record must be conducted. If the TPL already paid more than MA would have paid, we pay \$0. Issue an approval with a payment of \$0</p>   | <p>If the TPL already paid more than MA would have paid, we pay \$0. Issue an approval with a payment of \$0</p>  | <p>Non Contracted NEMT Provider – No Mechanism to Pay.</p> <p>If the bill comes from the contracted NEMT provider for that county:<br/><b>EOB</b> – evaluate the amount paid. If amount received from TPL is greater than MA would have paid, we pay \$0. Not a denial, rather issue an approval of \$0.</p>  |

<sup>1</sup> Memo forthcoming (03/21/18)

# **Medical Assistance Transportation Manual**

**Topic: Ambulance Screening – Dual Eligible Crossover Claims**

**Users: MDH Transportation Staff**

**Policy #: 10.09.19.04A(2) XOVER**

**Effective Date: 06-01-2018**

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<sup>1</sup> Maryland Medical Assistance Program General Provider Transmittal No. 79 PT 01-11

[https://mmcp.health.maryland.gov/docs/PT%2001-11\\_rev.pdf](https://mmcp.health.maryland.gov/docs/PT%2001-11_rev.pdf)

<sup>2</sup> Maryland Medical Assistance Program General Transportation Grants Transmittal No. 10

<https://mmcp.health.maryland.gov/Documents/PT%2019-13%20General%20Transportation%20Grants%20Transmittal%20No.%2010.pdf>

## Medical Assistance Transportation Manual

Topic: Available Resources – Exceptions

Users: MDH Transportation Staff

Policy #: 10.09.19.04A(1) AVAI

Effective Date: 06-30-2017

The following policies will be utilized in dealing with participants:

- **Participant Reports Unable to Drive Due To Medical Condition** -

Grant Manager will obtain a Provider Certification Form or a letter from the doctor stating the nature of the medical disability and the length of time that the participant cannot drive. Should the condition be on going, Grant Managers can refer the documentation to the MDH Transportation Unit for physician review. Grant Managers may allow 30 days of transportation until documentation is received.

- **Vehicle Not Operable** - the Grant Manager will request a mechanic's letter on an auto repair shop's letterhead that the vehicle is inoperable and the nature of the mechanical problem. A new letter will be required every 6 months.

- **Legally Responsible Individuals** – A legally responsible individual is defined as the spouse of a participant, the parents of minor child or an individual who has Guardianship of Person for the participant. The individuals listed above are expected to use their vehicles to provide transportation services where they have legal responsibility for the participant when available. Grant Managers may approve transportation based on the participant's situation as a case-by-case review. A minor is a child who is under the age of 18.

- **Funds Not Available to Pay for Fuel** - Staff of the Medical Assistance Transportation Unit or Grantees of the Program are not required to address financial hardship regarding a participant's inability to pay for fuel. It is reasonable to assume if a participant is paying for insurance, registration and title fees that the participant has sufficient resources to pay for fuel and other expenses such as tolls and parking. Participants who are denied NEMT due to a vehicle are eligible to appeal the transportation denial and will be made aware of their rights using the Notice of Fair Hearing Practices to be mailed out with the denial letter.

- **Need for an Attendant** – As per Policy 10.09.19.02(B)(2) ATTE – Need for an Attendant

Transportation can be refused on the date of service if a participant who has been deemed in need of an attendant does not furnish one **AND** the participant is known to be unable to travel safely without the attendant **OR** if the attendant furnished is not capable of meeting the needs of the participant.

# Medical Assistance Transportation Manual

Topic: Transportation Between Hospitals

Users: MDH Transportation Staff

Policy#: 10.09.19 PT10-8 BETW

Effective Date: 10-17-2007



STATE OF MARYLAND

# DHMH

PT 10-08

Office of Health Services  
Medical Care Programs

Maryland Department of Health and Mental Hygiene

201 W. Preston Street • Baltimore, Maryland 21201

Martin O'Malley, Governor – Anthony G. Brown, Lt. Governor – John M. Colmers, Secretary

**MARYLAND MEDICAL ASSISTANCE PROGRAM  
TRANSPORTATION GRANTS TRANSMITTAL NO. 8  
HOSPITAL TRANSMITTAL No. 198  
October 17, 2007**

**TO:** Transportation Grants Managers  
Hospital Administrators

**FROM:** Susan J. Tucker, Executive Director  
Office of Health Services

**RE:** Transportation between Hospitals

**NOTE:** Please ensure that appropriate staff members in your organization are informed of the contents of this transmittal.

The purpose of this transmittal is to clarify the circumstances under which transports between hospitals are covered under the Transportation Grants program, and when they are covered as a Hospital service. When a recipient needs to be transported from one hospital to another hospital, there are two possible coverage scenarios.

First, when the recipient is being discharged from one hospital and admitted to another, the transport is covered under the Transportation Grant. Examples of such transports include transfer of a woman in labor because the sending hospital lacks appropriate labor and delivery facilities, or the transfer of a psychiatric patient because the receiving hospital is the only hospital which has an open bed, etc. In such cases, the discharging hospital should call the local jurisdiction in which the recipient usually resides to make arrangements for the transport.

The second scenario involves situations where the recipient is not discharged from the first hospital nor admitted to the second hospital as an inpatient. Instead, the recipient merely receives a procedure not available at the first hospital (e.g., PET scan) and then returns on the same day to the first hospital for continued inpatient care. In such a case, the transportation is a covered hospital service and is reimbursed as such under the appropriate revenue code. Because the transportation is not a covered service under the Transportation Grant, the sending hospital should not contact the local jurisdiction to arrange for the transport.

If you have any questions regarding this transmittal, please call the Transportation staff specialist at 410-767-1739 or the Hospital Program staff specialist at 410-767-1722.

# Medical Assistance Transportation Manual

Topic: Transportation from Children's National Medical Center

Users: MDH Transportation Staff

Policy#: 10.09.19.04 (A)(5) CNMC

Effective Date: 02-15-2019



**MARYLAND**  
Department of Health

*Larry Hogan, Governor · Boyd K. Rutherford, Lt. Governor · Robert R. Neall, Secretary*

February 12, 2019

Children's National Medical Center  
111 Michigan Avenue, NW  
Washington, D.C. 20010  
ATTN: Rebecca Kabba

Dear Ms. Kabba:

The purpose of this letter is to clarify the provision of non-emergency medical transportation (NEMT) for participants being discharged from Children's National Medical Center (CNMC) to another facility or to their residence.

On November 14, 2008, the Program agreed to use the Baltimore City Transportation Program (BCT) as the single broker for all transports originating in the District of Columbia. The Program agreed to this accommodation in response to CNMC's experiences utilizing Maryland Medicaid's NEMT system. At the time of the agreement, the ability to allow BCT as the single broker was due to Lifestar being the transportation vendor for both entities. Unfortunately, Lifestar is no longer a contracted vendor for CNMC and due to the increase in eligible Medicaid participants, BCT's transportation vendor can no longer handle the capacity of providing this service.

We have been able to collaborate with the Montgomery County Department of Transportation and the Prince George's County Non Emergency Medical Transportation Programs to perform as CNMC's contact for transportation discharges. Effective February 12, 2019 the Baltimore City Transportation Program will no longer be the single broker for all transports originating in the District of Columbia. Instead, CNMC must contact either the Montgomery County Department of Transportation or the Prince George's County Non Emergency Medical Transportation Program to arrange discharge transports.

*201 W. Preston Street · Baltimore, MD 21201 · [health.maryland.gov](http://health.maryland.gov) · Toll Free: 1-877-463-3464 · TTY: 1-800-735-2258*

## Medical Assistance Transportation Manual

Topic: Transportation from Children's National Medical Center

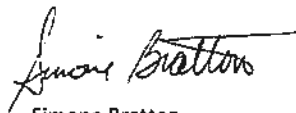
Users: MDH Transportation Staff

Policy#: 10.09.19.04 (A)(5) CNMC

Effective Date: 02-15-2019

Specific instructions to follow when contacting either program for discharge transports are attached. Should you have any issues or concerns regarding the quality of service, contact the NEMT Grant Manager as directed. Thank you once again for working with the Department to ensure that Medicaid participants received access to and from covered services.

Sincerely,



Simone Bratton  
Chief  
Division of Community Support Services

cc: Marlana R. Hutchinson  
John Pelton  
NEMT Grantees

## Medical Assistance Transportation Manual

Topic: Transportation from Children's National Medical Center

Users: MDH Transportation Staff

Policy#: 10.09.19.04 (A)(5) CNMC

Effective Date: 02-15-2019

### Montgomery County Medical Assistance Transportation Procedure for Scheduling Discharge/Transfer for Residents of other Counties

Business Hours: (8:00 a.m. – 4:30 p.m. M-F)

- Facility completes and sends the Maryland Statewide Medical Assistance Transportation Transfer/Discharge form, along with the discharge documents to the Montgomery County Medicaid Transportation office. The request could be submitted up to 7 days in advance, or the same day the trip is needed.
- Montgomery County reviews and responds to the facility, by scheduling ambulatory trips with a taxi vendor, or work with the facility to schedule wheelchair van or ambulance trips.

Main Line: 240-777-5890 (8:00 a.m. – 4:30 p.m. M-F)

Fax: 240-777-5891. Email: [Medicaidtransportation@montgomerycountymd.gov](mailto:Medicaidtransportation@montgomerycountymd.gov)

#### After Business Hours: (Ambulance)

- Facility completes and sends the Maryland Statewide Medical Assistance Transportation Transfer/Discharge form, along with the discharge document, directly to one of the Ambulance vendors.
- The ambulance vendor will ensure that the form is complete, conduct an EVS verification and provide the trip. The vendor will send copies of the Transfer/Discharge form, along with the discharge documents, to the Medicaid office on the first business day after the trip occurred.

#### Ambulance Vendors

All American Ambulance 301-952-1193

Freestate Ambulance: 410-609-2156

Butler Medical: 888-602-4007

# Medical Assistance Transportation Manual

Topic: Transportation from Children's National Medical Center

Users: MDH Transportation Staff

Policy#: 10.09.19.04 (A)(5) CNMC

Effective Date: 02-15-2019

## Prince George's County

### Non-Emergency Medical Transportation (NEMT) Discharge/ Transfer Process

- NEMT hours of operation are 8:30 am – 4:00 pm.
- Transportation requests are received and processed on the day of the trip. Requests made after 3:30 pm will be treated as "After Hour Trips".
- Therefore, the requesting facility is expected to communicate requests directly to the vendors. Prince George's County NEMT vendors are as follows:
  1. Falcon (wheelchair) 240-595-0960.
  2. Silver Cab for ambulatory clients (only during working hours)  
301-277-6000/ 301-577-2000
  3. Procure (ambulance services) 410-823-0030

### Required documentation for Discharge/Transfer:

1. A completed Discharge/Transfer form.
2. Patient's Face Sheet from the discharging facility.
3. Client's eligibility verification (Verified by Prince George's NEMT).

Please call NEMT @301-856-9458 or 301-856-9555 for assistance.

# Medical Assistance Transportation Manual

**Topic: Transportation for Dental Services**

**Users: MDH Transportation Staff**

**Policy #: 10.09.19 PT 01-10 DENT**

**Effective Date: 06-30-2017 (v 1.2)**

## Transportation for Dental Services

(Transportation Grants Transmittal No. 9)

As of July 1, 2009, the operation of Medical Assistance dental benefits has been centralized to one Dental Benefits Administrator (DBA). Currently, Scion Dental, Inc. administers the Maryland Healthy Smiles Dental Program<sup>1</sup>. Eligible beneficiaries are:

- Participants under the age of 21
- Pregnant women up to their date of delivery
- Individuals eligible under the Rare & Expensive Case Management Program (REM)
- Former Foster Care youth up to age 26 (Eligibility Group E05) are entitled to full dental benefits, under EPSDT through their 26<sup>th</sup> birthday.<sup>2</sup>

MCO's may elect to provide limited dental benefits to adult HealthChoice beneficiaries not otherwise eligible for dental coverage. In such cases, neither the MCO nor Medical Assistance Transportation is obligated to provide transportation to these services.

Eligible beneficiaries or their parent/representatives should call their local transportation number to schedule rides. Participants will be subject to the screening provisions as listed in the Screening Section. However, transportation for dental visits differs from other transportation requests in that:

- Transportation to initial dental appointments may be provided without medical documentation to support the mode of transportation authorized.
- Subsequent appointments will require the appropriate medical documentation to be completed. The documentation can be completed by the beneficiary's primary care physician, dentist or other medical professional who is knowledgeable of the beneficiary's medical condition. A separate Statewide Provider Certification Form is not required if there is a current document on file, unless the participant's condition has changed requiring a different mode of transport.
- There is no time or distance limitation when providing transportation to dental visits. The Dental Benefit Administrator will work with the beneficiary to ensure access to the closest appropriate dental provider.

<sup>1</sup> Revised for clarity 1/25/2018 (<https://mmcp.health.maryland.gov/Pages/maryland-healthy-smiles-dental-program.aspx>)

<sup>2</sup> Revised for clarity 1/25/2018 (<https://health.maryland.gov/newsroom/Pages/Federal-government-signs-off-on-Maryland-Medicaid%E2%80%99s-waiver-renewal.aspx>)

# Medical Assistance Transportation Manual

Topic: Transportation for Dental Services

Users: MDH Transportation Staff

Policy #: 10.09.19 PT 01-10 DENT

Effective Date: 06-30-2017 (v 1.2)

PT 01-10



STATE OF MARYLAND

Office of Health Services  
Medical Care Programs

Maryland Department of Health and Mental Hygiene

201 W. Preston Street • Baltimore, Maryland 21201

Martin O'Malley, Governor • Anthony G. Brown, Lt. Governor • John M. Colmers, Secretary

## MARYLAND MEDICAL ASSISTANCE PROGRAM

Transportation Grants Transmittal No. 9

July 1, 2009

TO: Maryland Medicaid Transportation Grant Managers

FROM: Susan J. Tucker, Executive Director  
*Susan J. Tucker*  
Office of Health Services

NOTE: Please ensure that appropriate staff members in your organization are informed of the contents of this transmittal

RE: **Dental Benefits Administrator (DBA)**

\*\*\*\*\*

Effective July 1, 2009, dental services are no longer provided by Managed Care Organizations (MCO). Instead, Maryland Medicaid has contracted with a statewide Dental Benefits Administrator (DBA) to assist all Medicaid beneficiaries entitled to dental services with obtaining access to them. Doral Dental has been selected to serve as the DBA for all eligible beneficiaries who include: children under twenty-one; pregnant women up to their date of delivery; and, individuals eligible under the Rare & Expensive Case Management Program (REM). MCOs may still elect to enrich the services provided to adult HealthChoice beneficiaries by providing dental services. However, in such cases, the MCO still must arrange for needed transportation.

Eligible beneficiaries in need of transportation or their parents/representatives will contact their local Transportation Grant Manager to arrange transportation to dental services. To allow time to arrange transportation service, beneficiaries are to request transportation no less than 24-hours prior to the appointment. There may be instances, however, where transportation to an urgent dental appointment may be needed with less than 24 hours notice. In such cases, Transportation Grant Managers and their contractors are requested to make all reasonable efforts to provide necessary transportation.

To effectively provide transportation for beneficiaries eligible for dental services, the Department is implementing the following:

1. Transportation Grant Managers and/or their vendors should continue to screen requests for transportation per the established guidelines. Such screening includes: confirmation of Medicaid eligibility for dental services; availability of transportation; and exploration as to what the most appropriate mode of transportation is to meet the beneficiaries' needs;

# Medical Assistance Transportation Manual

Topic: Transportation for Dental Services

Users: MDH Transportation Staff

Policy #: 10.09.19 PT 01-10 DENT

Effective Date: 06-30-2017 (v 1.2)

PT 01-10

Page 2

2. For transportation to initial dental appointments, transportation is to be provided without medical documentation to support the mode of transportation authorized (i.e., physician certification form). For subsequent appointments, the appropriate medical documentation can be completed and submitted by the beneficiary's primary care physician, dentist or other medical professional knowledgeable of the beneficiary's medical condition; and
3. The Department has not implemented a time or distance limitation when providing transportation for dental visits. The DBA works with the beneficiary to assure access to the closest appropriate dental provider.

Successful implementation of the dental program is a Departmental priority. Our expectation is that the Transportation Grant Managers will make all reasonable efforts to facilitate transportation of qualified Medicaid beneficiaries to dental services. It may be necessary for the Transportation Grant Manager to work with the DBA and the Medicaid beneficiary to ensure access to dental services in some instances.

Should you have any questions pertaining to this information, please do not hesitate to contact the Medicaid Transportation Program at 410-767-1739. Thank you for your continued service to Maryland Medicaid Beneficiaries.

## **Medical Assistance Transportation Manual**

**Topic: Arranging for Transportation Services – Established Participants**

**Users: MDH Transportation Staff**

**Policy#: 10.09.19.01B ARRA**

**Effective Date: 06-30-2017**

### **Arranging for Transportation Services – Established Participants**

For qualified and eligible participants, grantees are expected to ensure sufficient resources for the provision of non-emergency medical transportation. Most grantees accomplish this through contracts with local transportation providers, while other grantees provide the transportation directly.

Participants should be given a timeframe for pickup, either at the time of the request or when the trip schedule is completed. For trips scheduled during peak travel hours, the pickup window should not exceed 90 minutes. Peak travel hours are between the morning hours of 7:00am and 10:00am and afternoon hours of 3:00pm and 6:00pm. For trips scheduled outside of peak travel hours, the pickup window should not exceed one hour. Pick up times will be calculated for the participant depending on the distance to the appointment, anticipated traffic conditions, transportation needs of NEMT vehicle co-occupants, and other factors.

In order to ensure efficient and cost-effective operations, trips to appointments outside the region (e.g., Eastern Shore to Baltimore, Western Maryland to Baltimore or Morgantown, West Virginia) may occur once daily. Depending on demand and available resources, long distance trips may be limited to certain days of the week. When long distance trips are anticipated, participants or those assisting participants should find out in advance the transportation availability from their area and make appointments accordingly. When this proves impossible (e.g., vendor travels to Baltimore on Tuesday and Thursday, yet the provider cannot see the participant until Wednesday), grantees are to secure transportation for the day and time needed.

Transportation services under COMAR 10.09.19 are only provided to eligible and qualified participants. Eligibility is based on participant active enrollment in a full coverage Medicaid coverage group.

# **Medical Assistance Transportation Manual**

**Topic: Fixed Wing Air Transport Procedure**

**Users: MDH Transportation Staff**

**Policy #: 10.09.91 FIXE**

**Effective Date: 5-15-2017**

## **Purpose: Provide Guidance to MA Transportation Unit Staff for Approving and Processing Fixed Wing Air Ambulance Transport Requests**

1. The Air Ambulance Transport Request Form will be used to serve as a guide for required information and as a transport record.
2. Fixed wing air ambulance trips can only be done when:
  - The service is not available at the sending facility and
  - The service is not available in the State of Maryland and
  - The receiving facility has agreed to accept the participant and
  - Medical Assistance or the Managed Care Organization (MCO) has agreed to cover the service and
  - Medical Assistance is the provider of last resort e.g. no Medicare or private insurance.
3. The Air Ambulance Transport Request Form must be fully completed and the Medical Assistance number and MCO (if applicable) enrollment has been verified as active on MMIS or through EVS.
4. The sending hospital or the MCO case manager will generally contact the Program to arrange for fixed wing air transportation. In the event that the required information is not provided by the caller, MA Transportation will contact the sending hospital to obtain the reason for air transport to include:
  - The procedure to be performed that requires out of state transport
  - The requested transport date
  - Medical services required that necessitates air transport as listed in the "Medical Services Required"
  - Name and telephone number of a contact person at the receiving facility
5. MA Transportation staff will then verify if the service will be covered by Medical Assistance or the MCO:
  - MA Fee for Service – The MA Hospital Program will issue an authorization letter to the receiving facility authorizing the service. A copy of this letter must be given to the MA Transportation Unit.
  - MCO – obtain the name of the MCO case manager from the sending hospital and contact directly. They will need to provide an authorization number for the service.
6. MA Transportation will contact the receiving hospital to ascertain where in the facility the participant will be transported and the anticipated admission date.
7. Contact the fixed wing air ambulance provider to:
  - Provide clinical information and the specific transport pickup and drop-off locations. The Air Ambulance Transport Request Form can be securely sent to the provider

## **Medical Assistance Transportation Manual**

**Topic: Fixed Wing Air Transport Procedure**

**Users: MDH Transportation Staff**

**Policy #: 10.09.91 FIXE**

**Effective Date: 5-15-2017**

- Request a written estimate of the transport cost
- The provider will arrange for the appropriate level of care ground ambulance for transport from the sending facility to the airport and from the airport to the receiving facility.

8. Final approval will be made by the MA Transportation Supervisor or the Chief, Community Support Services. An email will be sent to the air ambulance provider authorizing the transport. All transport approvals will be in accordance with COMAR 10.09.19.

9. The air ambulance provider will contact the Program to provide updates to confirm pickup and delivery of the participant.

10. Upon completion of the transport, staff will scan the Air Ambulance Transport Form and written quote to Baltimore City Field Health Services for reimbursement.

## **Medical Assistance Transportation Manual**

**Topic: Transportation of HealthChoice Participants**

**Users: MDH Transportation Staff**

**Policy #: 10.09.19 PT 18-03 MCO**

**Effective Date: 06-30-2017**

### Transportation for HealthChoice (MCO) Participants

For participants enrolled in HealthChoice, serving providers must be part of the Managed Care Organization's (MCO's) provider network. Participants are, therefore, limited in their choice of health care providers, especially for primary and related care. It is the responsibility of the grantee to ensure a participant's access to health care appointments within their respective network. If, however, the participant's request for transportation bypasses an in-network provider of the same service, the grantee should assist the participant in accessing MCO-funded transportation by referring them to the county's Administrative Care Coordination Unit (ACCU) who will in turn assist the participant in arranging MCO-funded transportation. **The ACCU is a reliable resource in verifying MCO provider networks and should be accessed.**

All other screening requirements remain the same for both Health Choice and fee-for-service participants. Please note, however, that the Grant does not cover transportation to services paid for by the MCO that are not a covered Medicaid service; most notably dental coverage for adults not enrolled in REM. (Transportation Grant Transmittal No.3 and Transportation Grant Transmittal No. 9).

### MCO Reporting

MCO Transportation Tracking Sheets are due monthly on the second Friday following the close of the month.

#### *Instructions:*

The reporting of Managed Care Organization (MCO) transports from Local Health Departments (LHDs) enables the Department to assess provider network adequacy in addition to identifying HealthChoice members who may need increased care coordination/case management. To continue and maintain the exchange of reporting information to the Department, the reporting template has been updated to standardize the way in which LHDs report MCO transports. The required template fields remain the same, however the format and how the fields need to be recorded may be different.

#### *Format:*

The reporting spreadsheet includes all the previous requested fields and also includes a field for the LHDs Name and Report Month fields. All reports need to be provided in an Excel spreadsheet with field columns in the same order (i.e. Column A is always MA Participant Number and Column K is always Mileage). PDF file submission will not be accepted; previous submission of pdf files did not always allow for successful migration of data into an Excel document. Do not merge the report field columns or rows—to view more information within a

## **Medical Assistance Transportation Manual**

**Topic: Transportation of HealthChoice Participants**

**Users: MDH Transportation Staff**

**Policy #: 10.09.19 PT 18-03 MCO**

**Effective Date: 06-30-2017**

field either use “Wrap Text” or expand the column/row width/height. See the HealthChoice Local Health Department MCO Transport Report Fields documents for formatting specifics.

### ***Documentation:***

All fields/columns should be filled out as thoroughly as possible. Do not include extraneous fields/columns that are not requested. Fields that are missing or omitted do not provide an accurate description of the member’s transport needs and the LHDs transport efforts. See the HealthChoice Local Health Department MCO Transport Report Fields documents for documentation specifics. (Note: As of 1/1/2017, Riverside Health of Maryland is now University of Maryland Health Partners)

### ***Submission:***

If a report is received that does not meet submission requirements, the LHD will be notified and asked to resolve the discrepancy for resubmission. All reports should be saved as County\_MCO\_Transports\_numerical\_year\_numerical\_month (i.e. Allegany\_MCO\_Transports\_2017\_02). Completed reports or questions should be emailed to mdh.nemt@maryland.gov

### ***Feedback:***

Reinforcing these reporting requirements will ensure all LHDs reports remain uniform and will allow for better interpretation and analysis of reports. Reporting feedback will be provided to LHDs and MCOs at regular intervals. The feedback will identify HealthChoice members with the greatest transports needs and MCOs/Counties that may have access concerns.

# Medical Assistance Transportation Manual

Topic: Transportation Requests for Medicaid Pending

Policy #: 10.09.19 PT 18-05 MA PEND

Users: MDH Transportation Staff

Effective Date: 02-04-2005



STATE OF MARYLAND

**DHMH**

PT 18-05

Office of Health Services  
Medical Care Programs

Maryland Department of Health and Mental Hygiene

201 W. Preston Street • Baltimore, Maryland 21201

Robert L. Ehrlich, Jr., Governor – Michael S. Steele, Lt. Governor – S. Anthony McCann, Secretary

**MARYLAND MEDICAL ASSISTANCE PROGRAM  
TRANSPORTATION GRANTS TRANSMITTAL NO. 7  
NURSING HOME TRANSMITTAL NO. 192  
February 4, 2005**

**TO:** Transportation Grants Managers  
Nursing Home Administrators

**FROM:** Susan J. Tucker, Executive Director  
Office of Health Services

**SUBJECT:** Transportation Requests for Medicaid Applicants Pending Medicaid Approval

**NOTE:** Please ensure that appropriate staff members in your organization are informed of the contents of this transmittal.

The purpose of this transmittal is to clarify the Maryland Medicaid Program's policy for handling non-emergency transportation requests under the Transportation Grant for individuals who have applied for Medical Assistance and are awaiting a final determination, particularly residents of nursing facilities. It is the Program's goal to provide a means for these applicants to access the transportation necessary to obtain medical services, in much the same way that they generally have access to other Medicaid-covered services during the pending period of their eligibility. Obviously this goal is balanced by the need to assure that Medicaid funds are used only for those ultimately determined eligible.

In order to ensure that applicants who are residents of nursing facilities have access to transportation to needed out-of-facility services, grantees are strongly encouraged to enter into agreements with local nursing facilities to guarantee payment for transportation for these applicants. Such an agreement should incorporate the following:

1. The nursing facility requests non-emergency transportation using the grantee's established protocol;

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Web Site: [www.dhmh.state.md.us](http://www.dhmh.state.md.us)



## **Medical Assistance Transportation Manual**

**Topic: Retroactive Coverage of Ambulance Transport**

**Users: MDH Transportation Staff**

**Policy#: 10.09.19 RETR**

**Effective Date: 10-09-2014**

### **Retroactive Coverage of Ambulance Transport**

Transportation grantees will determine eligibility for retroactive NEMT coverage. Retroactive eligibility coverage may be determined for the period of 3 months immediately prior to the month of application. If the applicant is eligible for Medicaid, the grantee must pay all transport bills incurred during the retroactive period. A vendor has 12 months from the date on which eligibility was determined to submit a claim for payment. If the participant or other party made payment for the transportation during the 3 months retroactive eligibility coverage period, the vendor must make a full refund to the participant or other party. NEMT funds may not be used to cover the cost of transportation if eligibility is denied for the date(s) of service.

Effective 12-20-2017 - It is not reasonable to require a Statewide Provider Certification Form for ambulance services provided when the Medicaid status was not known by the requesting facility. In a retroactive coverage situation, a Physician Certification Statement (PCS) completed as part of the transportation request may be accepted in place of the Medicaid Statewide Provider Certification Form. Payment can still only be made to the vendor with whom there is a jurisdictional contract in place.

# Medical Assistance Transportation Manual

Topic: Retroactive Coverage of Ambulance Transport

Users: MDH Transportation Staff

Policy#: 10.09.19 RETR

Effective Date: 10-09-2014



STATE OF MARYLAND

DHMH


Maryland Department of Health and Mental Hygiene

201 W. Preston Street • Baltimore, Maryland 21201

Martin O'Malley, Governor – Anthony G. Brown, Lt. Governor – Joshua M. Sharfstein, M.D., Secretary

## MEMORANDUM

TO: Local Transportation Grants Managers

FROM: Simone Cook   
Division of Community Support Services

RE: Non-Emergency Medical Transportation (NEMT) Retroactive Coverage

DATE: October 9, 2014

\*\*\*\*\*

The purpose of this memorandum is to clarify retroactive eligibility coverage under the Non-Emergency Medical Transportation Grant (NEMT) for individuals in a nursing facility that applied for medical assistance. Transportation grantees will determine eligibility for retroactive NEMT coverage. Retroactive eligibility coverage may be determined for the period of 3 months immediately prior to the month of application. If the applicant is eligible for Medicaid, the grantee must pay all transport bills incurred during the retroactive period. A vendor has 12 months from the date on which eligibility was determined to submit a claim for payment. If the recipient or other party made payment for the transportation during the 3 months retroactive eligibility coverage period, the vendor must make a full refund to the Medicaid recipient or other party. NEMT funds may not be used to cover the cost of transportation if eligibility is denied for the date(s) of service.

If you have any questions regarding this transmittal, please contact the NEMT Program at 410-767-7283 or [dhmh.nemt@maryland.gov](mailto:dhmh.nemt@maryland.gov).

Toll Free 1-877-4MD-DHMH – TTY: Maryland Relay Service 1-800-735-2258  
Web Site: [www.dhmh.maryland.gov](http://www.dhmh.maryland.gov)

## **Medical Assistance Transportation Manual**

**Topic: Pharmacy Transport**

**Users: MDH Transportation Staff**

**Policy #: 10.09.19.04A PHAR**

**Effective Date: 07-15-2009**

NEMT may transport participants to the Pharmacy to pick up prescriptions. Ideally, this will be done as part of another scheduled transport. For both Fee-for-Service and MCO participants, grantees need only provide transportation to the closest pharmacy to the participant's location.<sup>1</sup> We have been informed that mechanisms exist for participants to transfer their prescriptions.

Additionally, some grantees have reported pharmacy trips listing the name of the pharmacy i.e. Wal-Mart or CVS. Please omit putting the pharmacy's name and instead list the service as "pharmacy."

Please feel free to contact the MA Transportation Program staff should you have any questions.

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<sup>1</sup> <https://health.maryland.gov/taibotcounty/TRANSPORTATION/Pages/Home.aspx>

## Medical Assistance Transportation Manual

Topic: Provider Certification for Mode of Transport (PCF)

Users: MDH Transportation Staff

Policy#: 10.09.19.04C PCF

Effective Date: 06-30-2017

### Physician Documentation for Transportation – Physician Certification Forms (PCF)

The Provider Certification Form is an attestation of clinical need for a specific mode of transportation. In order to assure the availability of Federal financial participation, the local jurisdiction must show/obtain documentation of the following items:

- That grant funds are spent only on arranging, providing and validating transportation services to Maryland Medicaid participants;
- Annual certification, using the Statewide Provider Certification Form, from the participant's provider validating the medical need for wheelchair and stretcher/ambulance transportation based on the participant's clinical needs. Intermittent certification is required should the participant's condition change; and
- Participants seeking medical attention for acute symptoms that make using public transportation medically contraindicated. Grantees may consider approving these requests in the absence of medical documentation only up to one month until documentation has been obtained. Recurring requests of this nature should warrant medical documentation at the onset of the request. Additional grace periods to allow transportation without that medical documentation must not be allowed.

Provider documentation must be specific as to the clinical diagnosis, symptoms, and treatment need that necessitates the special accommodation. A statement that the participant needs the accommodation, without supporting information, is insufficient. Providing diagnosis alone is also not sufficient as symptoms may vary between individuals. Documentation must indicate symptoms impacting specific mode of transportation requested. Ambulatory participants for whom no limited walking distance is listed shall be considered to have no accommodation needs pertaining to walking (unless otherwise specified on the form). Forms are only considered complete if they are signed **and** dated.

PCFs may be completed and signed by those clinicians who are able to prescribe medications in the State of Maryland.

## **Medical Assistance Transportation Manual**

**Topic: Attendant Policy**

**Users: MDH Transportation Staff**

**Policy #: 10.09.19.02(B)(2) ATTE**

**Effective Date: 06-30-2017**

### Need for an Attendant

The primary purpose of the Medicaid Transportation Grant program is to ensure that participants have transportation to needed medical care. This benefit is limited to the participant, a parent or guardian for a participant who is a minor, and an attendant who is needed to accompany the participant to the service. Minors may only be transported without an adult for the purposes of Policy #:10.09.19.05(N) MINO.

If a Provider Certification Form (PCF) indicates an adult must have an attendant, the participant must provide an attendant. Outside of authorizing the transportation expense for an attendant, the grantees are not responsible for furnishing an attendant. If the attendant requires a more costly mode of transportation than the participant (e.g., participant is ambulatory, attendant is non ambulatory and uses a wheelchair), both will be transported via the more costly mode. Beyond the participant receiving a medical service and requiring the assistance of a parent/guardian or medically necessary attendant (as documented on the Statewide Provider Certification Form), the Program does not cover the cost of providing transportation for other individuals, such as siblings or significant others.

## Medical Assistance Transportation Manual

Topic: Transporting Minors for Reproductive and Mental Health

Users: MDH Transportation Staff

Policy #:10.09.19.05(N) MINO

Effective Date: 6-30-2017

In *Guide to the Administration of the Transportation Grant Program* and in COMAR 10.09.19.05(N) reference is made to payment for a parent/designated attendant to accompany a minor who is being transported for a Medicaid covered service.

Grantees are reminded that a minor is defined as a child up to the age of 18. The Conditions of Award for FY 18 on page 8 states "A minor shall not be transported without an adult or legal guardian."

COMAR 10.09.19 does not state a requirement for a minor to have an adult as an attendant.

- Md. Code Ann., Health-Gen. II §20-104 (b)(1) states "A minor who is 16 years old or older has the same capacity as an adult to consent to consultation, diagnosis, and treatment of a mental or emotional disorder by a health care provider or a clinic".
- Adults with mental or emotional disorders are not required under 10.09.19 to have an attendant.
- A disabling emotional or mental disorder for which a Medicaid beneficiary receives Disability may necessitate reasonable accommodation.
- Md. Code Ann., Health-Gen. II §20-102 (c) (3-7) states "A minor has the same capacity as an adult to consent to: ... (3) Treatment for or advice about venereal disease; (4) Treatment for or advice about pregnancy; (5) Treatment for or advice about contraception other than sterilization; (6) Physical examination and treatment of injuries from an alleged rape or sexual offense; (7) Physical examination to obtain evidence of an alleged rape or sexual offense; and..."
- Md. Code Ann., Health-Gen. II §20-102 (f) states "Without the consent of or over the express objection of a minor, a licensed health care practitioner may, but need not, give a parent, guardian, or custodian of the minor or the spouse of the parent information about treatment needed by the minor or provided to the minor under this section, except information about an abortion."

In the situation where we have a 16 or 17 year old accessing mental health services, who is eligible and qualified for NEMT, the following should be undertaken:

1. Contact the mental health provider to request a letter stating their patient would be safe to transport without an attendant.
2. Grantee is to direct their staff to establish transportation to this mental health service, when requested by either the patient or their parent/guardian.
3. If the parent is requesting the transportation and is not interested in accompanying their child. The Grantee to send a letter of confirmation to the parent/guardian stating: This letter is to serve as confirmation of the following transportation arrangement: So and So Participant (DOB) is going to be transported via NEMT to \_\_\_\_\_ on Days of the week and times of pick up. So and So will be travelling unaccompanied

## Medical Assistance Transportation Manual

Topic: Transporting Minors for Reproductive and Mental Health

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Policy #:10.09.19.05(N) MINO

Effective Date: 6-30-2017

in our shared ride program, and is responsible for following all rules, policies, and regulations of the program as outlined in the Medical Assistance Transportation Brochure. If there is a change in schedule or a cancellation of these recurrent trips, you as parent/guardian will be responsible for making sure the cancellation policy is followed.

- o No signature is required on this confirmation
- o Full welcome packet should be included.
- o Participant or parent may schedule trips to this mental health clinic.

In the situation where we have a minor accessing reproductive health service, who is eligible and qualified for NEMT, the following should be undertaken:

1. Contact the health provider to request a letter stating their patient would be safe to transport without an attendant.
2. Grantee is to direct their staff to establish transportation to this reproductive health service, when requested by the patient or their parent/guardian.
  - o Remind staff that if a minor who is 16 or 17 years old requests their own transportation to reproductive health services, the parent is not to receive any information on this trip or visit.
3. Upon first request for reproductive health, if the parent is requesting the transportation and is not interested in accompanying their child. The Grantee to send a letter of confirmation to the parent/guardian stating: This letter is to serve as confirmation of the following transportation arrangement: So and So Participant (DOB) is going to be transported via NEMT to \_\_\_\_\_ on Days of the week and times of pick up. So and So will be travelling unaccompanied in our shared ride program, and is responsible for following all rules, policies, and regulations of the program as outlined in the Medical Assistance Transportation Brochure. If there is a change in schedule or a cancellation of these recurrent trips, you as parent/guardian will be responsible for making sure the cancellation policy is followed.
  - o No signature is required on this confirmation
  - o Full welcome packet should be included.
  - o Participant or parent may schedule trips to this clinic.

## Medical Assistance Transportation Manual

Topic: Transportation of Service Animals

Users: MDH Transportation Staff

Policy#: 10.09.19.05 (N) SVC ANIMALS

Effective Date: 03-01-2019

Guidance at this time is based on the Federal Laws pertaining to Support Animals. Become familiar with and adhere to the information outlined at: <https://adata.org/publication/service-animals-booklet>

Conduct a quick interview with the participant. You can let them know that we support the accommodation of a service animal but you'd like to ask a couple of questions for the record. The response to each question is equally important to determine whether or not the animal is a service animal under Title II and Title II of the ADA.

The interview is **NOT** to be conducted to determine if the participant has a disability. We cannot ask for documentation to justify the need.

1. The definition of a service animal (II): *to qualify as a service animal, there needs to be a specific task that is performed by this animal for the benefit of an individual with a disability, and directly related to their disability.*
2. Other support or therapy animals (III): *Emotional support animals (ESAs), comfort animals, and therapy dogs are **NOT** service animals under Titles II and III of the ADA.*
3. Handler's Rights. *We can only ask two questions. These questions should not be asked if you are meeting in person with the individual and the animal's service tasks are obvious (i.e. pulling a wheelchair, observing a dog guiding an individual who is blind or who has low vision).*

You may ask:

- a) *Is the animal required because of a disability?*
  - i) No - we will not transport the animal
  - ii) Yes - You can move forward to asking the second question
- b) *What work or task has the animal been trained to perform?*
  - i) Examples of tasks that a service animal may be trained to perform: *can include, among other things, pulling a wheelchair, retrieving dropped items, alerting a person to a sound, reminding a person to take medication, or pressing an elevator button.*

4. The ADA requires the animal to be under the control of the handler.

You may ask:

- a) *Is the animal vaccinated in accordance with state and local laws?* Document the answer, but do not make determination based on this answer.
- b) *Is the animal housebroken?* The animal must be housebroken.

## **Medical Assistance Transportation Manual**

**Topic: Transportation of Service Animals**

**Users: MDH Transportation Staff**

**Policy#: 10.09.19.05 (N) SVC ANIMALS**

**Effective Date: 03-01-2019**

5. A doctor's letter does not turn an animal into a service animal.
  
6. Businesses, public programs, and transportation providers may exclude a service animal when the animal's behavior poses a direct threat to the health or safety of others.

DRAFT

# Program Integrity

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## **Medical Assistance Transportation Manual**

**Topic: Complaints and Complaint Reporting**

**Users: MDH Transportation Staff**

**Policy#: 10.09.19.07 COMP**

**Effective Date: 06-30-2017**

### **Complaints and Complaint Resolution**

The Transportation Grant Program requires each local health department to devise and implement a Standard Operating Procedure to handle complaints. Complaints may be received via telephone, email, fax or mail. Staff should be designated to receive complaints and be able to determine the nature of the caller's intent. Specifically, is the caller providing information pertaining to a trip or calling to file a complaint? A process to document this information should be implemented.

Oftentimes, a caller may choose to contact the program to provide information regarding a trip. This information may include that the client is running late or request for an earlier departure or arrival. Calls of this nature would not be considered as a complaint.

A complaint is usually derived from a breach of contract, obligation or an agreement lending itself to a denial of expected outcome. In reference to non-emergency transportation services, this breach often lends itself to the inability of a participant to receive access to covered health care services or unsatisfactory customer service.

Complaints of this nature require fact-finding through an interview that includes the participant and the vendor accused of not providing services or meeting an obligation. This and any other information should be recorded and submitted quarterly with the Quarterly Reports on the Complaint-Resolution Report Form.

Participants are to call the local NEMT program with complaints, and should never be instructed to contact the vendor directly. Vendors are to refer all complaints back to the local NEMT program.

Complaints are to be logged on **each time** a participant calls, even if the complaint is recurrent. Complaint logs are due quarterly and need to enumerate the name and MA# of the complainant, date of the complaint, date of the incident/transport, details of the complaint, and actions taken towards resolution.

Complaint Reports are to be submitted with the quarterly reports to [mdh.nemt@maryland.gov](mailto:mdh.nemt@maryland.gov)

Accidents and significant incidents are to be reported to the Department within 24 hours, with a detailed report submitted within 5 business days.

## **Medical Assistance Transportation Manual**

**Topic: Disruptive Participants**

**Users: MDH Transportation Staff**

**Policy #: 10.9.19.04A(4) DISR**

**Effective Date: 06-16-2011**

### Suggested Procedures for Dealing with Unruly and Disruptive Participants

1. Document any incident to include names of witnesses, time and place, driver's name, and description of the incident.
2. Send a warning letter to the participant providing time and date of the incident to include:
  - a. Inform of unacceptable conduct
  - b. Possibility of law enforcement involvement if the behavior reoccurs
  - c. Risk of losing MA Transportation
  - d. Participant Bill of Rights
3. If the participant is in a mental health or substance abuse program, consider contacting the case manager/social worker.
4. If the participant attends a dialysis program, consider contacting their social worker.
5. Report all incidents requiring the involvement of law enforcement to the Department.
6. Neither the Program, Local Health Department nor the transport vendors can suspend riders. However, we can help search for and develop community based alternatives under COMAR 10.09.19.04A(4).

## Medical Assistance Transportation Manual

Topic: Program Integrity - Motor Vehicle Administration Routine Checks

Users: MDH Transportation Staff

Policy#: 10.09.19.04B(1) IDVR

Effective Date: 06-30-2017

### Motor Vehicle Administration Interactive Driver and Vehicle Record Access (IDVR)

The purpose of checking participants against the IDVR is to ensure program integrity and to promote awareness of vehicle availability. Grantees are to ensure that participants do not have vehicles registered in their name by asking the required screening questions.

Upon initial screening, and recertification, all applicants will be checked in the MVA database for Driver's License and Vehicle Registration. A positive match is defined as a participant found to have a Maryland registered vehicle. Owning a vehicle and having a valid driver's license preclude transportation by NEMT, and is reason to send a denial letter.

Prior to sending a denial letter, Grantees should review the participant's provider certification form and screening documentation to determine if there is information that supports the participant's eligibility for NEMT. An example would be that the participant has a temporary disability and is physically unable to drive their car. If that is the case the provider certification form should note the date that the participant will be able to drive. Follow-up with the doctor's office may be required.

The following policies will be utilized in dealing with participants:

- **Participant Reports Unable To Drive Due To Medical Condition** - Grant Manager will obtain a Provider Certification Form or a letter from the doctor stating the nature of the medical disability and the length of time that the participant cannot drive. Should the condition be ongoing, Grant Managers can refer the documentation to the MDH MA Transportation Unit for physician review. Grant Managers may allow 30 days of transportation until documentation is received.
- **Vehicle Not Operable** - the Grant Manager will request a mechanic's letter on an auto repair shop's letterhead that the vehicle is inoperable and the nature of the mechanical problem. A new letter will be required every 6 months.
- **Legally Responsible Individuals** – A legally responsible individual is defined as the spouse of a participant, the parents of minor child or an individual who has Guardianship or Power of Attorney of a client. The individuals listed above are expected to use their vehicles to provide transportation services where they have legal responsibility for the participant when available. Grant Managers may approve transportation based on the participant's situation as a case-by-case review.
- **Funds Not Available To Pay For Fuel** - Staff of the Medical Assistance Transportation Unit or Grantees of the Program are not required to address financial hardship regarding a participant's inability to pay for fuel. It is reasonable to assume if a participant is paying for insurance,

## **Medical Assistance Transportation Manual**

**Topic: Program Integrity - Motor Vehicle Administration Routine Checks**

**Users: MDH Transportation Staff**

**Policy#: 10.09.19.04B(1) IDVR**

**Effective Date: 06-30-2017**

registration and title fees that the participant has sufficient resources to pay for fuel and other expenses such as tolls and parking.

Participants who are denied NEMT due to a vehicle are eligible to appeal the transportation denial and will be made aware of their rights using the Notice of Fair Hearing Practices to be mailed out with the denial letter.

## **Medical Assistance Transportation Manual**

**Topic: No Shows**

**Policy # 10.09.19.05(N)**

**Users: MDH Transportation Staff**

**Effective Date: 06-30-2017 updated 10/31/2018**

### **No Shows**

Please refer to Transmittal PT 9-05 in appendices. Transportation Grants Transmittal No. 5 dated October 8, 2004 for guidance on handling the participant with serial No Shows.

The Transmittal is further clarified by guidance received from CMS during audits and reviews. CMS informed MDH there is a prohibition from paying vendors – in any capacity – for No Shows. Once made aware, all Grantees were informed of the need to change their contracts from flat rate, or payment for No Shows, to fees directly linked to loaded miles for a participant accessing a Medicaid covered service.

All contracts, reimbursement programs, and purchase of care items are exclusively for the assurance of transportation of the eligible and qualified individual, and their attendant if clinically required and validated, to and from Medicaid covered services.

# Medical Assistance Transportation Manual

Topic: Participant Rights and Responsibilities

Users: MDH Transportation Staff

Policy #:10.09.19 42 CFR(a){4}(ii)(D) RIGHTS

Effective Date: 2019-06-30

The following shall be provided to all new participants.

## Participant Rights and Responsibilities

The Non-Emergency Medical Transportation Program (NEMT) is a curbside-to-curbside shared ride program regulated by State and federal guidelines for qualified and eligible participants going to a Medicaid appointment. Minors shall be accompanied by a custodial adult. NEMT Program participants have the right to the following expectations. In addition to that right, participants have the **obligation** to make sure they are not denying any other participant *their* right to the same expectations.

### The right to:

- Clear instructions on how to access, schedule, and cancel services;
- Polite and courteous telephone interaction;
- Know the name of the transportation vendor;
- To be informed one day in advance of the pick-up time at the point of origin;
- Written instruction how to access transportation for return trips;
- To be informed of the anticipated wait time for transportation;
- A driver who is courteous and provides a temperature controlled environment adjusted to the comfort level of the passengers
  - ❖ Participants should dress in layers as temperatures may vary;
- A driver who has authority over the occupants and the vehicle, taking actions to maintain a safe environment including:
  - ❖ assigned seating, requiring seatbelts, engaging law enforcement when necessary
  - ❖ and issuing reports of participant misconduct;
- A driver who will stop the vehicle and make arrangements to remove the offending participant/passenger who imposes on another participants rights;
- A vehicle in which all passengers and the assistive devices are belted, buckled, and secured;
- A clean, well maintained vehicle operated in a safe manner by a trained driver who obeys traffic laws and transportation industry best practices;
- A vehicle free from Vaping, Smoke, and Tobacco Products;
- A vehicle free from weapons;
- A vehicle where the operators music will not be violent, loud, and have themes that may be considered offensive, violent, or sexual in nature;
  - ❖ Participants will wear headphones with all electronic devices.
- A vehicle where passengers consuming food or drink will leave the vehicle clean and remove all waste upon exiting the vehicle;
- A vehicle where there is no cursing, yelling, or aggressive behavior;
- A vehicle where passengers who choose to be unlawful, unruly, disruptive, rude, or intoxicated will not be tolerated;
- A vehicle where all passengers adhere to the Participant Rights and Responsibilities;
- A vehicle in which sexual abuse/harassment will not be tolerated;
- A vehicle in which physical abuse/harassment will not be tolerated;
- A vehicle in which verbal confrontation/harassment will not be tolerated;
- A vehicle in which discrimination will not be tolerated;
- A vehicle in which all riders comply with safety instruction and driver direction;
- A program which is compliant with the Federal Regulations pertaining to NEMT;

## **Medical Assistance Transportation Manual**

**Topic: Participant Rights and Responsibilities**

**Users: MDH Transportation Staff**

**Policy #:10.09.19 42 CFR(a)(4)(ii)(D) RIGHTS**

**Effective Date: 2019-06-30**

- A screening process for redetermination to occur at a minimum of 90 day intervals in person, in writing, or by telephone interview;
- A screening process including a Provider Certification Form (PCF) to be completed upon entering the program, when there is a change in condition, or at a minimum of 12 months from program entry – for ambulatory participants; and
- Written notification if there is to be a change to the transportation vendor, participant rules, denial, or if there is to be a termination of services.

By accepting assistance from the Transportation Grants Program, the participant acknowledges the expectation that the provider and participant will both follow the Participant Rights and Responsibilities.

## Medical Assistance Transportation Manual

Topic: Program Integrity – Screening for Excluded Parties

Users: MDH Transportation Staff

Policy#: 10.09.19 PT36-09 LEIE

Updated for Clarity: 09/01/2018

### Screening for Excluded Parties

Maryland Medicaid is prohibited from paying for any items or services furnished, ordered, or prescribed by excluded individuals or entities (General Provider Transmittal No. 73, <https://mmcp.health.maryland.gov/docs/PT36-09.pdf> ). It is the responsibility of the Grantee to attest monthly that all employees, contractors, and vendors have been routinely searched, as prescribed per the aforementioned transmittal. The Grantee must be able to demonstrate, upon request, that this verification has been performed utilizing the following databases: [www.exclusions.oig.hhs.gov](http://www.exclusions.oig.hhs.gov); and <https://mmcp.health.maryland.gov/Pages/Provider-Information.aspx> and any such other databases as the Maryland Department of Health may prescribe.

LEIE reports are due monthly to the [MDH.NEMT@Maryland.gov](mailto:MDH.NEMT@Maryland.gov) by month end.

### LEIE Screening Process:

Transportation providers are required to submit monthly attestations and electronic screenshots of the verification results to NEMT Grantees that all employees, subcontractors and subcontractor's employees have been verified as not being excluded prior to or during employment, and monthly thereafter. Verification is done through the List of Excluded Individuals/Entities (LEIE) website (<http://oig.hhs.gov/exclusions>) and the MDH Maryland Medicaid Sanctioned Provider List at <https://mmcp.health.maryland.gov/Pages/Provider-Information.aspx>

It is required that providers maintain documentation of the initial and monthly name searches performed, such as a printed screen-shot or an electronic file showing the results of the name searches, for six years.

- If a positive match of an excluded individual or entity is identified, the provider will inform the Grantee immediately and a copy of the findings will be forwarded to the NEMT Program for follow-up and further direction.
  - A positive match of an excluded individual not yet employed by the Provider does not require a report to the Grantee, as this individual **cannot** be hired, nor can the provider contract with an excluded entity to perform covered services.
  - A positive match of an employed excluded individual will be reported to the NEMT Grantee immediately. The Grantee will inform the Department and further instructions will follow.
  
- Grantees will verify all persons listed on the Provider Ownership and Disclosure Form through the aforementioned LEIE and Maryland websites on a monthly basis.

## Medical Assistance Transportation Manual

Topic: Program Integrity – Screening for Excluded Parties

Users: MDH Transportation Staff

Policy#: 10.09.19 PT36-09 LEIE

Updated for Clarity: 09/01/2018

- Grantees are required to submit monthly attestations and electronic screenshots of the verification results to the NEMT Program. It is also required that Grantees maintain these documents for six years.
- Volunteer drivers that would receive reimbursement for gas, tolls and parking to transport a recipient must also be searched monthly through the prescribed databases.
- Prior to hiring/transferring an individual to work in the NEMT Program (administrative staff, drivers, medical staff, etc.) the Grantee will perform a search of the prescribed databases. If the individual is on the list they cannot be employed. Once hired, monthly verifications are required.
  - The Grantee, or their designee, who is conducting the LEIE searches MAY NOT search or attest to the search of their own name. These individuals are to be screened by a designated Unit or person in Human Resources.
  - Vendors or providers contracted through the local jurisdiction will presumed to have been screened as part of the contract award process, as required to receive Federal Medicaid funds.
- Grantees will submit the following to the Program monthly:
  - Required provider/vendor and Grantee attestations of verifications and screenshots of LEIE verifications.
  - All findings will be reported to the Program electronically to [mdh.nemt@maryland.gov](mailto:mdh.nemt@maryland.gov) by close of business of the last business day of the month.

Notes:           \*\*Documentation from a provider, entity or employee that has self-verified is not acceptable.

                  \*\*The Department's sanction website **MUST** be verified as some Maryland sanctions do not qualify to be added to the OIG's LEIE database (e.g. revoked license).

**If you have additional questions, please contact a Program Specialists at 410-767-7283.**

## **Medical Assistance Transportation Manual**

**Topic: Program Integrity – Third Party Insurance Verification**

**Users: MDH Transportation Staff**

**Policy#: 10.09.19.01 EVS**

**Effective Date: 06-30-2017**

### **Third Party Insurance Verification**

When verifying participant eligibility using the Eligibility Verification System (EVS), grantees may learn that the Medicaid participant has other insurance. The EVS system will provide the name, policy and telephone number of the third party insurance, or it may show up as TPL – Third Party Liability. Grantees are required to verify insurance coverage for all ambulance and aero medical (fixed wing or helicopter) transports prior to authorizing NEMT services. If coverage is available from the participant's other insurance, refer the participant to their insurance carrier for transportation service or when applicable, refer the transportation provider to the other insurance carrier for payment. If transportation is not covered by the primary insurance and the participant is eligible for NEMT through screening, schedule the transport. A denial or Explanation of Benefits (EOB) must be kept on file from the primary insurer.

Medicaid is always the payor of last resort. If a participant is receiving treatment at a Medicaid provider that is due to an accident or injury for which there may be either another payor (Ex: Workman's Comp, Auto Accident) or if they are a victim of a criminal act (i.e. Gun Shot Wound, Assault, Bite, or Stabbing) email the Department with participant demographics, date of injury/accident, and mode of transportation so we may notify the Recoveries Unit.

## Medical Assistance Transportation Manual

Topic: Program Integrity - Verification of Appointments

Users: MDH Transportation Staff

Policy#: 10.09.19.07B VERI

Effective Date: 06-30-2017

### Verification of Appointments

Grantees are responsible for ensuring that requested trips are for scheduled medical appointments. Grantees are responsible for verifying at least ten percent of monthly trips provided. Jurisdictions shall make a random selection of five percent pre-trip verifications *and* random selection five percent post appointment and transport verifications. **In cases where participants have been found to misuse use Medicaid transportation, grantees are to verify all trips for a period of three to six months.** All trip verifications must be documented and available for review upon Department request.

Appointments for which a physician note is turned in to the program voluntarily by a participant shall not be included in the calculation of the 5% for post-appointment verifications.

# Responsibilities of Grantees

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Memos

October 9, 1998 – Record Retention  
October 9, 2014  
    Out of County Discharges  
    MCO Tracking  
    Transport Contact Memo Page  
Section 1557 Memo and Memo Guidance

Reference Materials

CMS MLN Matters SE0433  
COMAR 10.09.19  
Reading and Replying to a Virtru Encrypted Email

Reporting Forms

Sample – Complaint Log-Resolution Form  
Sample – Excluded Parties Attestation (rev. 7/17)  
Sample – Excluded Parties Provider Disclosure  
Sample – Local Health Department MCO Reporting Form  
Sample – Transportation Data Worksheet  
Sample – Quarterly Reports Appointment Verifications

Transmittals

PG 62-80 Cost of Aide to Accompany Patients  
PT 1-11 Transmittal 79 Part B Coinsurance  
PT 08-04 Emergency Services Transporters  
PT 9-05 No Shows  
PT 10-19 Winter 2018 Medicaid Program Updates  
PT 13-03 Air Ambulance  
PT 18-03 MCO and FFS Transportation  
PT 33-17 Spring 2017 Medicaid Program Updates  
PT 36-09 Screening for Excluded Parties  
PT 37-09 PERM  
PT 37-16 Gender Transition



**MARYLAND**  
Department of Health

## **Medical Assistance Transportation Manual**

**Topic: Arranging for Transportation Providers**

**Users: MDH Transportation Staff**

**Policy#:10.09.19.03B(2) ASSU**

**Effective Date: 6-30-2017**

### Arranging for Transportation Services

For qualified and eligible participants, grantees are expected to ensure sufficient resources for the provision of non-emergency medical transportation. Most grantees accomplish this through contracts with local transportation providers, while other grantees provide the transportation directly.

Participants should be given a timeframe for pickup, either at the time of the request or when the trip schedule is completed. For trips scheduled during peak travel hours, the pickup window should not exceed 90 minutes. Peak travel hours are between the morning hours of 7:00am and 10:00am and afternoon hours of 3:00pm and 6:00pm. For trips scheduled outside of peak travel hours, the pickup window should not exceed one hour. Pick up times will be calculated for the participant depending on the distance to the appointment, anticipated traffic conditions, transportation needs of NEMT vehicle co-occupants, and other factors.

In order to ensure efficient and cost-effective operations, trips to appointments outside the region (e.g., Eastern Shore to Baltimore, Western Maryland to Baltimore or Morgantown, West Virginia) may occur once daily. Depending on demand and available resources, long distance trips may be limited to certain days of the week. When long distance trips are anticipated, participants or those assisting participants are expected to find out in advance the NEMT transportation availability from their area and make appointments accordingly. When this proves impossible (e.g., vendor travels to Baltimore on Tuesday and Thursday, yet the provider the participant must see is available only on Wednesday), grantees are to secure transportation for the day and time needed.

## Medical Assistance Transportation Manual

Topic: Ensure Transportation Without Exception

Policy #: 10.09.19 42CFR431.53(A) ENSU

Users: MDH Transportation Staff

Effective Date: 12-19-2017

It is the responsibility of each grantee to assure their providers of services are not suspending riders, nor denying trips (42CFR 431.53 as cited below). Furthermore, it is the responsibility of the grantee or their designee to report vendor violation of this assurance to MDH *immediately*. The grantee must notify the vendor of this violation with a Cease and Desist order; the same must be forwarded to MDH with a Corrective Action Plan within 24 hours.

The Transportation Grant is obligated under 42 CFR 431.53(A) "...ensure necessary transportation for recipients to and from providers...". The Non-Emergency Medical Transportation (NEMT) is further expounded upon in 42CFR440.170(a)(4)(ii)(D):

"In referring or subcontracting for non-emergency medical transportation with transportation providers, a broker may not withhold necessary non-emergency medical transportation from a Medicaid recipient or provide non-emergency medical transportation that is not the most appropriate and cost-effective means of transportation for that recipient for the purpose of financial gain, or for any other purpose."

Per guidance received from CMS, there are no circumstances under which any entity receiving funds through the Transportation Grant may deny transportation to an eligible and qualified participant. Neither our grantees, nor any of their vendors, may suspend transport of a participant under ANY circumstances.<sup>1</sup>

All grantees must comply with Departmental guidelines, relevant to COMAR 10.09.19 and the CFR referenced above. Failure to do so will be viewed as a breach of agency agreement under the Memorandum of Understanding. Grantees are required to monitor the actions of vendors and be certain that there is absolutely NO autonomy in this area on the part of the vendors.

Continued funding by MDH under the Transportation Grant is contingent upon written acknowledgement of this notice, and the inherent obligation to comply, by grantees and *each* of their vendors.

Failure to execute this directive, as well as comply with all relevant CFR and COMAR, will be viewed as a breach of agency agreement under the Memorandum of Understanding and may result in recoupment of federal and State funding as well as additional actions up to and including rendering current contracts void and the inability to bid on future proposals under the Transportation Grant.

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<sup>1</sup> Designing and Operating Cost-Effective Medicaid Non-Emergency Transportation Programs A Guidebook for State Medicaid Agencies (1998) p.58 <https://ntl.bts.gov/lib/12000/12200/12290/medicaid.pdf>

# Medical Assistance Transportation Manual

**Topic: Responsibilities of Grantees - Screening**

**Users: MDH Transportation Staff**

**Policy #:10.09.19.04B SCRE**

**Effective Date: 6-30-2017**

With the acceptance of Medicaid funds, grantees accept the responsibility for ensuring access to transportation for qualified and eligible participants for the purpose of attending necessary medical appointments, in a clinically appropriate, efficient, and cost-effective manner. In carrying out this responsibility, the grantees are expected to perform administrative functions, some of which are detailed below;

## Screening

Grantees are expected to conduct an initial screening for all first-time requests, and at least quarterly for established participants. Additional screening should occur when receiving information potentially impacting mode of transport, or when the participant has a change in medical condition. Sample and minimum required screening questions can be found in COMAR 10.09.19.04(B).

A fundamental responsibility of grantees is the screening requestors for participant eligibility, clinically appropriate mode, and necessity of transportation. All trips, except for hospital discharges occurring on weekends, require preauthorization. Screening Medical Assistance clients for Program eligibility and mode of transport must not be performed by the vendor of service. A jurisdiction that has chosen to provide transportation, instead of using a vendor, may do so with approval from the Department; and represent the only time when the provider of transportation may also screen for eligibility

Screening may be conducted via telephone or in rare cases, written application. When a written application process is used, grantees must provide for a reasonable "interim" period in which the applicant has access to transportation as needed during the application process. When screening and engaging in any communication, written or verbal, Grantees must ensure that Limited English Proficiency (LEP) persons have meaningful and equal access to benefits and services.

Through the screening function, the grantee determines whether:

- The applicant is an eligible Maryland Medicaid participant and is potentially qualified for transportation;
- The requested transportation is necessary in order for the participant to receive needed medical care;
- The medical service is covered by Medicaid;
- The most efficient mode of transport necessary to meet the need is being used; and
- The participant has exhausted all other transportation options including publicly available paratransit, charitable organizations, family and friends, or other community resources.

## **Medical Assistance Transportation Manual**

**Topic: Responsibilities of Grantees - Screening**

**Users: MDH Transportation Staff**

**Policy #:10.09.19.04B SCRE**

**Effective Date: 6-30-2017**

- The requested transportation is not covered by another segment of the Program or otherwise prohibited by federal or state regulation.

These screening components are discussed in detail below.

\*\*\* Accommodation must be made for screening participants who identify the need for language assistance. Please refer to MDH Policy 01.02.05 pertaining to Limited English Proficiency.

## **Medical Assistance Transportation Manual**

**Topic: Responsibilities of Grantees - Screening**

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### Medicaid Eligibility

In order to be eligible for transportation services, the applicant must be enrolled in full Medicaid benefits. Individuals whose eligibility is limited to Medicare coinsurance (QMB), payment of Medicare premiums (SLMB), or family planning benefits are not eligible for transportation services. Each Medicaid participants' eligibility must be verified using the Eligibility Verification System (EVS) as a part of the screening process. Grantees must use the EVS system to ensure that a participant is Medicaid-eligible prior to each new transport request. A Grantee may choose to access EVS via the internet or telephone. Internet access provides the user with a confirmation number that must be printed and filed. When the system is accessed via telephone, the user must write down the confirmation number. Storing this information with all applicant documentation is the Grantees' proof that a participant was Medicaid eligible when transported and is required to be maintained in the file.

# Medical Assistance Transportation Manual

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## Necessity of Transportation

Fundamental to the grantees' responsibility is to ensure the participants request is an effort to secure medically necessary care. To this end, grantees are expected to consider alternatives, both of *transportation resources* and *provider resources*.

Other available transportation resources. First, the grantees are required to determine whether the participant has any other transportation resources available, or whether he/she is dependent on Medicaid-funded transportation to access medical care. Possible alternative transportation resources include but are not limited to:

- Public transportation, either fixed-route or paratransit. Participants, whose home and provider are within ¼ mile from the closest fixed-route stop, and who have no documented medical reasons why such transportation cannot be used, are expected to utilize publicly provided transportation or apply for publicly offered paratransit.
  - When a Grantee asks the participant if he/she has other means of transportation, eligibility for paratransit should be considered an available resource; failure to utilize available public transportation can disqualify the participant for NEMT. If the participant has been denied eligibility for paratransit services, a copy of the denial letter shall be provided and kept on file. A participant, who has been denied publically provided paratransit services **AND** meets all other screening criteria for NEMT, may be approved for NEMT services.
  - For further assistance, Grantees should check with their local public transportation providers for access to online trip planners. A trip planner is a valuable resource to determine the availability of public transportation.
- Vehicles belonging to the participant, others living in the household, or other family members or friends. As appropriate, participants may be directed to reschedule appointments to make use of this resource, if available; or
- Other resources, such as community and charitable organizations (ie. churches, non-profit agencies) or volunteers.

Grantees are not required to provide funds for the use of public transportation. However, grantees may furnish transportation or bus passes, in cases where the need to make frequent trips for medical services makes the use of public transportation an extreme financial burden (e.g., recurrent appointments). A completed Statewide Provider Certification Form will be required from the treating provider to verify the frequency and duration of recurrent medical appointments.

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The use of the Statewide Provider Certification Form (Ambulatory/Wheelchair and Ambulance) provides documentation for, and attestation to, a clinical need of:

- A Fee-for-Service participant being transported to provider while bypassing a closer provider of the same specialty;
  - A Statewide Provider Certification Form is not needed to justify and transport a participant out of the county if the provider is the closest appropriate provider.
  - The out of area form is needed in conjunction with the Statewide Provider Certification Form for *each* distant provider being seen by the Fee-for-Service participant.
- Validating the medical need for wheelchair or ambulance transportation;
- The need for ambulatory transportation when public transportation is available;
- Medical conditions potentially needing consideration when scheduling shared rides;
- Intermittent certification – needed if a participant’s condition changes, necessitating the need of a different mode of transport; and
- To clarify if the service to be rendered is covered by Medicaid.

After verification of eligibility and approval, a participant will be transported for the duration of the prescribed services. NOTE: With the exception of pregnancy or other self-limiting treatment, if a participant requires an out of area transport to a more distant provider as a result of a move, it is expected that after one transport to the distant provider, the participant will:  
1. Obtain a referral to the closest appropriate provider and transition care to that provider  
2. Remain with the distant provider with the knowledge that after the initial transport, NEMT will not provide transportation.

Availability of alternate providers – When determining the necessity of transportation in meeting the participant’s medical care needs, grantees also consider whether transporting to a specific location, either because it is the participant’s choice or it is in the managed care organizations (MCO’s) network is appropriate.

### **\*\*Special Instructions - HealthChoice Participants\*\***

For participants enrolled in HealthChoice, serving providers must be part of the Managed Care Organization’s (MCO’s) provider network. Participants are, therefore, limited in their choice of health care providers, especially for primary and related care. It is the responsibility of the grantee to ensure a participant’s access to health care appointments within their respective network. If, however, the participant’s request for transportation bypasses an in-network

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provider of the same service, the grantee should assist the participant in accessing MCO-funded transportation by referring them to the county's Administrative Care Coordination Unit (ACCU) who will in turn assist the participant in arranging MCO-funded transportation. **The ACCU is a reliable resource in verifying MCO provider networks and should be accessed.**

All other screening requirements remain the same for both Health Choice and fee-for-service participants. Please note, however, that the Grant does not cover transportation to services paid for by the MCO that are not a covered Medicaid service; most notably dental coverage for adults not enrolled in REM. (Transportation Grant Transmittal No.3; and Transportation Grant Transmittal No. 9) (attachment 6).

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### Closest Appropriate Provider

Fee-for-Service participants are those who are not enrolled in an MCO via HealthChoice. These participants may be transported to the closest appropriate provider in an efficient, cost-effective manner. To be considered the Closest Appropriate Provider the following requirements must be met:

- Participates in the Maryland Medicaid Program; or
- Has the training and skills necessary to provide the needed care (includes but is not limited to applicable licensure and/or certification); and
- Is willing to accept the participant as a patient.

In cases where the travel distance between two appropriate providers is minimal, grantees should honor the participant's choice of provider. When the distance between appropriate providers is significant, however, grantees may limit transportation to the closer provider.

In some cases, transportation is requested for a participant in a facility such as a hospital or nursing home to travel to another facility to receive care. Such requests are honored when the medical service to be provided at the destination facility is one that cannot be provided at the facility of origin. The transportation of the participant must be provided by the entity holding the NEMT contract for that county. Examples include:

- Transfers between hospitals where the sending hospital does not have the facilities to perform needed services or procedures; and
- Trips to the hospital emergency department from a nursing home for urgent care (e.g., re-insertion of a feeding tube or other non-emergent yet time-sensitive service that cannot be safely performed by facility nursing staff).

*Exceptions.* Grantees may authorize grant requests for transportation to a provider other than the closest appropriate one under the following circumstances:

- If the participant or provider has recently moved, and the provider is no longer the closest appropriate provider, grantees are to allow one trip to this provider to facilitate transfer of care to a closer provider, or to allow the participant to seek other transportation alternatives. Additional trips may be authorized under the following circumstances:
  - If the participant has been undergoing a course of treatment requiring provider continuity (e.g., physical therapy, chemotherapy, etc.) and will only need a few

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more visits, grantees will transport to the distant provider until the course of treatment is completed, or

- A pregnant participant in the latter half of her pregnancy who has been receiving prenatal care from a certain provider will be transported to the provider for the remainder of the pregnancy and a postnatal checkup.

\*\*\*At the time of booking such trip, the participant will be advised of the limitation of transportation to the distant provider, and that beyond these limits the participant will need to either find another provider or make other transportation arrangements.

- If a participant usually has other transportation resources, but needs a one-time trip because those resources are temporarily unavailable, the grantee will provide transportation to a distant provider. If such a request is made more than three times in a year, the grantee may, at its discretion, refuse the trip and direct the participant to either find another provider or make other transportation arrangements. The grantee, however, should give the participant advance notice of its intention to refuse future trips. (example: the participants family member loans them a vehicle, but that vehicle is at the mechanic, with the proper documentation, the grantee can provide that transportation)

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### Medicaid Covered Service

Grant funds for transportation are available only when the service to which participant requests transportation is coverable by Medicaid. Services that are not covered by Medicaid include but are not limited to:

- Dental services for participants age 21 and over (except for those enrolled in Rare and Expensive Case Management (REM) and pregnant participants);
- Follow-up visits to pick up eyeglasses for participants age 21 and over;
- Veterans Administration hospitals to receive treatment for a military-related condition;
- Community based support groups, including but not limited to Alcoholics Anonymous, Weight Watchers, diabetes support groups;
- Parent/guardian visits to children in hospitals
- Trips to providers that are not enrolled in Medicaid, either directly as a provider or through an MCO network, whether or not the service itself is covered by Medicaid;
- Trips for the purpose of receiving other services excluded from Medicaid coverage; and
- Trips where a medical service is not being delivered.

Participants who are dually eligible for full Medicaid and Medicare may need transportation to receive medical services that are coverable by Medicaid, but may be billed to Medicare or other third-party payer. In such cases, the grantee may approve the transportation as long as the medical service is one that Medicaid covers and that all other requirements (no other transportation available, closest appropriate provider, etc.) are met.

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### Appropriate Mode of Transport

The Medicaid Program covers all modes of transportation as needed (i.e., shared ride bus/van, sedan/taxi, wheelchair, ambulance, air transport). The Program will not cover a more expensive mode of transportation than is required by the participant's medical condition. For most participants, ambulatory transport such as a shared ride bus or van is appropriate. Wheelchair van service is covered only when the participant (or attendant) is non-ambulatory and can be safely mobilized in a wheelchair.

The most expensive mode of transportation, ambulance, is covered only for participants who require stretcher transport for the following reasons: the participant must be transported in a lying-down position, their medical condition requires the presence of at least basic life support (BLS) services during the transport, or upon hospital discharge, the participant's wheelchair is not available for transport to the home or nursing facility. The need for a participant to have a non-EMT attendant either during the trip or at the destination does not justify use of an ambulance. For example, if a participant in a nursing home can safely travel by ambulatory or wheelchair transportation but needs an attendant, the nursing home must send an aide to accompany the participant. (Nursing Home Guideline No. 38) (Attachment 4). Additionally, the failure of the medical provider to have resources to accommodate participants with disabilities does not justify use of an ambulance transport (45 CFR Part 84, Subpart C) (attachment 5). For example a participant requiring assistance getting on and off the examination table is the responsibility of the medical provider; an ambulance provider should not be provided for the sole purpose of furnishing assistance within the provider's place of service.

## **Medical Assistance Transportation Manual**

**Topic: Responsibilities of Grantees - Screening**

**Users: MDH Transportation Staff**

**Policy #:10.09.19.04B SCRE**

**Effective Date: 6-30-2017**

# Medical Assistance Transportation Manual

Topic: Coverage Groups Not NEMT Eligible

Policy #: 10.09.19 PT 19-13

Users: MDH Transportation Staff

Effective Date: 04-03-2013

PT 19-13



STATE OF MARYLAND

## DHMH

Maryland Department of Health and Mental Hygiene  
201 W. Preston Street • Baltimore, Maryland 21201

Martin O'Malley, Governor - Anthony G. Brown, Lt. Governor - Joshua M. Sharfstein, M.D., Secretary

### MARYLAND MEDICAL ASSISTANCE PROGRAM General Transportation Grants Transmittal No. 10 April 3, 2013

**To:** Transportation Grant Coordinators

**From:** Susan J. Tucker, Executive Director  
*Susan J. Tucker*  
Office of Health Services

**Note:** Please ensure that the appropriate staff members in your organization are informed of the contents of this transmittal.

**Re:** Clarification of provision of Non-Emergency Medical Transportation to Undocumented or Ineligible Immigrants.

The purpose of this transmittal is to provide clarification for the provision of Medicaid Non-Emergency Medical Transportation (NEMT) clients possessing eligibility as Undocumented or Ineligible Immigrants. Additionally, the program will also provide grantees with clarification of other coverage groups that are eligible for NEMT service.

Recipients in the Undocumented or Ineligible Immigrant coverage group are only eligible to receive transportation to and from renal dialysis treatment. Grantees should verify the eligibility of recipients currently being transported to ensure that Undocumented or Ineligible Immigrants are not being transported to services other than renal dialysis treatment. Undocumented or Ineligible Immigrants being transported to services other than renal dialysis treatment must be informed in writing that they are no longer eligible for transportation and informed of their right to appeal.

Attached is a guide for Grantees to use when verifying Medicaid recipient's eligibility for NEMT services. When using the Eligibility Verification System (EVS), either via telephone or eMedicaid, you will hear/see the message listed in the column labeled, "EVS Message." The next column labeled, "MMIS Eligibility/Category Group," lists the Medicaid eligibility code or category group. Guidance is provided in the last column labeled, "Action/Comments," as to whether or not a recipient is eligible for NEMT. Remember, verifying Medicaid eligibility is one step to further determining whether a recipient is eligible for transportation services. Grantees must document the confirmation number when using the telephone system or maintain a copy of the online verification in their files. Screening requirements per COMAR 10.09.19.04B are still in effect.

If you have any questions regarding information in this transmittal, please contact the Transportation Unit at 410-767-1739.

Toll Free 1-877-4MD-DHMH - TTY/Maryland Relay Service 1-800-735-2258  
Web Site: [www.dhmh.state.md.us](http://www.dhmh.state.md.us)

# Medical Assistance Transportation Manual

Topic: Coverage Groups Not NEMT Eligible

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PT 19-13

Screening Guide  
Eligibility Verification System (EVS) Messages  
NEMT Exclusions and Limitations  
September 26, 2012

Use this list of EVS messages to determine if a Medical Assistance recipient is in an eligibility category which excludes NEMT services, has certain limitations which require additional screening, or requires specific actions. If the EVS message is not among those listed below, the recipient is potentially eligible for NEMT and the screener should proceed with the screening process.

| EVS Message<br>Web EVS or IVR (phone)   | MMIS Eligibility/Category<br>Group  | Action/Comments   |
|---|---|---|
| <b>EVS messages that indicate recipient has no eligibility for NEMT</b>   |   |   |
| <i>Not Eligible for Date of Service</i>   | *****   | Stop screening; recipient is not eligible for Medical Assistance.   |
| <i>Recipient has Pharmacy and Outpatient Mental Health only</i>   | Primary Adult Care prior to MCO enrollment/S09  | Stop screening; recipient is not eligible for NEMT.   |
| <i>Recipient has PAC Primary Care Coverage: MCO name and phone number</i>   | Primary Adult Care with MCO/S09   | Stop screening; recipient is not eligible for NEMT.   |
| <i>Recipient is eligible for Family Planning Services Only; Abortion &amp; Infertility are not covered.</i>               | Family Planning Program /P10  | Stop screening; recipient is not eligible for NEMT.   |
| <i>Recipient is Qualified Medicare Beneficiary; Medicare is primary payer. Providers may not balance bill recipients.</i> | Qualified Medicare Beneficiary / S03  | Stop screening; recipient is not eligible for NEMT.   |
| <i>Recipient receives Medicare Part B premium payment only.</i>   | Specified Low Income Medicare Beneficiary/S07 or S14  | Stop screening; recipient is not eligible for NEMT.   |
| <b>EVS messages that indicate the need for additional screening for NEMT</b>  |   |   |
| <i>Recipient in a facility- Facility name and phone number</i>  | Aged, Blind or Disabled LTC or Families and Children LTC/ L01, L98, L99, T01, T02, T03, T04, T05, T99 | Determine if the facility is a private entity or State operated. If State operated, stop screening and do not approve NEMT. If the facility is private, continue screening and determine if the service can be provided in the facility. If no, continue screening. If yes, stop screening and do not approve NEMT. |
| <i>Approved emergency services on approved dates only</i>   | Undocumented or ineligible alien/X02  | Determine service type. If transport is for dialysis, continue screening; NEMT may be   |

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|  |  |  |
|--|--|--|
|  |  | approved. If transport request is to any other service, stop screening; do not approve NEMT.   |
| <i>Abortion and Infertility treatments are not covered</i>   | Pregnant or post partum women who were determined eligible for MA based on pregnancy/ P02, P11. Note: Abortion is covered for women in all other eligibility categories. | Determine service type. If transport request is to any service other than abortion or infertility services, continue screening for NEMT.   |
| <b>EVS messages that require vendor to seek payment from other insurance</b>   |  |  |
| <i>Medicare is primary payer. Providers may not balance bill recipients.</i>   | Recipient is enrolled in Medicare and Medical Assistance.  | Screen the recipient for NEMT.<br><br>Vendor must seek payment for ambulance transports from Medicare.<br><br>Proof of denial of payment from Medicare must be submitted with invoice prior to payment.                        |
| <i>Recipient has other insurance- Policy number, name and phone number of insurance.<br/><br/>The insurance company listed should be billed prior to State Medicaid. For further information, call 410-767-1773.</i> | Recipients may have other insurance in addition to Medical Assistance.   | Screen the recipient for NEMT.<br><br>Vendor must seek payment for ambulance transports from recipient's other insurance company.<br><br>Proof of denial from other insurance must be submitted with invoice prior to payment. |
| <i>Recipient is Enrolled in Medicare Advantage Plan. Benefit payer is.....<br/><br/>HMO name and phone number</i>  | Recipient is enrolled in Medicare and Medical Assistance and has opted to enroll in a Medicare Advantage Plan (HMO).   | Screen the recipient for NEMT.<br><br>Vendor must seek payment for ambulance transports from recipient's Medicare Plan.<br><br>Proof of denial from Medicare must be submitted with invoice prior to payment.                  |

## Medical Assistance Transportation Manual

Topic: Denial Letters

Users: MDH Transportation Staff

Policy #: 10.09.19.06 DENI

Effective Date: 06-30-2017

### Denial of Transportation Services

As stated in COMAR 10.09.19.06, grantees must provide recipients a denial letter when they are not eligible for transportation services. Generally, this is determined once screening is completed and it has been deemed that the recipient is not eligible for transportation.

A denial letter must be sent out within 24 hours after denying transportation services. Please be sure to include in the letter the following: recipients name, medical assistance number, date of request, and, to what medical services.

Recipients can be denied transportation for the following reasons:

- Service requested not covered by Medicaid
- Recipient has access to other means of transportation
- Request for transportation is not 24 hours in advance for a routine service
- Not a Medicaid Provider
- Closer Provider available
- Other transportation resources available

Denial letters need not to be sent if:

- Transportation request less than 24 hours
- Recipient is not a Medicaid recipient

Denial letters MUST be accompanied by:

- LEP Taglines
- Fair Hearings Procedures
- Authorized Representative Form

# Medical Assistance Transportation Manual

Topic: Denial Letters

Users: MDH Transportation Staff

Policy #: 10.09.19.06 DENI

Effective Date: 06-30-2017

## AUTHORIZED REPRESENTATIVE FORM

**Section I: For Applicants/Recipients: If you want an Authorized Representative, complete questions 1-18.** Submit this form via mail to: Maryland Department of Health, Office of Health Services, Attention: Appeals, 201 West Preston Street, 1<sup>st</sup> Floor, Baltimore, MD 21201.

An Authorized Representative is someone who you choose to act on your behalf with the Maryland Department of Health, like a family member or other trusted person. Some Authorized Representatives may have legal authority to act on your behalf.

|   |           |                               |
|---|-----------|-------------------------------|
| 1. Name of Authorized Representative (First Name, Middle Name, Last Name)                 |           |                               |
| 2. Address  |           | 3. Apartment or Suite Number  |
| 4. City   | 5. State  | 6. ZIP Code                   |
| 7. Phone Number   |           |                               |
| 8. Organization Name (if applicable)  |           |                               |
| 9. Your Name  |           | 10. Your Phone Number         |
| 11. Your Address  |           | 12. Apartment or Suite Number |
| 13. City  | 14. State | 15. ZIP Code                  |
| By signing below, you allow the person named in question 1 to act for you on your behalf. |           |                               |
| 17. Your Signature  |           | 18. Date                      |

**Section II: For Legal Representatives of Applicant/Recipient:** If you are completing this form as the legal representative of the applicant/recipient: 1. Complete this section by placing an "X" in the appropriate box below; 2. Fill-out questions 9-15 above with the applicant's information; and 3. Submit proof (e.g. guardianship order or advance directive naming a health care agent) with this form.

A. Responsible Adult (Parent, guardian, healthcare surrogate, attorney, or other individual as defined in COMAR

10.01.04.12.)

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B. Applicant's Power of Attorney

## **Medical Assistance Transportation Manual**

**Topic: Denial Letters**

**Users: MDH Transportation Staff**

**Policy #: 10.09.19.06 DENI**

**Effective Date: 06-30-2017**

### **Summary of Procedures for Fair Hearings**

You have 90 calendar days from the date on your denial notice to appeal. If you have been receiving services, you may be able to maintain those services if you appeal within 10 days. Please refer to your denial letter for information.

If you appeal our decision, you will have a hearing. A hearing is a meeting between you, someone from Maryland Department of Health, and an independent hearing officer. You can talk to them about why you think we made a mistake. For the hearing:

- You may invite a friend, relative, witness or lawyer to the hearing if you want.
- You should bring any documents or information you need to help us understand your concerns.
- If you are continuing Medicaid benefits and are appealing a decision regarding Medicaid eligibility, you and your witness may be eligible to receive transportation services to the hearing. For information about how to request coverage of these expenses call your local health department. Attorneys' fees are not covered. You may also be eligible for child care services.
- You or your representative are entitled to examine your records to assist in your preparation for the hearing.

You are entitled to designate an individual or an attorney to represent you in the fair hearing process. You may use any written form or a letter to make such a designation. Enclosed with this notice for your convenience is an Authorized Representative Form you may use. You may not be represented by your paid personal assistance provider.

If the hearing officer agrees with the Department and you lose your appeal, you may be responsible for reimbursing the Department for the cost of benefits received while you waited for the hearing.

When filing your appeal, you should include the following:

- A copy of your denial letter.
- Specific reason(s) why you are appealing.
- A completed Authorized Representative Form (included with this summary), if you are designating a representative and your representative is filing the appeal.

You may also include in your appeal the following:

- A request for Department records or a witness list.

## **Medical Assistance Transportation Manual**

**Topic: Denial Letters**

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- Specific requests for your hearing. This may include the county in which you would like the hearing to take place, the day(s) of week and your time preference (morning or afternoon), and if you require transportation to and from the hearing. The Office of Administrative Hearings cannot guarantee all of your requests.

You must appeal in writing by fax to 410-333-5154 or by mail to:

Maryland Department of Health  
Office of Health Services  
Attention: Appeals  
201 W. Preston Street, 1st Floor  
Baltimore, Maryland 21201

After you submit your appeal, you will receive a notice providing the time and location of your hearing. You must be present at your hearing. If you cannot attend at the time your hearing is scheduled, you should call the phone number provided on the hearing notice to reschedule the hearing.

You can find the rules governing the fair hearing process in the Code of Maryland Regulations (COMAR), 10.01.04, 10.09.24.12, 10.09.24.13, and 10.09.24.15 and in the Code of Federal Regulations (C.F.R.), 42 C.F.R. § 431.200.

For free legal advice, please contact:

Legal Aid Bureau at 1-866-635-2948

Disability Rights Maryland at 1-800-233-7201

# **Médical Assistance Transportation Manual**

**Topic: 30 Day Courtesy Transportation**

**Users: MDH Transportation Staff**

**Policy #: 10.09.19.08.B(2) COUR**

**Effective Date: 06-30-2017**

## **Using Presumptive Eligibility to Grant Courtesy Transportation Background:**

When screening participants for qualification for the NEMT program, whether initially or at the prescribed intervals, there are times when the participants answers to screening questions do not fit neatly into the qualifications. Following are some examples:

- Previously undetected, screening uncovers ownership of a vehicle
- Participant has a new injury/illness affecting the ability to drive their vehicle, but has no documentation as of screening date
- Vehicle is damaged, or otherwise inoperable
- Previously undetected, screening uncovers active use/qualification for of public Paratransit
- Screening uncovers availability of Public Transportation
- Screening uncovers availability of additional transportation resources
- New participant does not have a Primary Care Physician of record or another acceptable professional to complete the Physician Certification Form (PCF)
- New participant has a vehicle upon MVA verification, and states they cannot drive due to injury/illness but currently has no documentation
- New participant reports prior use of paratransit but due to deteriorating condition or new diagnosis states they are no longer able to travel safely but does not have a PCF

**Historical Basis:** Temporary Eligibility and Presumptive Eligibility are two forms of coverage that allow for a period of coverage for Medicaid Applicants while determination is pending.

**Intention:** Using this same concept, the Department has directed the jurisdictions to provide a one-time, non-renewable 30 day period of courtesy transportation to participants who:

- Need to apply for Paratransit
- Need to attend physician appointments to obtain documentation (ex: PCF, temporary or permanent inability to drive)
- Needs to obtain mechanic/MVA verification of vehicle in-operability
- Need to establish relationship with physician

## **Implementation:**

- Screening and rescreening shall occur at the regularly scheduled/mandated intervals
- Written verification of the one-time, non-renewable courtesy transport shall be sent to the participant with:
  - Specific actions participant is to complete during the 30 day period to transition to a fully qualified NEMT participant
  - Date through which transportation will be granted
  - Forms which need to be completed should be included
  - Fair Hearing information to be included
  - Specific statement of non-renewable nature of courtesy transportation

## **Medical Assistance Transportation Manual**

**Topic: 30 Day Courtesy Transportation**

**Users: MDH Transportation Staff**

**Policy #: 10.09.19.08.B(2) COUR**

**Effective Date: 06-30-2017**

### **Follow-up and Denials:**

- At the end of the 30 day courtesy period, the next time the participant requests transportation, they are either qualified, or denied.
  - If qualified, a new member packet should be sent, and transportation should be scheduled.
  - If denied, send the normal denial letter with the basis on which they are denied. Be sure to include appeal rights etc.
- At the end of the 30 day courtesy period, the next time the participant requests transportation, the absence of the requested information is noted – rendering the participant not qualified.
  - Do not extend the courtesy transportation period.
  - Issue a denial letter for the requested date of service listing the reason for denial. Please remember to include all the standard COMAR language and attachments.

# Medical Assistance Transportation Manual

Topic: Timely Filing

Policy #: 10.09.19 PT 25-09

Users: MDH Transportation Staff

Effective Date: 01-21-2009



STATE OF MARYLAND

DHMH

PT 25-09

Office of Health Services  
Medical Care Programs

Maryland Department of Health and Mental Hygiene  
201 W. Preston Street • Baltimore, Maryland 21201

Martin O'Malley, Governor • Anthony G. Brown, Lt. Governor • John M. Colmers, Secretary

## MARYLAND MEDICAL ASSISTANCE PROGRAM

General Provider Transmittal No. 71

January 21, 2009

To: All Providers *Susan J. Tucker*  
From: Susan J. Tucker, Executive Director  
Office of Health Services

Note: Please ensure that the appropriate staff members in your organization are informed of the contents of this memo.

Re: Time Limit for Submitting Claims

.....  
The Maryland Medical Assistance Program has made changes to the regulation that specifies the time frame for submitting claims to the Fee-for-Service Program. Specifically, COMAR 10.09.36.06 has been changed to allow providers twelve (12) months to submit claims. The specific regulation is cited below or can be viewed at:  
<http://www.dsd.state.md.us/comar/10/10.09.36.06.htm>.

10.09.36.06

### .06 Billing Time Limitations.

Unless specified in Regulation .03A(1) of this chapter, the following apply:

A. The Department may not reimburse the claims received by the Program for payment more than 12 months after the date of service.

B. Medicare Claims. For any claim initially submitted to Medicare and for which services have been:

(1) Approved, requests for reimbursement shall be submitted and received by the Program within 12 months of the date of service or 120 days from the Medicare remittance date, as shown on the Explanation of Medicare Benefits, whichever is later; and

(2) Denied, requests for reimbursement shall be submitted and received by the Program within 12 months of the date of service or 120 days from the Medicare remittance date, as shown on the Explanation of Medicare Benefits, whichever is later.

Toll Free 1-877-4MD-DHMH • TTY for Disabled - Maryland Relay Service 1-800-735-2258  
Web Site: [www.dhmh.state.md.us](http://www.dhmh.state.md.us)

## **Medical Assistance Transportation Manual**

**Topic: Section 1557 Affordable Care Act – Limited English Proficiency**

**Users: MDH Transportation Staff**

**Policy #: 10.09.19 ACA1557 LEP**

**Effective Date: 6-30-2017**

Per Maryland Department of Health MDH Policy 01.02.05, regarding Limited English Proficiency, When screening and engaging in any communication, written or verbal, Grantees must ensure that Limited English Proficiency (LEP) persons have meaningful and equal access to benefits and services in accordance with Section 1557 of the Affordable Care Act.

All communications to participants originating from the NEMT programs shall have LEP Tag Lines included. Each county provides telephonic interpretation for their Health Department; this service must be offered when necessary for interpretation services to participants.

See Appendix for [Section 1557 Notice Posting Requirement Guidance](#)

# Medical Assistance Transportation Manual

Topic: Vendor Monitoring Criteria

Users: MDH Transportation Staff

Policy#: 10.09.19 42CFR440.170(a)(4)(i) VEND

Effective Date: 10-05-2015

## CONTRACTOR MONITORING CRITERIA

Vendor Monitoring Reports are due to MDH yearly on January 15<sup>th</sup> for EACH of your vendors.

| Trans. Grant Manager Initial & Date | Title                            | Standard   |
|-------------------------------------|----------------------------------|--|
|                                     | Licensure and Compliance         | The contractor must have and provide copies of all current licenses required by federal or State laws.   |
|                                     | Organizational Structure         | The organization must have and provide a copy of their internal structure.   |
|                                     | Insurance                        | The organization must have and provide evidence of adequate insurance.   |
|                                     | Policies and Procedures          | The organization must have and maintain written policies and procedures. These should describe all aspects of the operations and address all operational requirements by state or federal law. |
|                                     | Backup Services Plan             | The organization must have and maintain Backup Services Plans for addressing vehicle malfunctions or communication outages.  |
|                                     | Complaint Tracking and Reporting | The organization must have and maintain a system to track and report complaints to the Grant Manager.  |
|                                     | Incident Reporting               | The organization must have and maintain a method of reporting incidents inclusive of accident reporting.   |
|                                     | Employee Substance Screening     | The organization must have and maintain current copies of employee substance abuse screening as required by law for all personnel providing patient services                                   |

## Medical Assistance Transportation Manual

Topic: Vendor Monitoring Criteria

Users: MDH Transportation Staff

Policy#: 10.09.19 42CFR440.170(a)(4)(i) VEND

Effective Date: 10-05-2015

| Trans. Grant Manager Initial & Date | Title                                       | Standard  |
|-------------------------------------|---|---|
|                                     | Driver's DMV and Criminal Background Checks | The organization must have on file Driver DMV and Criminal Background checks for all personnel providing patient services with routine rechecks at least annually.                      |
|                                     | Debarment                                   | The provider and their employees must not be on any applicable state or federal debarment list.   |
|                                     | Driver Training                             | The organization must have and maintain a driver training program that addresses utilization of safety restraints, non-smoking, safe driving, defensive driving and patient assistance. |
|                                     | Dispatcher Training                         | The organization must have a dispatcher training program and written procedures must exist.   |
|                                     | Vehicle Maintenance                         | The organization must have a documented vehicle cleaning and preventive maintenance program.  |
|                                     | Service Request                             | The organization must have the ability to document and maintain forms on all service requests.  |
|                                     | Response Time Reports                       | The organization must have the ability to track and report on actual response times.  |

After a review and inspection of all applicable documents and records, I attest that \_\_\_\_\_ has met the above requirements.

\_\_\_\_\_  
Transportation Grant Manager

\_\_\_\_\_  
Date

## **Medical Assistance Transportation**

**Manual Topic: Notice of Vendor Deficiency or Corrective Action**

**Users: MDH Transportation Staff**

**Policy #: 10.09.19 42CFR440.170(a)(4)(i)(C) VEND**

**Effective Date: 5-4-2017**

Written notification must be made to the Department within 24 hours of the vendor issues, including but not limited to:

- Grantee is informed of a Vendor issue.
- Vendor is notified of an operational deficiency, sanction, suspension, non-performance, or contract violation.
- Vendor is notified of an employee complaint or deficiency related to sexual harassment, inappropriate conduct, unsafe practices, or discrimination.
- Abandoning or stranding participants.
- Up-coding or questionable billing practices.

Within five (5) business days, there must be formal written documentation to the Department that includes:

- Name of vendor and vendor contact
- Date and time situation occurred
- How grantee became aware of the situation
- Type of notification to the vendor, including date and time of notification.
- Actions taken by the vendor
- Corrective action plan
- Copies of any documentation and correspondence related to the complaint or issue
  - Intake of complaint/situation
  - Grantee action
  - Notifications made to the vendor
  - Notifications to employees (if applicable)
- Summary and outcome

# Addendum

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## Memos



MEDICAL CARE POLICY ADMINISTRATION  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
201 WEST PRESTON STREET • BALTIMORE, MARYLAND 21201

Parris N. Glendening  
Governor

Martin P. Wasserman, M.D., J.D.  
Secretary

## Memorandum

To: Transportation Grants Coordinators

From: James G. Glover, Chief  
Division of Grants, Regulations, and Transportation

Date: October 9, 1998

Subject: Records Retention

\*\*\*\*\*

The State or federal government (or their agent) will periodically audit any operation which receives federal funding (directly or via a pass-through process). As you know, any Medicaid program, such as the Transportation Grants program, must retain their records for a minimum of six (6) years and make them readily accessible to this Department or our designee. This stipulation should be kept in mind at all times, and each contractor should be made well aware of this requirement, as it also pertains to them. To this end, it may be advisable to require a signature on a brief form to document the contractor's understanding of this principle.

If you have questions or comments regarding this issue, please contact me at (410) 767-1475. Thanks!



STATE OF MARYLAND

DHMH


Maryland Department of Health and Mental Hygiene

201 W. Preston Street • Baltimore, Maryland 21201

Martin O'Malley, Governor – Anthony G. Brown, Lt. Governor – Joshua M. Sharfstein, M.D., Secretary

MEMORANDUM

TO: Transportation Grants Managers

FROM: Simone Cook   
Division of Community Support Services

RE: Change in Screening Policy and Implementation of Tracking System

DATE: October 9, 2014

\*\*\*\*\*

Effective October 1, 2014, Transportation Grantees (grantees) are no longer required to screen HealthChoice recipients to determine if their request for transportation is to the nearest and closest provider. The grantees will authorize all eligible requests for transportation to Medicaid covered services within the recipient's MCO network without regard to time or distance criteria.

The grantee will however continue to screen HealthChoice recipients' requests for transportation per COMAR 10.09.19.04B. Screening criteria includes, but is not limited to, confirmation of Medical Assistance eligibility and availability of other means of transportation. The grantee will continue to screen recipients who are fee-for-service and not enrolled in an MCO and will continue limiting transportation to the nearest appropriate provider.

The Program is also implementing a transportation tracking system. Grantees are required to record and report to the Transportation Unit on a weekly basis, MCO transports that are 20 miles or greater from the HealthChoice recipients' residence. Facility discharges will not be tracked at this time and should not be reported. This information will be used to identify potential MCO network issues and to better assess the overall transportation needs of the Medicaid population.

Grantees must use the attached MCO Tracking Data Worksheet to record and report this information. The worksheet must be electronically submitted to [dhmh.nemt@maryland.gov](mailto:dhmh.nemt@maryland.gov) every Monday. An electronic version of the worksheet and instructions is located on <http://nmcp.dhmh.maryland.gov/communitysupport/SitePages/Home.aspx> under Community Support Services Provider Information. If you have any questions, please contact the Transportation Department at 410-767-7283 or [dhmh.nemt@maryland.gov](mailto:dhmh.nemt@maryland.gov).

cc: Health Officers

Attachment: Transportation Data Worksheet  
Transportation Worksheet Instructions

**Transportation Grant  
Transportation Tracking Form**

**Instructions for Completing MCO Transport Tracking Form**

- 1. MEDICAID RECIPIENT NUMBER and NAME**
  - a. Enter the MA recipient's number in the MA Recipient Number field.
  - b. Enter the last name of the MA recipient in the MA Recipient Last Name field.
  - c. Enter the first name of the MA recipient in the MA Recipient First Name field.
- 2. HEALTHCHOICE MANAGED CARE ORGANIZATION**
  - a. Determine the HealthChoice MCO that the MA recipient is enrolled.
  - b. Click on the drop down box under the MCO field.
  - c. Scroll through the list.
    - i. AMERIGROUP
    - ii. JAI Medical Systems
    - iii. Kaiser Permanente
    - iv. Maryland Physician Care
    - v. MedStar Family Choice
    - vi. Priority Partners
    - vii. Riverside Health of Maryland
    - viii. UnitedHealthcare
  - d. Click on the MCO that the MA recipient is enrolled.
- 3. DATE of SERVICE**

Enter the date of transport service.
- 4. PROVIDER TYPE**
  - a. Click on the drop down box under Provider Type.
  - b. Scroll through the five (5) Provider Types and click on the appropriate Provider Type.
    - i. Primary Care
    - ii. Pharmacy
    - iii. OB/GYN
    - iv. Diagnostic laboratory and X-ray
    - v. Specialty
- 5. PROVIDER SERVICE TYPE**
  - a. Click on the drop down box under Provider Service Type.
  - b. Scroll through the list of Primary Care Physician and Specialty service types. (PCP means Primary Care. SP means Specialty Provider)
    - i. PCP-General Practitioner
    - ii. PCP-Family Practitioner
    - iii. PCP-Internist
    - iv. PCP-Pediatrician
    - v. PCP-OB/GYN
    - vi. PCP-Certified Nurse Midwife
    - vii. PCP-Nurse Practitioner (Adult)
    - viii. PCP-Nurse Practitioner (Pediatric)
    - ix. PCP-Nurse Practitioner (Geriatric)
    - x. PCP-Nurse Practitioner (OB/GYN)
    - xi. PCP-Nurse Practitioner (School Nurse)
    - xii. PCP-Nurse Practitioner (Family)
    - xiii. SP-Allergy

- xiv. SP-Dermatology
- xv. SP-Endocrinology
- xvi. SP-Infectious Disease
- xvii. SP-Nephrology
- xviii. SP-Pulmonology
- xix. SP(c)-Cardiology
- xx. SP(c)-Gastroenterology
- xxi. SP(c)-Neurology
- xxii. SP(c)-Ophthalmology
- xxiii. SP(c)-Orthopedics
- xxiv. SP(c)-Otolaryngology (ENT)
- xxv. SP(c)-Surgery
- xxvi. Other

c. Click on the appropriate Primary Care or Specialty Service type of the provider.

**6. MODE of TRANSPORT**

a. Click on the drop down box under Mode of Transport.

b. Scroll through the Modes of Transport and click on the appropriate transport mode.

- i. Ambulance - ALS
- ii. Ambulance - BLS
- iii. Ambulance - Neonatal Transport
- iv. Ambulance - Specialty Care
- v. Bus Passes
- vi. Gasoline Vouchers
- vii. Other Ambulatory
- viii. Taxicab/Sedan
- ix. Wheelchair Van

**7. MILEAGE**

Using MAPQUEST, GOOGLE Maps, or another appropriate mapping system, enter in miles the distance between the MA recipient's address and the provider/facility location.





STATE OF MARYLAND

DHMH


Maryland Department of Health and Mental Hygiene

201 W. Preston Street • Baltimore, Maryland 21201

Martin O'Malley, Governor – Anthony G. Brown, Lt. Governor – Joshua M. Sharfstein, M.D., Secretary

**MEMORANDUM**

**TO:** Transportation Grants Managers  
Hospitals  
Nursing Homes

**FROM:** Simone Cook, Chief   
Division of Community Support Services

**DATE:** October 9, 2014

**RE:** Transport Contacts for Non Emergency Medical Transportation (NEMT) Program  
\*\*\*\*\*

The purpose of this memorandum is to clarify and update the contact information regarding transport of NEMT Medicaid recipients located in a facility outside of their county of residence.

Grantees have questioned who is responsible for the transport of a Medicaid recipient that is located at a facility outside of the recipient's county of residence. It is the responsibility of the transportation grantee of the county in which the facility is located to transport the recipient. The transportation grantee, facility, and contracted provider will follow the normal transportation procedures for that county to facilitate transportation. Normal procedures include screening and verification of covered services. Hospitals and nursing homes needing to access NEMT services after normal business hours may use the attached list of contacts. Please note the difference in hours of availability to call the grantee or the contracted vendor.

If you have any questions, please contact the Transportation Department at 410-767-7283 or [dlmh.nemt@maryland.gov](mailto:dlmh.nemt@maryland.gov).

cc: Health Officers

Attachment



## **Section 1557 Notice Posting Requirement Guidance**

Section 1557 of the Affordable Care Act (42 U.S.C. 18116) requires that covered entities post, in a conspicuously visible font size, a non-discrimination statement, language accessibility statement, grievance procedure and taglines advising that language assistance is available, at no cost, in at least the **top 15** languages spoken by individuals with limited English proficiency of the relevant State (Maryland). The non-discrimination statement and taglines must be posted in:

- 1.) Significant publications and significant communications targeted to beneficiaries, enrollees, applicants, and members of the public;
- 2.) In conspicuous physical locations where the agency interacts with the public;
- 3.) On the agency website, accessible from the homepage.

Section 1557 also allots for *small-sized* significant publications and communications (e.g. postcards and tri-fold brochures) to cite only the non-discrimination statement and taglines in the **top 2** languages spoken by individuals with limited English proficiency in Maryland.

Section 1557 allows covered entities to exhaust current stock of hard copy publications first rather than requiring a special printing of publications to include the new notice requirement.

Section 1557 does not define "significant publications and significant communications" and interprets this term broadly. The regulation does indicate that the term applies to both correspondence intended for the public at large such as outreach, education and marketing materials, as well as letters addressed to individuals that notify them of vital information or require a response from the individual.

Section 1557 encourages that the required posting and taglines are placed at the beginning of significant publications and communications but does not require it. The regulation acknowledges that placing the posting elsewhere within the publication/communication, including as a separate insert accompanying the English language significant document may be adequate.

The Equal Access Compliance Unit (EACU), Office of Equal Opportunity Programs (OEOP), Department of Health and Mental Hygiene (DHMH), is tasked with ensuring compliance with Section 1557. Delinda Johnson, Equal Access Compliance Manager is designated as the Section 1557 Coordinator for DHMH. Ms. Johnson may be reached at 410-767-5184 or via email at [Delinda.Johnson@maryland.gov](mailto:Delinda.Johnson@maryland.gov) to provide technical assistance regarding Section 1557.

To ensure compliance with Section 1557, all DHMH programs, services and local health departments, must perform the following:

1. If not already posted in a conspicuous physical location, post the *DHMH Notice to the Public: Non-Discrimination Policy Statement and Complaint Procedure* poster.
2. Using the enclosed templates titled *DHMH Notice to the Public: Non-Discrimination Notice and Accessibility Requirement* and *DHMH Notice to the Public: Section 1557 Non-Discrimination Notice and Grievance Procedure*, fill in the applicable main contact number and TTY number for **your program** under the Language Accessibility Statement (15 taglines) for both forms. Save both documents.



## **Section 1557 Notice Posting Requirement Guidance**

(Note: the telephone numbers you list must connect the public with appropriate staff within your entity who understands their requirement to provide meaningful language access or auxiliary aids, will connect the public to appropriately trained bilingual staff and/or is aware of how to utilize the interpretation, translation and visual communications services provided by the State of Maryland. This contact number should not be the DHMH main telephone number if your program has a different main telephone number that is published. This telephone number must also not be the number to EACU, OEOP. Providing an inaccurate or different telephone number than the general public utilizes to communicate with your program causes unnecessary delays in services and may also be viewed as differential treatment.)

3. Include the saved content from the *DHMH Notice to the Public: Non-Discrimination Notice and Accessibility Requirement* template referenced in Step 2 in all publications and communications deemed significant. For small-sized publications and communications, your program may elect to use the enclosed template titled *DHMH Non-Discrimination Statement and Taglines for Small-Sized Significant Publications and Communications*. However, the same aforementioned rules noted in Step 2 apply – your entity’s main contact number and TTY numbers must be typed into the template. Save this document.
4. Post the two saved documents cited in Step 2 on your program’s website **and** in conspicuous locations where the program interacts with the public. Include a link on your homepage to the documents. This is imperative as it provides your program’s contact number to receive services, including language access.
5. Provide electronic copies of the three saved documents for your program referenced in Steps 2 and 3 to Delinda Johnson, Equal Access Compliance Manager at [Delinda.Johnson@maryland.gov](mailto:Delinda.Johnson@maryland.gov) or Tina Smith, Equal Opportunity Compliance Officer at [Tina.Smith1@maryland.gov](mailto:Tina.Smith1@maryland.gov).
6. Post the *LanguageLine Solutions Language Identification poster* (a.k.a., 1-Speak Card) and/or the *LanguageLine Solutions brochure* in all reception areas and other applicable locations where staff interacts with the public. You may receive a copy of these documents by contacting LanguageLine Solutions directly at 1-800-752-6096, Option 2. You will need to provide your program’s Client ID to the LanguageLine Solutions representative.
7. Review and keep handy the *DHMH Interpretation, Translation and Visual Communications Services Packet*. This packet provides instructions on how to obtain oral interpretations, written document translations for limited English proficient constituents and visual communication services for individuals with disabilities.

EACU is currently working on developing a new poster that encompasses Section 1557 requirements along with other Federal and State regulations that fall within this unit’s purview. In addition, EACU is working to develop training that will assist DHMH staff to enrich their knowledge of Section 1557. Look for more information to follow as these projects progress.

More information on Section 1557 of the Affordable Care Act may be accessed at <http://www.hhs.gov/civil-rights/for-individuals/section-1557/>.

## **NOTICE TO THE PUBLIC**

### **NON-DISCRIMINATION STATEMENT AND ACCESSIBILITY REQUIREMENTS**

The Department of Health and Mental Hygiene (the Department) complies with applicable Federal civil rights laws and does not discriminate, exclude people, or treat them differently on the basis of race, color, national origin, age, disability, or sex.

The Department, upon request:

- Provides free aids and services to people with disabilities to communicate effectively with Department staff, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, please contact the Department's health program, service, local health department or health insurance marketplace directly

If you believe that the Department has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Delinda Johnson, Equal Access Compliance Unit, Office of Equal Opportunity Programs, Maryland Department of Health and Mental Hygiene, 201 West Preston Street, Room 514, Baltimore, Maryland 21201, 410-767-6600 (voice), 1-800-735-2258 (TTY), (410) 333-5337 (Fax), [delinda.johnson@maryland.gov](mailto:delinda.johnson@maryland.gov) (email).

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Delinda Johnson is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-868-1019, 800-537-7697 (TDD).

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

TEMPLATE FOR WEBSITES AND PHYSICAL LOCATIONS – GRIEVANCE PROCEDURE  
NOT REQUIRED TO BE POSTED IN PUBLICATIONS AND COMMUNICATIONS IF NOTICE  
AND TAGLINES ARE POSTED

**NOTICE TO THE PUBLIC**  
**SECTION 1557 NON-DISCRIMINATION STATEMENT**  
**AND GRIEVANCE PROCEDURE**

It is the policy of the Department of Health and Mental Hygiene (the Department) not to discriminate on the basis of race, color, national origin, sex, age or disability. The Department has adopted an internal grievance procedure providing for prompt and equitable resolution of complaints alleging any action prohibited by Section 1557 of the Affordable Care Act (42 U.S.C. 18116) and its implementing regulations at 45 CFR part 92, issued by the U.S. Department of Health and Human Services. Section 1557 prohibits discrimination on the basis of race, color, national origin, sex, age or disability in certain health programs and activities. Section 1557 and its implementing regulations may be examined in the office of Delinda Johnson, Equal Access Compliance Manager, Equal Access Compliance Unit, Office of Equal Opportunity Programs, Maryland Department of Health and Mental Hygiene, 201 West Preston Street, Room 514, Baltimore, Maryland 21201, [410-767-6600](tel:4107676600) (voice), [1-800-735-2258](tel:18007352258) (TTY), (410) 333-5337 (Fax), [delinda.johnson@maryland.gov](mailto:delinda.johnson@maryland.gov) (email), who has been designated to coordinate the efforts of the Department to comply with Section 1557.

Any person who believes someone has been subjected to discrimination on the basis of race, color, national origin, sex, age or disability may file a grievance under this procedure. It is against the law for the Department to retaliate against anyone who opposes discrimination, files a grievance, or participates in the investigation of a grievance.

Procedure:

- Grievances must be submitted to the Section 1557 Coordinator within (60 days) of the date the person filing the grievance becomes aware of the alleged discriminatory action.
- A complaint must be in writing, containing the name and address of the person filing it. The complaint must state the problem or action alleged to be discriminatory and the remedy or relief sought.
- The Section 1557 Coordinator (or her/his designee) shall conduct an investigation of the complaint. This investigation may be informal, but it will be thorough, affording all interested persons an opportunity to submit evidence relevant to the complaint. The Section 1557 Coordinator will maintain the files and records of the Department relating to such grievances. To the extent possible, and in accordance with applicable law, the Section 1557 Coordinator will take appropriate steps to preserve the confidentiality of files and records relating to grievances and will share them only with those who have a need to know.
- The Section 1557 Coordinator will issue a written decision on the grievance, based on a preponderance of the evidence, no later than 30 days after its filing, including a notice to the complainant of their right to pursue further administrative or legal remedies.

The availability and use of this grievance procedure does not prevent a person from pursuing other legal or administrative remedies, including filing a complaint of discrimination on the basis of race, color, national origin, sex, age or disability in court or with the U.S. Department of Health and Human Services, Office for Civil Rights. A person can file a complaint of discrimination electronically through the Office for Civil Rights Complaint Portal, which is available at: <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf> or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201.

Complaint forms are available at: <http://www.hhs.gov/ocr/office/file/index.html>. Such complaints must be filed within 180 days of the date of the alleged discrimination.

The Department will make appropriate arrangements to ensure that individuals with disabilities and individuals with limited English proficiency are provided auxiliary aids and services or language assistance services, respectively, if needed to participate in this grievance process. Such arrangements may include, but are not limited to, providing qualified interpreters, or assuring a barrier-free location for the proceedings. If you need these services, please contact the Department's health program, service, local health department or health insurance marketplace directly. The Section 1557 Coordinator will ensure that the Department provides such services free and upon request in accordance with applicable policies and regulations.

TEMPLATE FOR TAGLINE REQUIREMENT – NECESSARY ON WEBSITES, FULL-SIZED PUBLICATIONS AND COMMUNICATIONS AND PHYSICAL LOCATIONS

**Language Accessibility Statement**

**Interpreter Services Are Available for Free**

*Help is available in your language: 1-800-000-0000 (TTY: 1-800-000-0000).  
These services are available for free.*

**Español/Spanish**

Hay ayuda disponible en su idioma: 1-800-000-0000 (TTY: 1-800-000-0000). Estos servicios están disponibles gratis.

**አማርኛ/Amharic**

እነዚህ አገልግሎቶች ያለክፍያ የሚገኙ ነጻ ናቸው። 1-800-000-0000 (TTY: 1-800-000-0000) ።

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**العربية/Arabic**

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Effective Date: NA

Related CR Transmittal #: NA

Implementation Date: NA

## Skilled Nursing Facility Consolidated Billing As It Relates to Ambulance Services

**Note:** This article was revised on November 14, 2013, to add clarifying language regarding "Transfers between Two SNFs" on page 4. All other information is unchanged.

### Provider Types Affected

Skilled Nursing Facilities (SNFs), physicians, ambulance suppliers, and providers submitting claims to Medicare Administrative Contractors (MACs) should review this article.

### Provider Action Needed

This Special Edition article describes SNF Consolidated Billing (CB) as it applies to ambulance services for SNF residents.

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**Clarification:** The SNF CB requirement makes the SNF responsible for including on the Part A bill that it submits to its MAC almost all of the services that a resident receives during the course of a Medicare-covered stay, except for a small number of services that are specifically excluded from this provision. These “excluded” services can be separately furnished to the resident and billed under Medicare Part B by a variety of outside sources. These sources can include other providers of service (such as hospitals), which would submit the bill for Part B services to their MAC, as well as practitioners and suppliers who would generally submit their bills to a MAC. (Bills for certain types of items or equipment would be submitted by the supplier to their DME MAC.

## Background

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When the SNF Prospective Payment System (PPS) was introduced in 1998, it changed not only the way SNFs are paid but also the way SNFs must work with suppliers, physicians, and other practitioners. CB assigns the SNF the Medicare billing responsibility for virtually all of the services that the SNF residents receive during the course of a covered Part A stay. Payment for this full range of service is included in the SNF PPS global per diem rate.

The only exceptions are those services that are specifically excluded from this provision, which remain separately billable to Medicare Part B by the entity that actually furnished the service. See MLN Matters® Article SE0431 for a detailed overview of SNF CB, including a section on services excluded from SNF CB. This instruction can be found at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE0431.pdf> on the Centers for Medicare & Medicaid Services (CMS) website.

Ambulance services have not been identified as a type of service that is categorically excluded from the CB provisions. However, certain types of ambulance transportation have been identified as being separately billable in specific situations ( i.e. based on the reason the ambulance service is needed). This policy is comparable to the one governing ambulance services furnished in the inpatient hospital setting, which has been subject to a similar comprehensive Medicare billing or “bundling” requirement since 1983. Since the law describes CB in terms of services that are furnished to a “resident” of a SNF, the initial ambulance trip that brings a beneficiary to a SNF is not subject to CB, as the beneficiary has not yet been admitted to the SNF as a resident at that point.

Similarly, an ambulance trip that conveys a beneficiary from the SNF at the end of a stay is not subject to CB when it occurs in connection with one of the events specified in regulations at 42 CFR 411.15(p)(3)(i)-(iv) as ending the beneficiary’s SNF “resident” status. The events are as follows:

- A trip for an inpatient admission to a Medicare-participating hospital or critical access hospital (CAH) (See discussion below regarding an ambulance trip made for the purpose of transferring a beneficiary from the discharging SNF to an inpatient admission at another SNF.);
- A trip to the beneficiary’s home to receive services from a Medicare-participating home health agency under a plan of care;

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- A trip to a Medicare-participating hospital or CAH for the specific purpose of receiving emergency services or certain other intensive outpatient services that are not included in the SNF's comprehensive care plan (see further explanation below); or
- A formal discharge (or other departure) from the SNF that is not followed by readmission to that or another SNF by midnight of that same day.

### *Ambulance Trips to Receive Excluded Outpatient Hospital Services*

The regulations specify the receipt of certain exceptionally intensive or emergency services furnished during an outpatient visit to a hospital as one circumstance that ends a beneficiary's status as an SNF resident for CB purposes. Such outpatient hospital services are, themselves, excluded from the CB requirement, on the basis that they are well beyond the typical scope of the SNF care plan.

Currently, only those categories of outpatient hospital services that are specifically identified in Program Memorandum (PM) No. A-98-37, November 1998 (reissued as PM No. A-00-01, January 2000) are excluded from CB on this basis. These services are the following:

- Cardiac catheterization;
- Computerized Axial Tomography Imaging (CT) scans;
- Magnetic Resonance Imaging (MRI) services;
- Ambulatory surgery involving the use of an operating room (the ambulatory surgical exclusion includes the insertion of percutaneous esophageal gastrostomy (PEG) tubes in a gastrointestinal or endoscopy suite);
- Emergency room services;
- Radiation therapy;
- Angiography; and
- Lymphatic and venous procedures.

Since a beneficiary's departure from the SNF to receive one of these excluded types of outpatient hospital services is considered to end the beneficiary's status as an SNF resident for CB purposes with respect to those services, any associated ambulance trips are, themselves, excluded from CB as well. Therefore, an ambulance trip from the SNF to the hospital for the receipt of such services should be billed separately under Part B by the outside supplier. Moreover, once the beneficiary's SNF resident status has ended in this situation, it does not resume until the point at which the beneficiary actually arrives back at the SNF; accordingly, the return ambulance trip from the hospital to the SNF would also be excluded from CB.

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### *Other Ambulance Trips*

By contrast, when a beneficiary leaves the SNF to receive offsite services other than the excluded types of outpatient hospital services described above and then returns to the SNF, he or she retains the status of a SNF resident with respect to the services furnished during the absence from the SNF. Accordingly, ambulance services furnished in connection with such an outpatient visit would remain subject to CB, even if the purpose of the trip is to receive a particular type of service (such as a physician service) that is, itself, categorically excluded from the CB requirement.

However, effective April 1, 2000, the Balanced Budget Refinement Act of 1999 (BBRA 1999, Section 103) excluded from SNF CB those ambulance services that are necessary to transport an SNF resident offsite to receive Part B dialysis services (Social Security Act, Section 1888(e)(2)(A)(iii)(I)).

### *Transfers Between Two SNFs*

When an individual leaves a SNF via ambulance and does not return to that or another SNF by midnight, the day is not a covered Part A day and, accordingly, CB would not apply. However, a beneficiary's departure from an SNF is not considered to be a "final" departure for CB purposes if he or she is readmitted to that or another SNF by midnight of the same day (see 42 CFR 411.15(p)(3)(iv)). Therefore, when a beneficiary travels directly from SNF 1 and is admitted to SNF 2 by midnight of the same day, that day is a covered Part A day for the beneficiary, to which CB applies. Accordingly, a medically necessary ambulance trip that conveys the beneficiary would be bundled back to SNF 1 since, under 42 CFR 411.15(p)(3), the beneficiary would continue to be considered a resident of SNF 1 (for CB purposes) up until the actual point of admission to SNF 2.

However, it should be noted that in addition to the "medical necessity" criterion in the regulations at 42 CFR 409.27(c) pertaining specifically to ambulance transports under the SNF benefit (i.e., the patient's medical condition is such that transportation by any means other than ambulance would be contraindicated), coverage in this context also involves the underlying requirement of being reasonable and necessary for diagnosing or treating the patient's condition. For example, a transfer between two SNFs would be considered reasonable and necessary in a situation where needed care is unavailable at the originating SNF, thus necessitating a transfer to the receiving SNF in order to obtain that care. By contrast, an SNF-to-SNF transfer that is prompted by non-medical considerations (such as a patient's personal preference to be placed in the receiving SNF) is not considered reasonable and necessary for diagnosing or treating the patient's condition and, thus, would not be bundled back to the originating SNF.

### *Roundtrip to a Physician's Office*

If a SNF's Part A resident requires transportation to a physician's office and meets the general medical necessity requirement for transport by ambulance (i.e., using any other means of transport would be medically contraindicated) (see 42 CFR 409.27(c)), then the ambulance roundtrip is the responsibility of the SNF and is included in the PPS rate. The preamble to the July 30, 1999 final rule (64 Federal Register 41674-75) clarifies that the scope of the required service bundle furnished to Part A SNF residents under the PPS specifically encompasses coverage of transportation via ambulance

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under the conditions described above, rather than more general coverage of other forms of transportation.

**NOTE:** Confusion sometimes arises over the issue of an ambulance roundtrip that transports an SNF resident to the physician's office, as the separate Part B ambulance benefit does not normally cover transportation to this particular setting. However, the regulations at 42 CFR 409.27(c), which describe the Part A SNF benefit's scope of coverage for ambulance transportation, incorporate by reference *only* the Part B ambulance benefit's *general medical necessity* requirement at 42 CFR 410.40(d)(1) (i.e., that transportation by any other means would be medically contraindicated), and *not* any of the more detailed coverage restrictions that apply under the separate Part B benefit, such as the limitation of coverage to only certain specified destinations (42 CFR 410.40(e)). Thus, if an SNF's Part A resident requires transportation to a physician's office and meets the general medical necessity requirement for transport by ambulance, that ambulance roundtrip would be the responsibility of the SNF.

### ***Noncoverage of Transportation by Any Means Other Than Ambulance***

In contrast to the ambulance coverage described previously, Medicare simply does not provide any coverage at all under Part A or Part B for any *non-ambulance* forms of transportation, such as ambulette, wheelchair van, or litter van. Further, as noted in the preceding section, in order for the Part A SNF benefit to cover transportation via ambulance, the regulations at 42 CFR 409.27(c) specify that the ambulance transportation must be *medically necessary*--that is, that the patient's condition is such that transportation by any other means would be medically contraindicated.

This means that in a situation where it is medically feasible to transport an SNF resident by means other than an ambulance--for example, via wheelchair van--the wheelchair van would not be covered (because Medicare does not cover any non-ambulance forms of transportation), and an ambulance *also* would not be covered (because the use of an ambulance in such a situation would not be medically necessary). As with any noncovered service for which a resident may be financially liable, the SNF must provide appropriate notification to the resident under the regulations at 42 CFR 483.10(b)(6), which require Medicare-participating SNFs to ". . . inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate."

### **Additional Information**

See MLN Matters® Special Edition SE0431 for a detailed overview of SNF CB. This article lists services excluded from SNF CB and can be found at <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE0431.pdf> on the CMS website.

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The CMS MLN CB website is at <http://www.cms.gov/Medicare/Billing/SNFConsolidatedBilling/index.html> on the CMS website.

It includes the following relevant information:

- General SNF CB information;
- HCPCS codes that can be separately paid by the MAC (i.e., services not included in CB);
- Therapy codes that must be consolidated in a non-covered stay; and
- All code lists that are subject to quarterly and annual updates and should be reviewed periodically for the latest revisions.

The SNF PPS CB website is available at <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPSP/index.html> on the CMS website.

It includes the following relevant information:

- Background;
- Historical questions and answers;
- Links to related articles; and
- Links to publications (including transmittals and Federal Register notices).

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# **Title 10 DEPARTMENT OF HEALTH AND MENTAL HYGIENE**

## **Subtitle 09 MEDICAL CARE PROGRAMS**

### **Chapter 19 Transportation Grants**

**Authority: Health-General Article, §§2-104(b), 15-103, and 15-105, Annotated Code of Maryland**

#### **.01 Scope.**

These regulations govern the administration of grants to counties, municipal corporations, and nonprofit organizations for the provision of safety-net transportation services to Medical Assistance Program recipients. The grant funds are to be used by grantees to:

- A. Screen requests for transportation by recipients;
- B. Arrange for transportation;
- C. Expand existing and develop new transportation resources; and
- D. Provide transportation services where no other transportation is available to the recipient.

#### **.02 Definitions.**

A. In this chapter, the following terms have the meanings indicated.

B. Terms Defined.

(1) "Ambulance" means a specially designed vehicle used for transporting the sick or injured, which has necessary patient care equipment including a stretcher, clean linens, first aid supplies, oxygen equipment, and, in addition, other safety and lifesaving equipment which may be required by State or local laws to classify the vehicle as an ambulance.

(2) "Attendant" means an individual needed to accompany a recipient who is unable to travel alone.

(3) "Department" has the meaning stated in COMAR 10.09.36.01.

(4) "Emergency" means a situation requiring prompt diagnosis and treatment of conditions having the potential of causing imminent disability or death.

(5) "Emergency services" means services provided in hospital emergency facilities after the onset of a medical condition manifesting itself by symptoms of sufficient severity that the absence of immediate medical attention

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could reasonably be expected by a prudent layperson, possessing an average knowledge of health and medicine, to result in:

- (a) Placing health in jeopardy;
  - (b) Serious impairment to bodily functions;
  - (c) Serious dysfunction of any bodily organ or part; or
  - (d) Development or continuance of severe pain.
- (6) "Grantee" means a recipient of grant funds from the Department pursuant to this chapter.
- (7) "Medical Assistance Program" means a program of comprehensive medical and other health-related care for indigent and medically indigent individuals.
- (8) "Medicare" has the meaning stated in COMAR 10.09.36.01.
- (9) "Necessary" has the meaning stated in COMAR 10.09.36.01.
- (10) "Nonambulatory" means a condition which renders a recipient physically unable to use a bus, taxicab, or private automobile in going to or from a hospital to receive needed medical treatment.
- (11) "Program" has the meaning stated in COMAR 10.09.36.01.
- (12) "Recipient" means an individual who is certified as eligible for, and is receiving, Medical Assistance benefits.
- (13) "Wheelchair van" means a van equipped with either a lift tailgate or side lift which is used for loading patients who are nonambulatory but who do not require the use of equipment found in an ambulance.

**.03 Procedure for Submission of Proposals.**

A. The Secretary shall request proposals for the award of transportation grants.

B. An applicant shall include in the applicant's proposal a description of how the applicant intends to carry out the duties required by these regulations. At a minimum, the applicant shall include the following items in the proposal:

- (1) The criteria which the applicant will use to determine the recipient's need for transportation services;
- (2) A discussion of how the applicant will arrange and provide transportation;
- (3) If applicable, a description of how volunteers will be recruited and reimbursed;
- (4) The reporting methodology that will be used by the grantee; and
- (5) An itemized budget for administrative costs, including:
  - (a) A staffing plan;
  - (b) Descriptions of individual job responsibilities and salaries;

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(c) A budget form; and

(d) Other pertinent material.

C. If an applicant intends to enter into subcontracts for transportation services referred to in §B(2) of this regulation, the applicant shall provide the following information:

(1) The names of the subcontractors;

(2) The scope of services to be subcontracted;

(3) The payment arrangement and payment level; and

(4) The plan for monitoring the performance of the subcontractors.

#### **.04 Services to Recipients.**

A. A grantee is responsible for arranging or providing nonemergency transportation to and from medically necessary covered services to Medical Assistance recipients and, when necessary, their attendants, who have no other means of transportation available. In carrying out this duty, a grantee:

(1) Shall screen recipients' requests for transportation in order to identify whether transportation is available to the recipients from other sources;

(2) When determining the appropriate means of transport for a recipient who appears to have a mental or physical disability which would prevent the recipient from using public transportation, shall request documentation prepared by the recipient's physician which indicates that the recipient's medical condition makes it medically contraindicated for the recipient to use public transportation;

(3) Shall refer recipients to organizations and programs which might be able to provide transportation and otherwise arrange for transportation when appropriate;

(4) Shall encourage the development and expansion of transportation resources such as churches and other community organizations;

(5) Shall provide transportation to recipients for whom there is no other transportation resource available, in the most efficient and cost-effective manner possible, including the use of volunteers and charitable organizations whenever possible; and

(6) May refuse to pay for transportation services if the recipient requests transportation less than 24 hours before the time the transportation is to be provided.

B. Screening referred to in §A(1) of this regulation includes obtaining the information listed below, as appropriate:

(1) Whether a recipient or a member of the recipient's household owns a vehicle;

(2) Availability of vehicles owned by friends or relatives with whom a recipient does not share a household;

(3) Availability of a volunteer using a privately owned vehicle;

(4) Availability of a volunteer from a public or private agency;

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- (5) Availability of transportation services provided for free by any other city, county, or State agency programs;
- (6) Methods by which a recipient previously reached medical services or currently reaches nonmedical services, such as the grocery store;
- (7) Whether a recipient can walk to the medical service;
- (8) Whether public bus transportation operates between a recipient's home and medical service;
- (9) Whether a recipient is mentally or physically disabled;
- (10) Whether a recipient is chronically ill or otherwise requires medical services on a frequent and ongoing basis; and
- (11) Whether a recipient can reschedule an appointment to a time when transportation would be available.

C. When the recipient is unable without assistance to obtain the documentation referred to in §A(2) of this regulation, and has no family member or other representative who can provide assistance, the grantee shall offer to contact the recipient's health care provider to request documentation of disability.

**.05 Limitations.**

Monies from a grant provided under these regulations may not be used to pay for the following:

- A. Emergency transportation services;
- B. Medicare ambulance services;
- C. Transportation to or from Veterans Administration hospitals unless it is to receive treatment for a non-military-related condition;
- D. Transportation to or from any correctional institutions;
- E. Transportation of recipients committed by the courts to mental institutions;
- F. Transportation between a nursing facility and a hospital, for routine diagnostic tests, nursing services, or physical therapy which can be performed at the nursing facility;
- G. Transportation services from a facility for treatment when the treatment is provided by the facility in which the recipient is located;
- H. Transportation to receive nonmedical services;
- I. Gratuities of any kind;
- J. Transportation between a medical day care facility and the recipient's home;
- K. Transportation to or from a State facility while the patient is a resident of that facility;
- L. Transportation of non-Medical Assistance recipients;

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- M. Trips for purposes related to education, recreational activities, or employment;
- N. Transportation of anyone other than the recipient, except for an attendant accompanying a minor or when an attendant is medically necessary;
- O. Wheelchair van service for ambulatory recipients;
- P. Ambulance service for a recipient who does not need to be transported in a prone position;
- Q. Transportation between a community rehabilitation program (CRP) and the recipient's home;
- R. Transportation between a day habilitation program and the recipient's home;
- S. Transportation to or from services that are not medically necessary.

**.06 Notices to Recipients.**

Whenever a grantee determines that the grantee will not arrange or provide transportation for a recipient who has requested transportation at least 24 hours in advance, even though the recipient has no available transportation resource, the grantee shall send the recipient a notice on a form, approved by the Department, that states the recipient has a right to a fair hearing pursuant to COMAR 10.09.24.13.

**.07 Documentation.**

A grantee shall document the following items and make the documentation available to the Department upon request:

- A. Whether the recipient had other transportation available or could reschedule the appointment to a time when transportation would be available;
- B. That any transportation paid for out of grant funds was to or from a medically necessary service for a recipient; and
- C. Which recipients the grantee denied transportation and the reason or reasons why.

**.08 Accountability.**

The Department shall:

- A. Follow all applicable policies required by COMAR 10.04.04 when approving grants; and
- B. Reconcile each grant on a yearly basis.

**.09 Responsibility to Recipients.**

A grantee is expected to meet the transportation needs of recipients in a grantee's county out of grant funds. In those circumstances when the grant funds are insufficient, the grantee shall contact the Program's staff specialist for transportation services, who shall evaluate and assist in resolving transportation requests. A grantee may not refuse services or assistance to a recipient who requests transportation on the basis that the grantee's grant funds have been exhausted.

[http://www.dsd.state.md.us/COMAR/SubtitleSearch.aspx?search=10.09.19.\\*](http://www.dsd.state.md.us/COMAR/SubtitleSearch.aspx?search=10.09.19.*) Accessed 05/18/2017

## **.10 Interpretive Regulation.**

These regulations shall be interpreted in conformity with applicable federal statutes and regulations.

*10.09.19.9999*

### **Administrative History**

Effective date: June 26, 1981 (8:13 Md. R. 1139)

Regulation .03A amended effective January 6, 1983 (9:26 Md. R. 2572); January 30, 1984 (11:2 Md. R. 113)

Regulation .07F amended effective January 30, 1984 (11:2 Md. R. 113); September 10, 1984 (11:18 Md. R. 1584)

Regulation .09A amended effective May 12, 1986 (13:9 Md. R. 1029)

Regulation .11 amended effective June 6, 1983 (10:11 Md. R. 974)

Regulation .12 adopted effective October 25, 1982 (9:21 Md. R. 2106)

Regulations .01—.12 repealed effective July 1, 1987 (14:4 Md. R. 418)

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Regulations .01—.12 adopted effective July 1, 1987 (14:4 Md. R. 418)

Regulation .01B amended effective July 1, 1989 (16:12 Md. R. 1336)

Regulations .01B and .05A amended as an emergency provision effective July 17, 1990 (17:16 Md. R. 1984), amended permanently effective November 1, 1990 (17:20 Md. R. 2427)

Regulations .01B and .05A amended, and .04G adopted as an emergency provision effective May 1, 1991 (18:7 Md. R. 765); amended permanently effective October 1, 1991 (18:15 Md. R. 1726)

Regulation .03A—C amended effective July 1, 1989 (16:12 Md. R. 1336)

Regulation .04A amended effective July 1, 1989 (16:12 Md. R. 1336)

Regulation .05 amended effective July 1, 1989 (16:12 Md. R. 1336)

Regulation .06A and B amended effective July 1, 1989 (16:12 Md. R. 1336)

Regulation .07 amended effective July 1, 1989 (16:12 Md. R. 1336)

Regulation .07A amended as an emergency provision effective January 28, 1991 (18:3 Md. R. 301), emergency status expired April 8, 1991 (18:9 Md. R. 1004)

Regulation .07A amended as an emergency provision effective April 9, 1991 (18:9 Md. R. 1005); amended permanently effective October 7, 1991 (18:18 Md. R. 2004)

Regulation .08C and D amended effective July 1, 1989 (16:12 Md. R. 1336)

Regulations .01—.12, General Transportation, repealed effective May 24, 1993 (20:10 Md. R. 851)

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[http://www.dsd.state.md.us/COMAR/SubtitleSearch.aspx?search=10.09.19.\\*](http://www.dsd.state.md.us/COMAR/SubtitleSearch.aspx?search=10.09.19.*) Accessed 05/18/2017

**COMAR 10.09.19 NEMT**

Regulations .01— .10, Transportation Grants, adopted effective May 24, 1993 (20:10 Md. R. 851)

Regulation .02B amended effective July 1, 1994 (21:12 Md. R. 1060)

Regulation .05 amended effective July 1, 1994 (21:12 Md. R. 1060)



# Reading and replying to a Virtru encrypted email without having Virtru installed

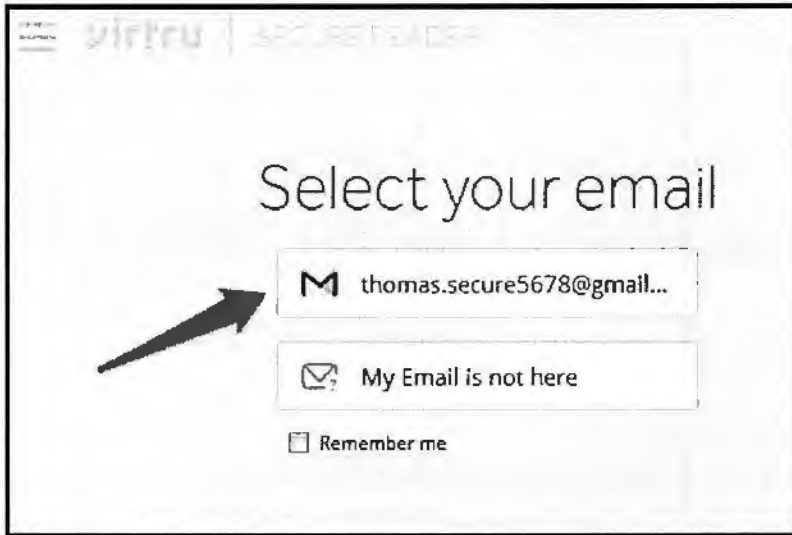
If you're reading this you've likely received a Virtru-secured email, but you don't have Virtru installed. We'll show you just how easy it is to read and reply to your message, as well as how to add secure attachments.

## Step by step instructions:

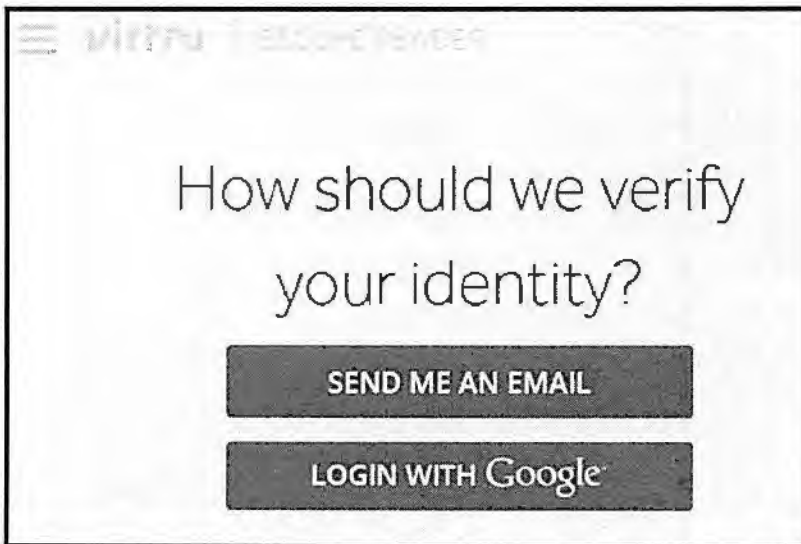
- Open the email in your inbox and click "Unlock Message". A new tab will open.



- When prompted, select your email address. If you don't see yours listed, click "My Email is not here" and enter your information.



- Choose how you'd like to verify your identity.
  - Google & Office 365 users can use their preexisting credentials to log in directly using *Login with Google* or *Login with Office 365*. You'll be taken directly to your message.
  - Select *Send me an email* if you use a different provider to verify your identity via email.



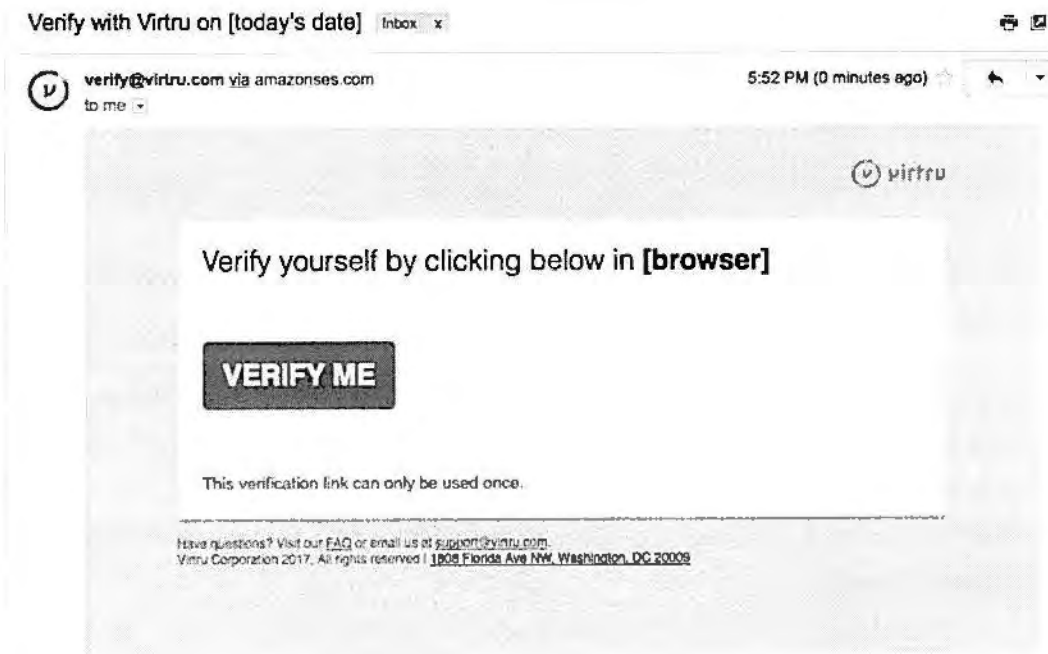
- Check your inbox for your verification email, coming from [verify@virtru.com](mailto:verify@virtru.com).

## Check your inbox for the verification email

We sent a message to [thomas.secure5678@gmail.com](mailto:thomas.secure5678@gmail.com) with the subject "Verify with Virtru on [Today's Date]" to verify your identity.

Click the provided link and make sure it opens in the same browser or try logging in again.

- Open the verification email and click "Verify Me" to open your message.



### Note:

Both the "Unlock Message" and "Verify Me" links need to be opened in the same

browser on the same device in order to confirm your identity.

Please note, Virtru now also offers a “cookie-less” verification pathway. If we detect that cookies and local storage have been disabled in the browser, we send a verification/validation code via email. This code, once received, simply needs to be pasted into the proper field in the you browser in order to grant access. If you are having trouble entering all 8 digits, please check to make sure there is not a space in front of the code in the entry box.

- Your message will open in a new tab in the browser.

#### HOW TO REPLY



- To send a secure reply, click into the text field at the bottom of the message or click "Secure Reply".
  - At the top left of the Reply box, you can select whether to reply to the sender only or all of the recipients on the email by selecting the "Reply" option. After you finish composing your message, click "Send Secure Reply".
  - Attachments can be added by clicking "Add Attachment". These will be sent securely as well.

Subject: **In response to job offer**  
From: sally.secure1234@gmail.com  
To: thomas.secure5678@gmail.com  
Date: Tuesday, Jan 6, 2015 - 10:47am



  
Encrypted Message

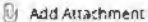
Hello Mr. Carrick,

I would like to thank you for offering me a contract and let you know that I will happily accept the position.

Best Regards,  
Sally Jones



Reply ▾ To: brett@virtruprivacy.com

 Add Attachment

⚠️ To use our advanced secure send functionality for [maximum security](#), we recommend you download the [free Virtru client](#) for client-side email encryption.

## Reporting Forms





# MARYLAND Department of Health

Larry Hogan, Governor · Boyd K. Rutherford, Lt. Governor · Robert R. Neill, Secretary

## Excluded Parties Verification Attestation

The Health and Human Services Office of the Inspector General (HHS-OIG) imposes a payment suspension on a provider based on credible allegations of fraud, waste or abuse, whether the provider has an existing Medicaid overpayment, or the provider has been excluded by the OIG or another State's Medicaid program within the previous 10 years.

All Medicaid providers of service are required to search the following databases on a monthly basis, to determine and document whether employees and contractors are excluded individuals or entities (General Provider Transmittal No. 73):

- The List of Excluded Individuals/Entities (LEIE) ([http://oig.hhs.gov/exclusions/exclusions\\_list.asp](http://oig.hhs.gov/exclusions/exclusions_list.asp));
- The Maryland Department of Health "MMA Provider & Other Sanctioned Entities List" (<https://mmcp.health.maryland.gov/Pages/Provider-Information.aspx>); and
- Any other databases as the Maryland Department of Health may prescribe.

### Attestation:

I, \_\_\_\_\_ (Transportation Vendor Authorized Representative), affirm that \_\_\_\_\_ (Name of Contracting Individual/Business/Organization) shall comply with all state and federal laws and regulations concerning Medicaid and Medicaid Non-emergency Medical Transportation Services.

\_\_\_\_\_ (Name of Contracting Individual/Business/Organization) affirms that the prescribed databases were searched on \_\_\_\_\_ (Date). Searches of the databases yielded \_\_\_\_\_ no excluded individuals; or \_\_\_\_\_ the following excluded individuals:

| EXCLUDED INDIVIDUAL | RESULTS |
|---------------------|---------|
|                     |         |
|                     |         |

Attached are screenshots of all employees, contractors and sub-contractors and their employees verified using the LEIE and Maryland databases.

SIGNATURE: \_\_\_\_\_

PRINTED NAME: \_\_\_\_\_

TITLE: \_\_\_\_\_

COMPANY/ORGANIZATION: \_\_\_\_\_

DATE: \_\_\_\_\_

### Mail Completed Attestation To:

(NEMT Grantee Contact Information)  
(Address and E-Mail)



# MARYLAND Department of Health

Larry Hogan, Governor · Boyd K. Rutherford, Lt. Governor · Robert R. Neall, Secretary

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## NON-EMERGENCY MEDICAL TRANSPORTATION PROVIDER OWNERSHIP AND DISCLOSURE FORM (Applicable to all Providers<sup>1</sup> of items or services)

Provider Name: \_\_\_\_\_

Provider Address: \_\_\_\_\_

Pursuant to 42 CFR 455.100 et seq., the disclosure of the following is required of Maryland Medicaid Non-Emergency Medical Transportation Providers. Please answer the following questions and sign this document affirming that this information is true and complete.

A. Name any person, who, with respect to the Title XIX Provider<sup>2</sup>

1. ... is an officer or director.

Name: \_\_\_\_\_ Address: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

Name: \_\_\_\_\_ Address: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

Name: \_\_\_\_\_ Address: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

2. ... is a partner.

Name: \_\_\_\_\_ Address: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

Name: \_\_\_\_\_ Address: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

Name: \_\_\_\_\_ Address: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

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<sup>1</sup> "Provider" or "provider of services" means a hospital, a skilled nursing facility, an intermediate care facility, a clinic, a psychiatric facility, a mental institution, an independent clinical laboratory, a health maintenance organization, a pharmacy, and any other entity that furnishes or arranges for the furnishing of services for which payment is claimed under the Medicaid program. It does not include individual practitioners or groups of practitioners.

<sup>2</sup> Identify any persons named, who are related to others named, as spouse, parent, child or sibling.

<sup>3</sup> a) "Ownership interest" means the possession of equity in the capital of, stock in, or of any interest in the profits of the disclosing entity.

b) "Indirect ownership interest" means any ownership interest in an entity that has ownership interest in the disclosing entity. The term includes an ownership interest in any entity that has an indirect ownership interest in the disclosing entity.

c) "Determination of ownership or control percentage"

1) Indirect ownership interest- The amount of indirect ownership interest is determined by multiplying the percentages of ownership in each entity. For example, if A owns 10 percent of the stock in a corporation which owns 80 percent of the stock of the disclosing entity, A's interest equates to an 8 percent indirect ownership interest in the disclosing entity and must be reported. Conversely, if B owns 80 percent of the stock of a corporation which owns 5 percent of the stock of the disclosing entity, B's interest equates to a 4 percent indirect ownership interest in the disclosing entity and need not be reported.

2) Person with an ownership or control interest- In order to determine percentage of ownership, mortgage, deed of trust, note, or other obligation, the percentage of the disclosing entity's assets used to secure the obligation. For example, if A owns 10 percent of a note secured by 60 percent of the provider's assets, A's interest in the provider's assets equates to 6 percent and must be reported. Conversely, if B owns 40 percent of a note secured by 10 percent of the provider's assets, B's interest in the provider's assets equates to 4 percent and need not be reported.

3. ...has direct or indirect ownership interest<sup>3</sup> of 5% or more.

Name: \_\_\_\_\_ Address: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

Name: \_\_\_\_\_ Address: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

Name: \_\_\_\_\_ Address: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

4. ...has a combination of direct or indirect ownership interests equal to 5% or more in the Provider.

Name: \_\_\_\_\_ Address: \_\_\_\_\_ Date

of Birth: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

Name: \_\_\_\_\_ Address: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

Name: \_\_\_\_\_ Address: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

5. ...is an owner (in whole or in part) of an interest of 5% or more in any mortgage, deed of trust, note, or other obligation secured (in whole or in part) by the Provider or its property or assets if that interest equals at least 5% of the value of the property or assets of the Provider.

Name: \_\_\_\_\_ Address: \_\_\_\_\_ Date

of Birth: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

Category: \_\_\_\_\_

Name: \_\_\_\_\_ Address: \_\_\_\_\_ Date

of Birth: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

Category: \_\_\_\_\_

Name: \_\_\_\_\_ Address: \_\_\_\_\_ Date

of Birth: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

Category: \_\_\_\_\_

B. With respect to any subcontractor in which the Title XIX Provider has, directly or indirectly, an ownership or control interest of 5% or more, name any person who falls within Part A. 1-5 above, as applied to the subcontractor, and specify which of the above categories he falls within.

Name: \_\_\_\_\_ Address: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

Category: \_\_\_\_\_

Name: \_\_\_\_\_ Address: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

Category: \_\_\_\_\_

Name: \_\_\_\_\_ Address: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

Category: \_\_\_\_\_

- C. 1. If any person named in response to Part A. 1-5, above, has any of the relationships described in that Part with any Title XIX Provider of items or services other than the applicant, or with any entity that does not participate in Medicaid but is required to disclose certain ownership and control information because of participation in any of the programs established under Title V, XVII, or XX of the Social Security Act, state the name of the person, the name of the other Provider, and the nature of the relationship.

Name: \_\_\_\_\_ Provider: \_\_\_\_\_

Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Provider: \_\_\_\_\_

Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Provider: \_\_\_\_\_

Relationship: \_\_\_\_\_

2. If the answer to Part C. 1. above, contains the names of more than two persons, state whether any of those so reported are related to each other as spouse, parent, child or sibling.

Relationship: \_\_\_\_\_

- D. Name any person who has been convicted<sup>4</sup> of a criminal offense related to his involvement with any program operated under Title XVIII, XIX, or XX of the Social Security Act, and who, with regard to the Title XIX Provider, falls within the provisions of A.1-5, above, or is an agent or a managing employee [an individual, including a general manager, administrator and director, who exercises operational or managerial control or who directly or indirectly conducts the day-to-day operations].

Name: \_\_\_\_\_

Name: \_\_\_\_\_

Name: \_\_\_\_\_

I hereby affirm that this information is true and complete to the best of my knowledge and belief, and that the requested information will be updated as changes occur. I further certify that upon specific request by the Secretary of the Department of Health and Human Services, or the Maryland Department of Health and Mental Hygiene, full and complete information will be supplied within 35 days of the date of the request, concerning:

- A. the ownership of any subcontractor with which the Title XIX Provider has had, during the previous 12 months, business transactions in an aggregate amount in excess of \$25,000.00 and
- B. any significant business transactions<sup>5</sup>, occurring during the 5 year period ending on the date of such request, between the Provider and any wholly-owned supplier<sup>6</sup> or any subcontractor.

AUTHORIZED SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

PRINTED NAME: \_\_\_\_\_ POSITION: \_\_\_\_\_

<sup>4</sup> "Convicted" means that a judgment of conviction has been entered by a Federal, State, or local court, irrespective of whether an appeal from that judgment is pending.

<sup>5</sup> "Significant business transaction" means any business transaction or series of transactions that, during any one fiscal year, exceeds the lesser of \$25,000 or 5 percent of the total operating expense of a provider.

<sup>6</sup> "Supplier" means an individual, agency, or organization from which a provider purchases goods and services used in carrying out its responsibilities under Medicaid (e.g., a commercial laundry, a manufacturer of hospital bed, or a pharmaceutical firm).



MCO Transport Report Template

| <u>Field</u>                          | <u>Field Format</u> | <u>Field Description</u>               | <u>Documentation/Comment</u>  |
|---------------------------------------|---------------------|--|---|
| <b><u>MA Recipient Number</u></b>     | Text*/Numeric       | Recipient's full Medicaid number       | *Text allows for preceding zeroes. Remain consistent in format when providing data (i.e. always provide field as text field or a numeric field)   |
| <b><u>MA Recipient Last Name</u></b>  | Text                | Recipient's full last name             |   |
| <b><u>MA Recipient First Name</u></b> | Text                | Recipient's full first name            |   |
| <b><u>MCO</u></b>                     | Text                | Aetna Better Health                    | <b>Do NOT</b> include Fee-For-Service transports  |
| -                                     |                     | Amerigroup                             |   |
| -                                     |                     | Jai Medical Systems                    |   |
| -                                     |                     | Kaiser Permanente                      |   |
| -                                     |                     | Maryland Physicians Care               |   |
| -                                     |                     | MedStar Family Choice                  |   |
| -                                     |                     | Priority Partners                      |   |
| -                                     |                     | UnitedHealthcare                       |   |
| -                                     |                     | University of Maryland Health Partners |   |
| <b><u>Date of Service</u></b>         | Date                | mm/dd/yyyy                             | <b>DO NOT</b> include future/prospective transports   |
| <b><u>Provider Type</u></b>           | Text                | Primary Care                           |   |
| -                                     |                     | Pharmacy                               |   |
| -                                     |                     | OB/GYN                                 |   |
| -                                     |                     | Diagnostic laboratory and X-ray        |   |
| -                                     |                     | Specialty                              |   |
| <b><u>Provider Service Type</u></b>   | Text                | PCP-General Practitioner               | <b>Do NOT</b> include Substance Abuse, Behavioral Health, or other carved out Fee-For-Service benefit   |
| -                                     |                     | PCP-Family Practitioner                |   |
| -                                     |                     | PCP-Internist                          |   |
| -                                     |                     | PCP-Pediatrician                       | If Provider Type was indicated as "Primary Care" or "OB/GYN", then Provider Service Type selection should be an option that begins with "PCP-..." |
| -                                     |                     | PCP-OB/GYN                             |   |
| -                                     |                     | PCP-Certified Nurse Midwife            | If Provider Type was indicated as "Pharmacy", or "Diagnostic laboratory and X-ray", then Provider Service Type selection should be "Other"        |
| -                                     |                     | PCP-Nurse Practitioner (Adult)         |   |
| -                                     |                     | PCP-Nurse Practitioner (Pediatric)     |   |
| -                                     |                     | PCP-Nurse Practitioner (Geriatric)     | If Provider Type was indicated as "Specialty", then Provider Service Type   |
| -                                     |                     | PCP-Nurse Practitioner (OB/GYN)        |   |

MCO Transport Report Template

|                          |         |   |  |
|--------------------------|---------|---|--|
| -                        |         | PCP-Nurse Practitioner (School Nurse)     | selection should be an option that begins with "SP..."   |
| -                        |         | PCP-Nurse Practitioner (Family)           |  |
| -                        |         | SP-Allergy                                |  |
| -                        |         | SP-Dermatology                            |  |
| -                        |         | SP-Endocrinology                          |  |
| -                        |         | SP-Infectious Disease                     |  |
| -                        |         | SP-Nephrology                             |  |
| -                        |         | SP-Pulmonology                            |  |
| -                        |         | SP(c)-Cardiology                          |  |
| -                        |         | SP(c)-Gastroenterology                    |  |
| -                        |         | SP(c)-Neurology                           |  |
| -                        |         | SP(c)-Ophthalmology                       |  |
| -                        |         | SP(c)-Orthopedics                         |  |
| -                        |         | SP(c)-Otolaryngology (ENT)                |  |
| -                        |         | SP(c)-Surgery                             |  |
| -                        |         | SP(c)-Urology                             |  |
| -                        |         | Other                                     |  |
| <b>Provider Name</b>     | Text    | Provider full name (First & Last)         |  |
| <b>Provider Address</b>  | Text    | Provider address (transport destination)  |  |
| <b>Mode of Transport</b> | Text    | Ambulance-BLS                             |  |
| -                        |         | Ambulance-ALS                             |  |
| -                        |         | Ambulance - Specialty Care                |  |
| -                        |         | Ambulance - Neonatal Transport            |  |
| -                        |         | Wheelchair Van                            |  |
| -                        |         | Taxicab/Sedan                             |  |
| -                        |         | Bus Passes                                |  |
| -                        |         | Gasoline Vouchers                         |  |
| -                        |         | Other Ambulatory                          |  |
| <b>Mileage</b>           | Numeric | Mileage to destination location (ONE WAY) | <b>Do NOT</b> provide round trip mileage. Urban/Suburban counties include transports 20+ miles; Rural counties include only transports that are 30+ miles. |
|                          |         |   |  |

SAMPLE

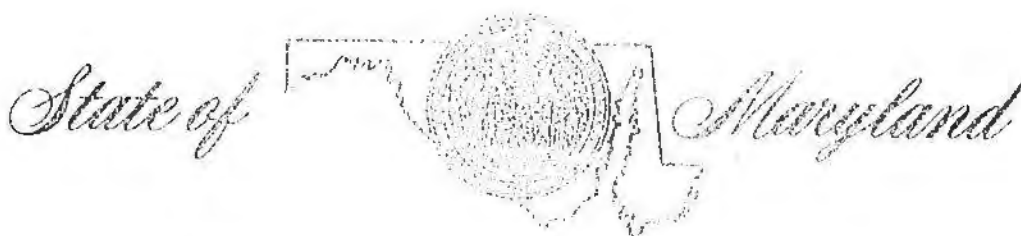
Q\_FY' 20 Transportation Data Worksheet<sup>40</sup>

| County or Subdivision          |                   |     | Current Reimbursement Rate | Date Last Adjusted | # Participants Using Service* |         | Number of Trips**                   |         | Mileage                             |        |                                     |
|--------------------------------|-------------------|-----|----------------------------|--------------------|-------------------------------|---------|-------------------------------------|---------|-------------------------------------|--------|-------------------------------------|
|                                | Approved Services | Yes |                            |                    | No                            | FY 2019 | FY 2020: (report cumulative FY #'s) | FY 2019 | FY 2020: (report cumulative FY #'s) | FY2019 | FY 2020: (report cumulative FY #'s) |
|                                |                   |     |                            |                    |                               |         |                                     |         |                                     |        |                                     |
| Ambulance-BLS                  |                   |     |                            |                    |                               |         |                                     |         |                                     |        |                                     |
| Ambulance-ALS                  |                   |     |                            |                    |                               |         |                                     |         |                                     |        |                                     |
| Ambulance - Specialty Care     |                   |     |                            |                    |                               |         |                                     |         |                                     |        |                                     |
| Ambulance - Neonatal Transport |                   |     |                            |                    |                               |         |                                     |         |                                     |        |                                     |
| Air Ambulance                  |                   |     | \$1,500 + \$20.00/air mile |                    |                               |         |                                     |         |                                     |        |                                     |
| <b>Total Ambulance</b>         |                   |     |                            |                    | 0                             | 0       | 0                                   | 0       | 0                                   | 0      |                                     |
| Wheelchair Van                 |                   |     |                            |                    |                               |         |                                     |         |                                     |        |                                     |
| Ambulatory Van Service         |                   |     |                            |                    |                               |         |                                     |         |                                     |        |                                     |
| Taxicab/Sedan                  |                   |     |                            |                    |                               |         |                                     |         |                                     |        |                                     |
| Bus Passes                     |                   |     |                            |                    |                               |         |                                     |         |                                     |        |                                     |
| Gasoline Vouchers              |                   |     |                            |                    |                               |         |                                     |         |                                     |        |                                     |
| Other Ambulatory               |                   |     |                            |                    |                               |         |                                     |         |                                     |        |                                     |
| <b>Total Ambulatory</b>        |                   |     |                            |                    | 0                             | 0       | 0                                   | 0       | 0                                   | 0      |                                     |
| <b>TOTAL FOR COUNTY</b>        |                   |     |                            |                    | 0                             | 0       | 0                                   | 0       | 0                                   | 0      |                                     |
| <b>Denied Services</b>         |                   |     |                            |                    |                               |         |                                     |         |                                     |        |                                     |
| Distant Provider               |                   |     |                            |                    |                               |         |                                     |         |                                     |        |                                     |
| Non-Covered Service            |                   |     |                            |                    |                               |         |                                     |         |                                     |        |                                     |
| Not MA Provider                |                   |     |                            |                    |                               |         |                                     |         |                                     |        |                                     |
| Other Reason                   |                   |     |                            |                    |                               |         |                                     |         |                                     |        |                                     |
| Other Transportation           |                   |     |                            |                    |                               |         |                                     |         |                                     |        |                                     |
| <b>Total Number of Denials</b> |                   |     |                            |                    | 0                             | 0       | 0                                   | 0       |                                     |        |                                     |
| No Shows***                    |                   |     |                            |                    |                               |         |                                     |         |                                     |        |                                     |
| <b>Additional Comments:</b>    |                   |     |                            |                    |                               |         |                                     |         |                                     |        |                                     |

<sup>40</sup> Updated 1/7/2017



# Transmittals



MEDICAL ASSISTANCE POLICY ADMINISTRATION  
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
 201 WEST PRESTON STREET • BALTIMORE, MARYLAND 21201

Charles R. Buck, Jr., Sc.D., Secretary

MARYLAND MEDICAL ASSISTANCE PROGRAM

NURSING HOME GUIDELINE NO. 38

March 27, 1980

TO: Administrators, All Nursing Facilities  
 Local Departments of Social Services

FROM: Charles C. Putnam, Director *CCP*  
 Medical Assistance Policy Administration

RE: Cost of Aids to Accompany Patients

It has come to our attention that some nursing facilities have been charging their patients, patients' relatives, or others for the cost of aides or escorts to accompany patients to obtain medical services outside the nursing facilities.

This expense is an allowable cost in the determination of the facility's per diem rate, and therefore no charge should be made to the patients, patients' relatives, guardian/sponsors, or other sources for this service.

Also family members or others should not be informed by provider nursing facilities that the family members or others are to assume the responsibility for the above-mentioned function.

Questions regarding this Guideline should be directed to the Staff Specialist, Nursing Home Services, telephone (301) 383-2773.

CCP:nlh



STATE OF MARYLAND

DHMH

## Maryland Department of Health and Mental Hygiene

201 W. Preston Street • Baltimore, Maryland 21201

Martin O'Malley, Governor • Anthony G. Brown, Lt. Governor • John M. Colmers, Secretary

**MARYLAND MEDICAL ASSISTANCE PROGRAM****General Provider Transmittal No. 79****July 14, 2010**

**TO:** Providers *Susan J. Tucker*

**FROM:** Susan J. Tucker, Executive Director  
Office of Health Services

**RE:** Part B Coinsurance Payments

**NOTE:** **Please ensure that the appropriate staff members in your Organizations are informed of the content of this transmittal.**

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As a result of budget reductions taken by the Board of Public Works, the Medicaid program will no longer pay Part B Medicare coinsurance or copayments for dates of service beginning August 1, 2010, on claims where the Medicare payment exceeds the Medicaid fee schedule. Therefore, if Medicare pays the claim at an amount equal to or greater than the Medicaid fee schedule, Medicaid will make no additional payment. If Medicare pays the claim at an amount less than the Medicaid fee schedule, Medicaid will pay all or part of the coinsurance to bring the total payment to the provider equal to the Medicaid fee schedule.

This methodology will not be applied when:

- The amount submitted to Medicaid is for the deductible;
- The service is not covered by Medicaid;
- The service is a mental health service;
- The service is billed using a HCPCS beginning with a letter from A to W;
- CPT codes are priced by report; or
- The service is billed using CPT codes 00100 to 01999

Please remember that Medicaid providers are prohibited from balance billing recipients. If you have any questions about the information in this transmittal, please send your questions to [Medicaid@dhmh.state.md.us](mailto:Medicaid@dhmh.state.md.us). You will receive a response within one business day.



STATE OF MARYLAND

**DHMH**

PT8-04

Office of Health Services  
Medical Care Programs

Maryland Department of Health and Mental Hygiene  
201 W. Preston Street • Baltimore, Maryland 21201

Robert L. Ehrlich, Jr., Governor – Michael S. Steele, Lt. Governor – Nelson J. Sabatini, Secretary

**MARYLAND MEDICAL ASSISTANCE PROGRAM  
EMERGENCY SERVICES TRANSPORTERS  
TRANSMITTAL NO. 1**

September 25, 2003

Emergency Services Transporters  
*Susan J. Tucker*  
FROM: Susan J. Tucker, Executive Director  
Office of Health Services

**NOTE:** Please ensure that appropriate staff members in your organization and all appropriate billing agencies are informed of the contents of this transmittal.

New Billing Code for Emergency Services Transportation – Effective  
October 16, 2003

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Due to system changes as a result in the Health Insurance Portability and Accountability Act (HIPAA), Maryland Medical Assistance will be changing the billing code for Emergency Services Transportation, effective October 16, 2003. ALS Emergency Transport, Ambulance Services provided on or before October 15, 2003 must be billed using Code A0220. Services provided on or after October 16, 2003 must be billed using Code A0427. The reimbursement rate per emergency trip will remain \$100.00.

If you have any questions regarding information in this transmittal, please contact the Transportation Policy Specialist at 410-767-1739.





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Maryland Department of Health and Mental Hygiene  
201 W. Preston Street • Baltimore, Maryland 21201

Robert L. Ehrlich, Jr., Governor – Michael S. Steele, Lt. Governor – S. Anthony McCann, Secretary

**MARYLAND MEDICAL ASSISTANCE PROGRAM  
TRANSPORTATION GRANTS TRANSMITTAL NO. 5**

**October 8, 2004**

**TO:** Transportation Grants Managers

**FROM:** Susan J. Tucker, Executive Director  
*Susan J. Tucker*  
Office of Health Services

**SUBJECT:** Policies for Handling No-Shows

**NOTE:** Please ensure that appropriate staff members in your organization are informed of the contents of this transmittal.

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The issue of Medicaid recipients who schedule transportation through the Transportation Grant Program, then either do not appear at the pickup location at the appointed time or who refuse the ride, without canceling in advance, presents an ongoing challenge to grantees and the Medical Assistance Program in wasted fiscal expenditures and other resources. The purpose of this transmittal is to provide a framework for grantees in developing and implementing policies to minimize the occurrence of these “no-shows.”

The Program recommends that grantees experiencing a significant number of no-shows (particularly if the grantee is contractually obligated to reimburse a contractor for the failed trip) develop and implement policies that require persistent “no-show” recipients to confirm future transports and cancel those transports that are not confirmed in accordance with the written policies. Grantees (or designees as appropriate) should share their no-show policies with recipients, preferably at the time of the recipient’s initial contact with the Transportation program.

The policies regarding no-shows should encompass the following factors:

- 1. Definition of no-show** - the policy should define a no-show as occurring when a recipient either is not at the arranged pickup point at the appointed time or refuses the ride at that time and has not canceled the trip in advance. The policy should state how long the driver would wait, as well as providing instructions for advance cancellation of rides. The policy should take into account situations where language barriers may exist, where recipients may lack telephone access, and other extenuating circumstances beyond the recipient’s control. Finally, the policy should allow for situations where the driver is late beyond a reasonable time.

2. **Warnings for initial no-shows** - the grantee should provide the recipient with a written warning and a copy of the grantee's no-show policy. The written warning should contain the following information:
  - a. Date of no-show;
  - b. Pick-up address;
  - c. Time of expected pick-up, driver arrival time, and time driver left;
  - d. Statement that future no-shows without appropriate notification may result in the recipient having to call the grantee the day before any future scheduled trips to confirm the trip.
  
3. **Sanctions for repeat no-shows** - the policy should provide that for continued no-shows (particularly consecutive no-shows) the recipient will be required to call the grantee in advance to confirm future trips. The written notice should contain the following information:
  - a. Date of no-show;
  - b. Pick-up address;
  - c. Time of expected pick-up, driver arrival time, and time driver left;
  - d. Reference to previous no-shows; and
  - e. Statement that for future trips, the recipient will be required to call the grantee the day before to confirm the trip. An effective date for imposing this requirement, not earlier than five calendar days from the date of the letter, should be given.
  
4. **Confirmation of Future Trips** - The letter should provide instructions for confirming future trips. When the grantee is aware that the recipient has a case manager or social worker actively involved with him or her, that individual should be alerted to the situation and invited to contact the grantee if he/she believes that there are circumstances that the grantee should consider before imposing this requirement.
  
5. Should the recipient fail to confirm the trip in accordance with the instructions given, the grantee should cancel the trip.
  
6. Should the recipient's performance improve to where the grantee determines that confirming trips is no longer necessary, the grantee may lift the requirement.

Sample letters (warning and imposition of sanctions) are attached to this transmittal. The grantee may choose to use either or both letters, or may choose to develop its own letters provided that the above elements are included.

If you have any questions regarding this transmittal, please feel free to contact the Transportation Grant Staff Specialist at 410-767-1739.

**FAILURE TO SHOW FOR  
MEDICAL ASSISTANCE TRANSPORTATION  
WARNING**

Date

Name  
Address  
City, State

Dear \_\_\_\_\_:

The (name of local jurisdiction) has recently learned that you had scheduled Medical Assistance transportation on the following date(s):

Date: \_\_\_\_\_  
Pick-up Address: \_\_\_\_\_  
Time of Expected Pick-up: \_\_\_\_\_ Driver Arrived: \_\_\_\_\_ Driver Left: \_\_\_\_\_

According to our records, however, you (choose one: "were not at the pickup address" or "refused the ride when the driver arrived"). Our records also indicate that you did not call in advance to cancel the ride.

To help Medical Assistance provide reliable transportation to you and other recipients, it is very important that you be at the pick-up point at least (timeframe) minutes before the scheduled pick-up time, and that you wait at least (timeframe) after the scheduled pick-up time. If you know that you cannot keep an appointment, you must call (phone number) and cancel the ride before (cancellation deadline). A copy of our Transportation No-Show Policy is enclosed.

Failure to show up for future rides without canceling in advance may result in your being required to confirm all future rides at least (timeframe) before service, or have your ride cancelled. I hope this will not become necessary.

If you believe the above information is incorrect or you wish to discuss this matter please contact me at (phone number), Monday through Friday, (business hours).

Sincerely,

(Transportation Manager)  
(Local Jurisdiction)

Enclosure

**FAILURE TO SHOW FOR  
MEDICAL ASSISTANCE TRANSPORTATION  
ADVANCE CONFIRMATION FOR ALL FUTURE RIDES REQUIRED**

Date \_\_\_\_\_

Name \_\_\_\_\_  
Address \_\_\_\_\_  
City, State \_\_\_\_\_

Dear \_\_\_\_\_:

The (name of local jurisdiction) has recently learned that you had scheduled Medical Assistance transportation on the following date(s):

Date: \_\_\_\_\_  
Pick-up Address: \_\_\_\_\_  
Time of Expected Pick-up: \_\_\_\_\_ Driver Arrived: \_\_\_\_\_ Driver Left: \_\_\_\_\_

According to our records, however, you (choose one: "were not at the pickup address" or "refused the ride when the driver arrived") without calling in advance to cancel the ride.

Our records also indicate that you did not show up for or refused a ride on the following date(s):

|             |                             |
|-------------|-----------------------------|
| Date: _____ | Expected Pick-up Time _____ |
| Date: _____ | Expected Pick-up Time _____ |
| Date: _____ | Expected Pick-up Time _____ |

Following these no-show rides, you were given a copy of the \_\_\_\_\_ (local jurisdiction's) \_\_\_\_\_ policy on no-shows for transportation and warned that future incidents may result in your being required to confirm all future rides at least (timeframe) before service, or have your ride cancelled.

Due to your repeated failure to show up for rides or cancel in advance, **you will now be required to confirm all future rides by calling (phone number), (required timeframe for calling in confirmations), to confirm whether you will be taking that ride. If you do not call to confirm your ride during the above timeframe, your ride will be automatically canceled. This requirement will become effective on (effective date) and will continue until further notice.**

I regret that this action has become necessary. If you believe the above information is incorrect or you wish to discuss this matter please contact me at (phone number), Monday through Friday, (business hours).

Sincerely,

(Transportation Manager)  
(Local Jurisdiction)

Enclosure

cc: Caseworker or other representative (optional)



# MARYLAND Department of Health

Larry Hogan, Governor · Boyd K. Rutherford, Lt. Governor · Robert R. Neall, Secretary

**MARYLAND MEDICAL ASSISTANCE PROGRAM  
General Provider Transmittal No. 86  
December 10, 2018**

**To:** Clinics  
Durable Medical Equipment (DME) Providers  
Durable Medical Supplies (DMS) Providers  
Federally Qualified Health Centers  
Hospitals  
Local Health Departments  
Managed Care Organizations  
Nurse Anesthetists  
Nurse Midwives  
Nurse Practitioners  
Pharmacies  
Physicians  
Physician Assistants

**From:** Jill Spector, Director *Jill Spector*  
Office of Health Services

**Re:** Medicaid Program Updates for Winter 2018

**Note:** Please ensure that the appropriate staff members of your organization are informed of the contents of this memorandum.

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#### **Disposable Medical Supplies – Preauthorization Requests**

Effective October 1, 2018 Telligen, Inc., Maryland Department of Health's (MDH) utilization control agent, assumed responsibility for completing reviews for Maryland Medicaid participants who request disposable medical supplies (DMS) requiring preauthorization. Telligen has been performing similar authorizations for durable medical equipment (DME) and oxygen services since September 1, 2016. Telligen conducts these reviews to determine eligibility, medical necessity, utilization or continuation of medical need for the items provided to Maryland Medicaid participants in order to support their independence in their home, school, worksite, and community per Code of Maryland Regulations (COMAR) 10.09.12.

Providers must submit DMS requests electronically through Telligen's web-based provider portal, Qualitrac. Qualitrac is a web application that allows healthcare providers to submit review requests for consideration. MDH will no longer accept preauthorization requests for DMS services.

For questions about DME and DMS services, please contact the Division of Community Support Services at 410-767-7283.

### **Medicaid Provider Enrollment, Eligibility, and Disaster Response**

The Centers for Medicare and Medicaid Services (CMS) provide guidance to States regarding public health emergencies. CMS may waive residential eligibility requirements to allow individuals displaced by a natural disaster to apply for Medicaid coverage in other states. For example, an individual displaced by a hurricane seeking to reside in Maryland may apply for Medicaid coverage via the Maryland Health Connection.

For Medicaid participants who intend to return to their home state, the individual's home state Medicaid agency may waive provider enrollment requirements, including application fees, criminal background checks, site visits, or state licensure/certification, to enable providers to temporarily enroll in the home state's Medicaid Program to receive reimbursement for services rendered. The authority for these waivers is Section 1135 of the Social Security Act.

The guidance states that CMS may waive certain eligibility and provider enrollment requirements to provide care and receive subsequent reimbursement for services rendered to displaced individuals when the HHS Secretary declares a public health emergency due to a natural disaster that requires a state's residents to evacuate. As a general rule, providers should consult with the individual's home state Medicaid Program website if they want to provide care and be reimbursed for services. Please direct any specific questions you may have regarding the disaster response waiver to Trina Roberts at 404-562-7418 or [Shantrina.Roberts@cms.hhs.gov](mailto:Shantrina.Roberts@cms.hhs.gov).

For more comprehensive guidance about Medicaid and natural disaster evacuees, please review the materials in CMS' Disaster Response Toolkit: <https://www.medicaid.gov/state-resource-center/disaster-response-toolkit/index.html>.

### **Pharmacist Prescribers**

Maryland Senate Bill 363 (2017) allows qualified pharmacists to prescribe certain contraceptive medications and self-administered contraceptive devices. Effective January 1, 2019, qualified pharmacists and pharmacies may enroll with Maryland Medicaid as a Pharmacist Prescriber provider type. Once enrolled, pharmacist prescribers may bill for the patient assessment rendered in order to determine whether to prescribe contraceptives and which contraceptive to prescribe.

In order for Medicaid to reimburse providers for these services, Pharmacies must take three steps. First, the Pharmacy must obtain a new NPI for the location they intend to enroll as a Pharmacist Prescriber. Second, the Pharmacy must enroll as a group Pharmacist Prescriber provider. Third, the individual qualified pharmacist must enroll as a Pharmacist Prescriber renderer. The Pharmacist Prescriber group would bill the patient assessment via a CMS-1500. Pharmacies should NOT bill Conduent for the patient assessment.

Pharmacy providers who intend to participate as Pharmacist Prescribers should look for more information at [https://numcp.health.maryland.gov/Pages/pharmacist\\_prescribers.aspx](https://numcp.health.maryland.gov/Pages/pharmacist_prescribers.aspx).

### **Revalidations through the electronic Provider Revalidation and Enrollment Portal (ePREP)**

All Maryland Medical Assistance Program (Medicaid) providers must revalidate their Medicaid enrollments at least every five years to continue participation in the Medicaid Program. For group and facility providers, this requires each provider location enrolled with Maryland Medicaid to revalidate their enrollment. Once scheduled, the Maryland Department of Health (MDH) will send a Revalidation Request notice to the provider by mail. Additionally, enrollment revalidation requirements apply to providers who only render services through HealthChoice managed care organizations (MCOs).

A provider will receive a Revalidation Request instructing providers to enter ePREP and submit a revalidation application. Prior to ePREP implementation, providers could submit paper revalidation applications at any time without receiving a Revalidation Request. Now, a provider may only submit a revalidation application once the ePREP system schedules it. Providers who have already created a business profile in ePREP will receive an email notification as well as a hard copy of the Revalidation Request notice. Failure to submit a complete and accurate revalidation application will result in suspension of enrollment.

Providers may submit supplemental applications at any time to update information and demographics. ePREP does not limit or schedule such supplemental changes to providers' enrollment record.

For questions about Medicaid enrollment, please contact us at 1-844-4MD-PROV (1-844-463-7768). For more information about ePREP, including revalidation instruction resources and other ePREP user functions, please visit <https://mmcp.health.maryland.gov/Pages/ePREP.aspx>.

### **Clarification of Provider Transmittal 07-19 (EPSDT Transmittal No. 42) re: Billing of Hearing and Vision Screenings**

The purpose of Provider Transmittal 07-19 was to inform EPSDT providers that both Medicaid Fee-for Service and Managed Care Organizations will reimburse for hearing and vision screenings as a separate service, in addition to a preventive health visit. EPSDT Transmittal #42 and the Coding and Billing Guidelines for Vision and Hearing Screenings Attachment may be found at [https://mmcp.health.maryland.gov/MCOupdates/Documents/pt\\_07-19.pdf](https://mmcp.health.maryland.gov/MCOupdates/Documents/pt_07-19.pdf).

For questions please contact the EPSDT Program at 410-767-1836 or [Lesa.Watkins@maryland.gov](mailto:Lesa.Watkins@maryland.gov).

### **Attending Providers on Institutional Claims**

Effective April 1, 2019, institutional claims submitted to Maryland Medicaid must include the NPI of an attending physician who is actively enrolled as a Maryland Medicaid provider.

Under section 6401 of the Affordable Care Act and Code of Federal Regulations section 42 CFR § 455.410(h), ordering, referring and prescribing (ORP) providers are required to "be enrolled as participating providers" with the state Medicaid agency in order for their ordered, referred, and

prescribed services to be billable to Medicaid. The Centers for Medicare and Medicaid Services (CMS) interprets this enrollment requirement to include attending physicians supervising care in institutional settings, including hospitals, nursing facilities, and residential treatment centers. This federal policy applies to providers seeking Medicaid reimbursement for serving patients in institutional settings under the care of an attending physician. For such services, the attending physician serves as the ORP provider, and must be enrolled with the state Medicaid program for the service to be billable to Medicaid.

To comply with this federal rule, Maryland Medicaid will require that all claims submitted via 837i electronic claim form include the NPI of a valid individual attending provider who is actively enrolled in the Maryland Medicaid program. To receive payment, an institutional provider's claim will be required to meet the following criteria:

- The attending provider NPI field must be completed with a valid 10-digit number.
- The attending provider NPI must be a Type 1 (Individual) NPI belonging to an individual practitioner. A Type 2 (Organizational) NPI belonging to a professional group or facility is not permitted in the attending field.
- The attending provider NPI must belong to a provider who is actively enrolled in the Maryland Medicaid program.

Claims that do not meet these criteria will be at risk of denial as of April 1, 2019.

Attending physicians and other ORP providers must enroll with Maryland Medicaid using the electronic Provider Revalidation and Enrollment Portal (ePREP). Physicians who do not wish to enroll with Maryland Medicaid as independent solo practitioners may enroll as rendering providers by submitting an affiliation application together with their facility. Please visit <http://health.maryland.gov/eprep> for enrollment and affiliation instructions, and contact the ePREP call center at (844)-463-7768 for enrollment assistance.



STATE OF MARYLAND  
**DHMH**

Office of Health Services  
Medical Care Programs

**Maryland Department of Health and Mental Hygiene**

201 W. Preston Street • Baltimore, Maryland 21201

Robert L. Ehrlich, Jr., Governor – Arlene H. Stephenson, Acting Secretary

**MARYLAND MEDICAL ASSISTANCE PROGRAM  
General Transportation Grants Transmittal No. 2**

**TO:** Transportation Grants Coordinators  
Air Ambulance Providers  
Hospitals

**FROM:** Susan J. Tucker, Executive Director  
Office of Health Services

**NOTE:** Please ensure that appropriate staff members in your organization and appropriate contractors are informed of the contents of this transmittal.

**RE:** Updated Air Ambulance Transportation Policy under the  
Transportation Grants Program

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The Maryland Medical Assistance Program has updated its policy governing authorization and reimbursement of transportation via air ambulance (hereafter known as air transportation). This transmittal, which applies to transportation via fixed and rotor-wing aircraft, supersedes the Transportation Grants Transmittal No. 1 issued December 18, 2000.

The following policy describes the requirements for Medical Assistance reimbursement for air transportation. It outlines the procedures for obtaining authorization for transports and requirements for billing. The Program's reimbursement rate is also provided. Finally, it outlines procedures for appealing denials of reimbursement.

**General Requirements for Air Transportation Providers**

- A. Providers shall, to the extent required by law, be licensed and legally authorized to provide this service in the State of Maryland; and
- B. Providers shall have in effect a provider agreement with the Maryland Medicaid Program through the Baltimore City Health Department.

## **Conditions for Reimbursement**

In order for a provider to receive Medicaid reimbursement for air transportation, the following requirements shall be met:

- A. The individual being transported is a Maryland Medicaid recipient;
- B. The receiving hospital is a Maryland Medicaid provider;
- C. The service to be rendered at the receiving hospital is covered by Maryland Medicaid;
- D. The air transport has not occurred as a result of a request from a "911" system, and is not otherwise coverable by another payor;
- E. The treating physician from the sending hospital has completed a Physician Certification for Medical Assistance Air Transportation;
- F. The receiving hospital has agreed to accept the recipient; and
- G. Air transportation is medically necessary and appropriate.
  - a. Criteria for medical necessity and appropriateness. Air transport is considered medically necessary and appropriate when all the following conditions are met:
    - i. The recipient requires services that the sending hospital is not able to provide;
    - ii. The receiving hospital has the services required by the recipient;
    - iii. The receiving hospital is the one closest to the sending hospital that has the services required by the recipient;
    - iv. The receiving hospital agrees to accept the recipient; and
    - v. The recipient's medical condition is such that using ground transportation can reasonably be expected to result in placing the recipient's health in further jeopardy.
  - b. Factors to be considered in determining medical necessity and appropriateness include, but are not limited to:
    - i. Recipient's diagnosis and medical history;

- ii. Level of care required;
- iii. Adjunct equipment needed for the recipient's care;
- iv. Reasons the discharging facility cannot medically manage the recipient;
- v. Reasons the receiving facility was chosen;
- vi. Reasons why air transport is necessary as opposed to land transport;
- vii. Weather conditions (air and ground);
- viii. Availability of aircraft; and
- ix. Availability of flight staff.

#### **Authorization Process**

- A. The following requirements and procedures apply when preauthorization is being requested:
  - a. Requirements
    - i. Preauthorization should be requested in circumstances where the recipient's Medical Assistance status and Medical Assistance number are known to the sending hospital.
    - ii. The sending hospital only may request preauthorization, except that the receiving hospital may do so if they will be sending a specialty team to the sending hospital to accompany the recipient during the transport.
  - b. Procedure
    - i. The requesting facility shall call the Baltimore City Health Department, Office of Field Health Services at (410) 396-7433 between 8:30 a.m. and 4:30 p.m., or (410) 396-3100 after hours. To expedite approval, the caller shall have the following information ready:
      - 1. Valid Medical Assistance number;
      - 2. Name of recipient;

3. Date of birth;
4. Home address/county;
5. Diagnosis;
6. Level of care with adjunct equipment;
7. Name of sending physician;
8. Name of receiving physician; and
9. Name of receiving facility.

ii. The Office of Field Health Services shall determine whether the requirements in II.a above have been met, and will either approve or deny the request accordingly.

iii. If the request is approved, the treating physician from the sending hospital shall complete the Physician's Certification of Air Transportation and submit one copy each to the Office of Field Health Services and to the air transport provider.

B. The following requirements and procedures apply when postauthorization is being requested:

a. Requirements

i. Postauthorization shall be utilized in situations where the recipient's Medical Assistance number is not known.

ii. The postauthorization process may be used in situations where preauthorization is appropriate. To help ensure reimbursement for the transport, however, air providers are strongly encouraged to request sending hospitals to employ the preauthorization process when feasible.

b. Process. The postauthorization process is accomplished concurrently with the payment request process detailed in V. below.

### **Billing Requirements and Instructions**

- A. In accordance with COMAR 10.09.36, requests for payment shall be submitted and received by the Program within nine months of the date of service. A request which is rejected for payment due to improper completion or incomplete information shall be paid only if it is properly completed, resubmitted, and received by the Program within the original nine-month period, or within 60 days of rejection, whichever is later.
- B. Payment shall be requested using the HCFA 1500, with the following areas completed:
- a. Item 1 - Insurance type;
  - b. Item 1a - Insured's I.D. Number (MA#);
  - c. Item 2 - Patient's Name;
  - d. Item 3 - Patient's Birth Date;
  - e. Item 5 - Patient's Address, City, ZIP Code, and Telephone Number;
  - f. Item 8 - Patient's Status;
  - g. Item 10 - Is patient's condition related to: a.employment? b.auto accident? c.other accident? (must answer all three questions)
  - h. Item 12 - Patient's or Authorized Person's Signature (if "Signature on File" is entered here, a copy of the signature should accompany this document);
  - i. Item 14 - Date of current illness/injury/pregnancy(LMP);
  - j. Item 17 - Name of referring physician (from sending facility);
  - k. Item 17a - MA Provider Number of referring physician;
  - l. Item 19 - Reserved for local use (use this space to record additional comments; if no comments state "none");
  - m. Item 21 - Diagnosis or nature of illness or injury;
  - n. Item 24a-k - related to dates of service, places, type, etc.;
  - o. Item 25 - Federal tax ID number;

- p. Item 30 - Balance due; and
  - q. Item 32 - Name and address of facility (identify sending and receiving facilities in this area).
- C. The following shall accompany the HCFA 1500:
- a. Physician's Certification for Medical Assistance Air Transportation, completed by the treating physician from the sending hospital and including the sending physician's Medical Assistance Provider Number (and authorization number when appropriate);
  - b. Completed copy of the sending hospital's discharge summary; and
  - c. Completed copy of the Flight Medical Record.
- D. If the HCFA 1500 is incomplete, or one or more of the documents detailed in IV.b are missing, the request cannot be processed and will be returned to the provider.
- E. Requests for payment should be mailed to: Irene Lumpkins, Coordinator, Medical Assistance Air Transportation, 211 E. 25th Street, Baltimore, Maryland 21218.

#### **Reimbursement rates**

- A. For air transportation, the reimbursement rate is:
  - a. Flat rate of \$2,300 per one way trip, plus
  - b. Mileage rate of \$30.00 per air mile per one way trip.
- B. For land transportation related to air transportation (e.g., to airport), the reimbursement shall be commensurate with the ground ambulance rate of the recipient's local jurisdiction of residence, if available. If an appropriate rate is not available, the rate will be determined by the Baltimore City Health Department based on estimates provided by local ambulance providers.

#### **Appeals**

- A. The air transport provider has the right under COMAR 10.09.36 to request a provider hearing regarding a denial of reimbursement for air transport for a valid Maryland Medicaid recipient in cases where

postauthorization had been requested. Please note that this right of appeal does not extend to denial of preauthorization requests. Preauthorization denials are denials of service, consequently only the recipient has legal standing to appeal.

- B. When reimbursement is denied as described in VII.a above, the Baltimore City Health Department shall notify the air transport provider in writing of this action. The notice shall state the reasons for the denial, and shall state instructions for appealing the decision.
- C. To reserve the right to a provider hearing, the provider must request the hearing within 30 days of receipt of the notice.

If you have any questions regarding this transmittal, please call the Transportation staff specialist at 410-767-1739.

**Maryland Department of Health and Mental Hygiene**

201 W. Preston Street • Baltimore, Maryland 21201

Parris N. Glendening, Governor - Georges C. Benjamin, M.D., Secretary

**MARYLAND MEDICAL ASSISTANCE PROGRAM  
TRANSPORTATION GRANTS TRANSMITTAL NO. 3  
MCO TRANSMITTAL NO. 39**

January 15, 2003

**TO:** Local Transportation Grants Administrators  
Managed Care Organizations

**FROM:** Susan J. Tucker, *Susan J. Tucker*  
Executive Director  
Office of Health Services

**NOTE:** Please ensure that appropriate staff members in your organization are informed of the contents of this transmittal.

**SUBJECT:** Transportation Requests for Medicaid Fee-for-Service and HealthChoice Beneficiaries

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The purpose of this transmittal is twofold:

- a. To clarify the requirement that local jurisdictions (also known as grantees) are only required to transport Medicaid beneficiaries to the closest appropriate provider; and
- b. To provide instruction to grantees in applying the "closest appropriate provider" requirement to requests by HealthChoice/MCO beneficiaries for transportation to medical services covered under HealthChoice.

**Background – General Requirements**

Federal Medicaid regulations require that States provide transportation to enable Medicaid beneficiaries to obtain necessary medical care and services covered by the Medicaid Program. Transportation grantees must provide transportation in the most efficient and cost-effective way (COMAR 10.09.19.04(A)(5)). Therefore, when, no other transportation resource exists, grantees may approve transportation to the closest appropriate provider of such services. An "appropriate provider" is defined as a provider that:

- a. Participates in the Maryland Medicaid Program;
- b. Has the training and skills necessary to provide the services required by the beneficiary. "Training and skills" includes but is not limited to applicable licensure and/or certification; and
- c. Is willing to accept the beneficiary as a patient.

As a rule, grantees should transport only to the provider that is closest to the beneficiary's home. When two or more appropriate providers are located a comparable distance from the beneficiary's home, grantees may transport to the provider of the beneficiary's choosing. When the differential distances between potential providers and the beneficiary's home are significant, however, grantees are to transport to the closest provider.

#### Clarification of Requirements for HealthChoice/MCO Beneficiaries

Under HealthChoice, beneficiaries are usually limited to receiving care by providers that participate in their managed care organizations' (MCOs') networks. For purposes of handling transportation requests from HealthChoice/MCO beneficiaries, an "appropriate provider," in addition to the criteria listed in the Background section above, is also a provider that participates in the beneficiary's MCO provider network or for whom the MCO has approved an out-of-network referral. Grantees should, therefore, approve and schedule transportation in a way that supports the beneficiary's MCO provider network, within the limits established below.

Grantees should authorize requests for transportation to primary care, pharmacy, OB/GYN, dental, diagnostic, laboratory and x-ray when the destination is:

- a. within 30 minutes travel time or within a 10-mile radius of the beneficiary's residence in urban areas, or
- b. within 30 minutes travel time or within a 30 mile radius in rural areas.

These limits are consistent with the Program's geographic access requirements for MCOs' covered services (COMAR 10.09.66.06).

The grantee should also approve transportation that is marginally beyond these limits if the provider is the closest appropriate one. Transportation to primary services beyond these limits may be denied and become the MCOs' responsibility.

When transportation to specialty care is being sought, grantees shall approve all medically necessary and appropriate transportation requests in

support of the beneficiary's MCO network, as long as the MCO is not bypassing local specialists and sending beneficiaries out of area for locally-available specialty care. If an MCO arranges for a beneficiary to see a specialist outside the area, even though other qualified specialists (in- or out-of-network) are located in the area, the MCO is responsible for the transportation. In these cases, grantees should assist beneficiaries in accessing MCO-funded transportation by working with the Administrative Care Coordination Unit (ACCU) in that county. The ACCU will in turn assist the beneficiary in arranging MCO-funded transportation.

### Reporting

The Program is endeavoring to ensure that MCOs make all reasonable efforts to enroll an adequate number and variety of local providers. To assist the Program in this endeavor, grantees are requested to record and report to the State all requests for medically necessary and appropriate transportation of MCO beneficiaries to medical care beyond the travel time-distance limits for primary providers or outside the local area for specialists (these reports are requested within 15 days of the end of each calendar quarter). Reporting such transactions enables the Program to address network adequacy with the MCOs.

If you have any questions, please call the Transportation staff specialist at 410-767-1739.

cc: Administrative Care Coordination Units



STATE OF MARYLAND

PT 33-17

DHMH

Maryland Department of Health and Mental Hygiene

*Larry Hogan, Governor - Boyd K. Rutherford, Lt. Governor - Dennis R. Schrader, Secretary*

**MARYLAND MEDICAL ASSISTANCE PROGRAM**

**General Provider Transmittal No. 84**

**June 29, 2017**

**TO:** Dental Providers  
Federally Qualified Health Centers  
General Clinics  
Hospitals  
Local Health Departments  
Managed Care Organizations  
Nurse Midwives  
Nurse Practitioners  
Physicians  
Physician Assistants

**FROM:** Susan J. Tucker, Executive Director  
Office of Health Services  
*Susan J. Tucker*

**RE:** Medicaid Program Updates for Spring 2017

**NOTE:** Please ensure that appropriate staff members in your organization are informed of the contents of this transmittal.

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**Provider Enrollment Effective Date – No Backdating**

Effective immediately, Maryland Medicaid will not backdate enrollment for new providers and practice locations or re-enrollment for terminated providers. Federal regulations (42 CFR Part 455) require State Medicaid agencies to screen all initial applications for Medicaid provider enrollment, including applications for a new practice location, and re-enrollment of terminated providers, based on a provider's categorical risk level. CMS guidance on these regulations provides that in the absence of exceptional circumstances, such as a medical emergency, the date of initial enrollment or re-enrollment must be on or after the date that Maryland Medicaid has completed all appropriate screening.

Accordingly, in the absence of a documented emergency, Maryland Medicaid will not reimburse providers for services rendered to Maryland Medicaid participants prior to receiving an enrollment letter.

If you have questions regarding this memorandum, please contact [dhmh.providerenrollment@maryland.gov](mailto:dhmh.providerenrollment@maryland.gov)

## 2017 Physician Updates

Effective January 1, 2017, the Maryland Medical Assistance Program (Maryland Medicaid) updated the Professional Services Fee Schedule (formerly The Physicians' Services Fee Schedule). To view the 2017 Professional Services Fee Schedule and Manual, please go to: [dhmh.maryland.gov/providerinfo](http://dhmh.maryland.gov/providerinfo). In addition to the changes made above, the Professional Services Fee Schedule also includes new CPT codes for 2017, as well as a separate section for injectable/provider administered drugs (J codes) and their rate of reimbursement.

**NOTE:** Please be aware that Maryland Medicaid will not reimburse for injectable/provider administered drugs that are obtained from manufacturers that do not participate in the federal Drug Rebate Program. Maryland Medicaid will deny claims for drugs if the National Drug Code (NDC) is not rebatable. To avoid denied claims, please identify whether the NDC associated with the J Code is able to be rebated by going to the National Drug Code (NDC) Unit of Measure Listing on the eMedicaid site at: <http://enervpt.emdhealthchoice.org/emedicaid/>.

The listing can be accessed via the "NDC Unit of Measure List" link on the left menu of the first screen that you will be presented with after you have successfully logged into the system. If the NDC is not found in this list it is not available for rebate. This list is updated monthly.

## Preauthorizations for Physician's Services

Effective June 15, 2017, all preauthorizations that are approved for physician's services will be valid for 90 days, rather than 60 days as previously authorized.

## Developmental and Behavioral Health Screening Guidance

Maryland Medicaid requires that primary care providers conduct a variety of developmental and mental health screenings for children as a part of the Healthy Kids Preventive Health Schedule and recommends as best practice certain mental health screenings for children, pregnant women, and other adults. In order for primary care providers to better understand the requirements associated with billing for these screenings, Maryland Medicaid has developed a resource entitled, "Billing Guidelines for Developmental and Mental Health Assessment in Primary Care" that can be viewed at the following site: <https://mmcp.dhmh.maryland.gov/epsdt/healthykids/AppendixSection6/Coding-Guidelines-for-Screening-Tools-Primary-Care-final.pdf>

## Maryland Prenatal Risk Assessment

Maryland Medicaid would like to remind Maryland HealthChoice and fee-for-service prenatal care providers about the importance of completing the Maryland Prenatal Risk Assessment (MPRA) form-DHMH 4850. COMAR 10.09.65.08C requires providers to complete the MPRA for all pregnant women who are Maryland Medicaid participants during the first prenatal care visit. The billing code for the completion of the MPRA and development of the plan of care is H1000. The MPRA links pregnant women to important health-related resources in their communities by referring them to the local health department Administrative Care Coordination Unit (ACCU). The referral process also

- strengthens partnerships between patients, providers, MCOs, and local health departments to assure that pregnant women get the complete care they need.

If you have any questions about the MPRA process, please contact the Division of Care Coordination at 410-767-6750.

### **Non-Invasive Prenatal Testing for Fetal Aneuploidy**

Maryland Medicaid will cover non-invasive prenatal testing for fetal aneuploidy using cell-free DNA (NIPT) for eligible participants when determined to be medically necessary. NIPT must be preauthorized by Maryland Medicaid. The preauthorization requirements and medical necessity criteria can be found in the Dental and Laboratory Information section at [dhmh.maryland.gov/providerinfo](http://dhmh.maryland.gov/providerinfo)

### **Self-Referral Fact Sheet**

A self-referral service is a health care service for which, under specified circumstances, Managed Care Organizations (MCOs) are required to pay an out-of-network provider without a referral or authorization by the primary care provider (PCP). MCOs are required to pay for self-referral services at the Maryland Medicaid fee-for-service rate. For more information about self-referral provisions for HealthChoice members, please review Factsheet #1 under "Reproductive Health Provider Resources" at [dhmh.maryland.gov/providerinfo](http://dhmh.maryland.gov/providerinfo).

### **Provider Enrollment Vendor**

Maryland Medicaid will launch a new Electronic Provider Revalidation and Enrollment Portal (ePREP) in late Fall 2017. ePREP will be the one-stop shop for enrollment, re-enrollment, re-validation, provider updates, and demographic changes. Maryland Medicaid will also launch a call center to coincide with ePREP's go-live date. Stay tuned for links and more information in the coming months.

### **Prescriber Enrollment**

The Centers for Medicare and Medicaid Services (CMS) require State Medicaid agencies to enroll providers who prescribe medications to Medicaid participants (see Code of Federal Regulations, Title 42 Public Health, Part 455). Effective June 6, 2017, prescriptions written by unenrolled prescribers will deny at the point of sale. If rendering practitioners at your organization are prescribing to Maryland Medicaid participants and are not enrolled in Maryland Medicaid, please make sure they enroll as the provider type affiliated with their medical license. If the renderer is a resident or intern, they may enroll as Provider Type 92 (prescribing only). Providers enrolling for the first time can apply via Maryland's eMedicaid portal at <http://enrypt.emdhealthchoice.org/emedicaid/>

Providers who are unable to enroll via eMedicaid, can download the application for their provider type from this webpage: [dhmh.maryland.gov/providerinfo](http://dhmh.maryland.gov/providerinfo)

We appreciate your cooperation to meet Maryland Medicaid's federal mandates associated with prescriber enrollment.

## **Ordering/Referring**

The Affordable Care Act (ACA) requires State Medicaid agencies to enroll all ordering/referring professionals who provide services to Maryland Medicaid participants. All billing providers must identify the ordering/referring provider on applicable claims by reporting the valid ten-digit NPI of an individual ordering/referring provider in the designated field within the claim form. Maryland Medicaid will be monitoring providers to ensure that claims include ordering/referring NPIs in the coming months. Claims for an ordered/referred service without a valid ordering/referring NPI will be subject to denial.

If you have professionals within your practice who order/refer services please ensure that they are enrolled with Maryland Medicaid. To enroll, providers should submit an individual application, available at: [dhmh.maryland.gov/providerinfo](http://dhmh.maryland.gov/providerinfo).

Please ensure that all claims submitted to Maryland Medicaid for ordered/referred services include a valid NPI for the ordering/referring provider.

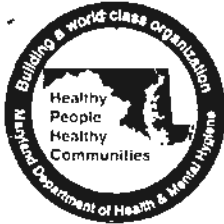
## **Hospital Presumptive Eligibility (HPE) EVS Change & Reminder**

### *Electronic Verification System (EVS) Message Change as of July 1, 2017*

Currently, the EVS message for HPE enrollees states: "Recipient eligible. Full fee-for-service benefits: Hospital Presumptive Eligibility." Because Maryland Medicaid is adding a new Presumptive Eligibility program which has the same coverage span rules as HPE, Maryland Medicaid has changed the EVS message to identify an individual as a Presumptive Eligibility enrollee generally. As of July 1, 2017, the message for HPE and other Presumptive Eligibility enrollees will say: "Recipient eligible. Full fee-for-service benefits: Presumptive Eligibility."

### *EVS Update Schedule Reminder*

While HPE eligibility determinations are immediate, records in the Eligibility Verification System (EVS) are updated only once per day. Applicants enrolled in HPE Monday-Friday will appear in EVS the following day. Applicants enrolled in HPE on the weekend will not appear in EVS until Tuesday morning. Therefore, pharmacies checking EVS cannot fill prescriptions immediately, because HPE participants do not show in the system. To help ensure HPE participants have access to necessary medication, Maryland Medicaid requests that hospitals provide, when possible, take-home supplies of necessary medication. Hospitals should provide a three-day supply of medications for HPE-approved individuals. Hospitals should provide a five-day supply of medications for applicants whose HPE application is "Under Review".



Office of Health Services  
Medical Care Programs

Maryland Department of Health and Mental Hygiene  
201 W. Preston Street • Baltimore, Maryland 21201

Martin O'Malley, Governor - Anthony G. Brown, Lt. Governor - John M. Colmers, Secretary

**Maryland Medical Assistance Program  
General Provider Transmittal No. 73  
April 17, 2009**

**TO:** Medicaid Providers  
*Susan J. Tucker*  
**FROM:** Susan J. Tucker, Executive Director  
Office of Health Services

**NOTE:** Please ensure that the appropriate staff members in your organization are informed of the contents of this transmittal.

**SUBJECT:** Providers' Responsibility to Screen for Excluded Parties

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**Background**

When the Health and Human Services Office of the Inspector General (HHS-OIG) has excluded a provider, the Medicaid program is prohibited from paying for any items or services furnished, ordered, or prescribed by excluded individuals or entities. This payment ban applies to any items or services reimbursable under a Medicaid program that are furnished by an excluded individual or entity, and extends to:

- All methods of reimbursement, whether payment results from itemized claims, cost reports, fee schedules, or a prospective payment system;
- Payment for administrative and management services not directly related to patient care, but that are a necessary component of providing items and services to Medicaid recipients, when those payments are reported on a cost report or are otherwise payable by the Medicaid program; and
- Payment to cover an excluded individual's salary, expenses or fringe benefits, regardless of whether they provide direct patient care, when those payments are reported on a cost report or are otherwise payable by the Medicaid program.

In addition, no Medicaid payments can be made for any items or services directed or prescribed by an excluded physician or other authorized person when the individual or entity furnishing the services either knew or should have known of the exclusion. This prohibition applies even when the Medicaid payment itself is made to another provider, practitioner or supplier that is not excluded.

### **Consequences of Payment to Excluded Providers**

When Medicaid has reimbursed a provider for any service or item provided by an excluded provider as described above, this is considered an overpayment and the Department will recoup this money. Additionally, civil monetary penalties may be imposed against providers and managed care organizations that employ or enter into contracts with excluded individuals or entities to provide items or services to Medicaid recipients.

### **Medicaid Providers Must Screen for Exclusions**

All Medicaid providers should take the following steps to determine whether their employees and contractors are excluded individuals or entities:

- Screen all employees and contractors to determine whether any of them have been excluded.
- Search the HHS-OIG website (<http://www.oig.hhs.gov/fraud/exclusions.asp>) monthly to capture exclusions and reinstatements that have occurred since the last search (see additional information below).
- Routinely search the Sanctioned Providers and Entities Excluded from Participation in Maryland Medicaid Program database located at [http://www.dhmf.state.md.us/oig/pdf/2009/013009\\_exclusion.pdf](http://www.dhmf.state.md.us/oig/pdf/2009/013009_exclusion.pdf).
- Immediately report any exclusion information discovered to the Department.

### **Where Providers Can Look for Excluded Parties**

Providers can search the List of Excluded Individuals/Entities (LEIE) on the HHS-OIG website by the names of any individual or entity. The LEIE website is located at <http://www.oig.hhs.gov/fraud/exclusions.asp> and is available in two formats. The on-line search engine identifies currently excluded individuals or entities. When a match is identified, it is possible for the searcher to verify the accuracy of the match using a Social Security Number (SSN) or Employer Identification Number (EIN). The downloadable version of the database may be compared against an existing database maintained by a provider. However, unlike the on-line format, the downloadable database does not contain SSNs or EINs.

### **Conclusion**

The Department appreciates your support to prevent fraud and abuse in the Medicaid program. If you have questions concerning this transmittal, please contact Pam Owens, Chief Compliance Officer, Office of the Inspector General, at 410-767-5784. To report exclusion information, please write to Dina Smoot, Administrator, Office of Health Services, Department of Health and Mental Hygiene, 201 W. Preston St., Baltimore, MD 21201.



STATE OF MARYLAND



Office of Health Services  
Medical Care Programs

Maryland Department of Health and Mental Hygiene  
201 W. Preston Street • Baltimore, Maryland 21201

Martin O'Malley, Governor – Anthony G. Brown, Lt. Governor – John M. Colmers, Secretary

**Maryland Medical Assistance Program  
General Provider Transmittal No. 74  
April 17, 2009**

**TO:** Medicaid Providers  
*Susan J. Tucker*  
**FROM:** Susan J. Tucker, Executive Director  
Office of Health Services

**NOTE:** Please ensure that the appropriate staff members in your organization are informed of the contents of this transmittal.

**SUBJECT:** Providers' Recordkeeping Requirements  
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**Background**

The Centers for Medicare and Medicaid Services has implemented the Payment Error Rate Measurement (PERM) program to measure improper payments in the Medicaid program and the State Children's Health Insurance Program (SCHIP). Every three years, starting in FY 2007 Maryland Medicaid claims will be audited by CMS.

CMS recently employed contractors to audit a random sample of FY 2007 MD Medicaid claims. The next PERM audit will begin soon and will be conducted on Maryland's FY 2010 Medicaid claims. A new random sample of providers and claims will be drawn for the FY 2010 audit.

If you have claims that are selected for the PERM audits, federal contractors will examine those claims' medical records to ensure there is documentation that supports medical necessity and to verify coding accuracy. You may be requested to provide additional documentation. If the auditors still determine that there is insufficient documentation of medical necessity or that the claim was incorrectly billed, you will have to reimburse DHMH for the overpayment.

**Medicaid Providers Must Produce Records Upon Request**

This transmittal serves as a reminder, pursuant to your provider agreements and to COMAR 10.09.36.03, that you are required to produce records upon request by the Department or its designee. This is a key aspect of the PERM audit process, and you must respond in a timely fashion to all requests for documentation from the Department, the federal contractors, and other Department designees.

### **Medicaid Providers Must Keep Adequate Records**

Also pursuant to your provider agreements and COMAR 10.09.36.03, you are required to keep adequate records and to maintain them for six years. As part of the FY 2010 PERM audit, federal contractors will be reviewing records for documentation of medical necessity and for coding accuracy.

### **Where Providers Can Seek Assistance**

The Medical Care Training and Liaison Unit offers free training sessions to providers about billing requirements related to services rendered under the Maryland Medicaid Program.

Regularly scheduled trainings are offered at various sites throughout the State; a list of dates and locations can be found at [http://www.dhmh.state.md.us/nma/providerinfo/html/train\\_info.htm](http://www.dhmh.state.md.us/nma/providerinfo/html/train_info.htm). If you are unable to attend the regularly scheduled trainings, one-on-one trainings are available. Out-of-state providers may request telephone-based trainings.

If you need assistance or are interested in any of these options, contact the Provider Training & Liaison Unit at (410) 767-6024. Please consider taking advantage of these sessions in order to ensure that you have a better understanding of the Medicaid process.

Providers can also find up-to-date information on the Department's website at <http://www.dhmh.state.md.us/nma/providerinfo/index.html>.

### **Conclusion**

The Department appreciates your cooperation with our recordkeeping requirements and with the PERM audit process. If you have additional questions concerning the upcoming PERM audit, CMS has posted supplementary information on their website at <http://www.cms.hhs.gov/perm/>.



STATE OF MARYLAND

DHMH

Maryland Department of Health and Mental Hygiene

*Larry Hogan, Governor - Boyd Rutherford, Lt. Governor - Van Mitchell, Secretary*

PT 37-16

Office of Health Services  
Medical Care Programs

**MARYLAND MEDICAL ASSISTANCE PROGRAM  
Managed Care Organizations Transmittal No. 110  
March 10, 2016**

TO: Managed Care Organizations

FROM: *Susan J. Tucker*  
Susan J. Tucker, Executive Director  
Office of Health Services

RE: Gender Transition: Covered Services, Coverage Criteria, Limitations and Exclusions

NOTE: **Please ensure that appropriate staff members in your organization are informed of the contents of this transmittal**

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The purpose of this transmittal is to reinforce that, in addition to hormone therapy, HealthChoice Managed Care Organizations (MCOs) are now responsible for covering medically necessary gender transition services including gender reassignment surgery. The Department promulgated regulations effective December 10, 2015 to COMAR 10.09.02.05 to add coverage for gender reassignment surgery. The Department is also amending COMAR 10.09.02.05, .06, 10.09.03.06, 10.09.06.06, 10.09.09.05, 10.09.67.26-2 and 10.90.67.27 to reflect current policy.

When reviewing requests for gender transition services, MCOs will be responsible for the attached list of services. Gender reassignment surgery requires a behavioral health diagnosis of gender dysphoria. MCOs should verify that behavioral health treatment has taken place prior to gender reassignment surgery in accordance with the attached authorization criteria.

Please see the attached optional templates for providers that may be used prior to authorizing gender transition services.

If you have questions regarding this transmittal, please contact Dr. Tiffany Wedlake, Physician Specialist for Managed Care, at [Tiffany.wedlake@maryland.gov](mailto:Tiffany.wedlake@maryland.gov) or (410)767-6250.

Attachments