DHS Oregon Department of Human Services

**Division of Medical Assistance Programs**

# Medical Transportation Program

# Rulebook

Includes:

1) Table of Contents

2) Current Update Information (changes since last update)

3) Other Provider Resource Information

4) Complete set of Medical Transportation Program Administrative Rules

# DEPARTMENT OF HUMAN SERVICES

# MEDICAL ASSISTANCE PROGRAMS

# DIVISION 136

# MEDICAL TRANSPORTATION SERVICES

Update Information (most current Rulebook changes)

Other Provider Resources Information

**Administrative Rules:**


410-136-0030 Contracted Medical Transportation Services

410-136-0040 Reimbursement

410-136-0045 Copayment for Standard Benefit Package

410-136-0050 Out-of-State Transportation

410-136-0060 Taxi Services

410-136-0070 Wheelchair Car/Van Service

410-136-0080 Additional Client Transport

410-136-0100 Deceased Client

410-136-0120 Transportation of Inpatient Client from Hospital to Other Hospital (or Facility) and Return

410-136-0140 Conditions for Payment

410-136-0160 Non-Emergency Medical Transportation

410-136-0180 Base Rate

410-136-0200 Emergency Medical Transportation (With Need for an Emergency Medical Technician)

410-136-0220 Air Ambulance Transport

410-136-0240 Secured Transports

410-136-0260 Neonatal Intensive Care Transport

410-136-0280 Required Documentation

410-136-0300 Authorization

410-136-0320 Billing

410-136-0340 Billing for Clients Who Have Both Medicare and Medicaid Coverage

410-136-0350 Billing for Base Rate -- Each Additional Client

410-136-0360 Billing - Ambulance

410-136-0420 Emergency Medical Transportation Procedure Codes

410-136-0440 Non-Emergency Medical Transportation Procedure Codes

410-136-0800 Prior Authorization of Client Reimbursed Mileage, Meals and Lodging

410-136-0820 Qualifying Criteria for Meals/Lodging/Attendant

410-136-0840 Common Carrier Transportation

410-136-0860 Overpayments -- Client Mileage/Per Diem

# Medical Transportation Program Rulebook

# Update Information

# for

# September 25, 2009

DMAP updated the Medical Transportation Services Program Rulebook by permanently amending the following temporary administrative rules:

- 410-136-0240
- 410-136-0300

DMAP temporarily amended the rules listed above to clarify text that had the potential to prohibit certain appropriate transports of eligible OHP Plus clients to Oregon Health Plan-covered medical services. There is no change in policy with these revisions. DMAP revised the text in OAR 410-136-0300, Authorization; section (12) (c) to clarify that DMAP will not reimburse for secured transports if a person is in the custody of a law enforcement agency or institution. And, in keeping with the text in OAR 410-136-0300, DMAP revised the text in OAR 410-136-0240, Secured Transports; section (4) to clarify that an OHP Plus client is eligible to receive medical transportation benefits to mental health and addictions services if they are court ordered, provided this is not a person who is in the custody of a state, county or federal prison or facility.

When rule text is unchanged from the temporary to permanent status, DMAP simply places the permanent effective date at the bottom of the rule and informs providers of the change in status.

If you have questions, contact a Provider Services Representative toll-free at 1-800-336-6016 or direct at 503-378-3697.

## Other Provider Resources

DMAP has developed the following additional materials to help you bill accurately and receive timely payment for your services.

### Supplemental Information

The Medical Transportation Services Supplemental Information booklet contains important information not found in the rulebook, including:

- ✓ Billing instructions
- ✓ Third Party Resource codes and destination codes
- ✓ Forms
- ✓ Electronic claims information
- ✓ Billing requirements for Medicare-Medicaid ambulance services
- ✓ Other helpful information not found in the rulebook

Be sure to download a copy of the Medical Transportation Services Supplemental Information booklet at:

http://www.dhs.state.or.us/policy/healthplan/guides/medtrans/main.html

Note: DMAP revises the supplement booklet throughout the year, without notice. Check the Web page regularly for changes to this document.

### Provider Contact Booklet

This booklet lists general information phone numbers, frequent contacts, phone numbers to use to request prior authorization, and mailing addresses.

Download the Provider Contact Booklet at:

http://www.oregon.gov/DHS/healthplan/data_pubs/add_ph_conts.pdf

### Other Resources

We have posted other helpful information, including provider announcements, at:

http://www.oregon.gov/DHS/healthplan/tools_prov/main.shtml

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http://www.oregon.gov/DHS/govdelivery.shtml

## 410-136-0030 Contracted Medical Transportation Services

(1) Contracts may be implemented for the provision of medical transportation services in order to achieve one or more of the following purposes:

(a) To obtain services in a more cost effective manner, i.e., to reduce the cost of program administration and/or to obtain comparable services at a lesser cost to the Division of Medical Assistance Programs (DMAP);

(b) To ensure access to necessary medical services in areas where transportation may not otherwise be available or existing transportation would be at a higher cost to DMAP;

(c) To more fully specify the scope, quantity and/or quality of the medical transportation services provided.

(2) Reimbursement for contracted medical transportation services will be made according to the terms defined in the contract language.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.085

2-1-07

**410-136-0040 Reimbursement**

(1) The Division of Medical Assistance Programs (DMAP) will reimburse according to the approved rate or schedule of maximum allowances for:

(a) Ambulance, Air Ambulance, Stretcher Car, Wheelchair Car/Van:

(A) Base Rate;

(B) Mileage;

(C) Base Rate -- each additional client;

(D) Extra Attendant.

(b) Aid Call -- service or care is provided at the scene by the responding emergency ambulance provider and no transport of client was required;

(c) Taxi;

(d) Secured Transport;

(e) Fixed Route Bus Service.

(2) The provider cannot bill DMAP if:

(a) County or city ordinance prohibits any provider from charging for services identified in the Medical

(b) Transportation Services Administrative Rules;

(c) The provider does not charge the general public for such services;

(d) The provider did not provide transport, medical services, or treatment; or,

(e) The provider is providing the transport through a transportation brokerage.

(3) DMAP will make payment for medical transportation when those services have been authorized by either the client's local branch office or DMAP. DMAP may recoup such payments if, on subsequent review, it is found that the provider did not comply with DMAP Administrative Rules. Non-compliance includes, but is not limited to, failure to adequately document the service and the need for the service.

(4) Reimbursement is based on the condition that the service to be provided at the point of origin and/or destination is a medical service covered under the Medical Assistance Programs and that the service billed is adequately documented in the provider's records prior to billing.

(5) DMAP will reimburse at the lesser of the amount charged the general public (public billing rate), the amount billed or the DMAP maximum allowed, less any amount paid or payable by another party.

(6) DMAP will base reimbursement for transportation services covered by Medicare on the lesser of Medicare's allowed amount or the DMAP maximum allowed, less any amount paid or payable by another party.

(7) DMAP will only reimburse for the mode of transportation authorized by the local branch office or DMAP.

(8) DMAP will only reimburse when a transport of the client has occurred or in the case of aid calls where service or care was provided at the scene by an ambulance provider and no transport of the client occurred.

(9) DMAP reimbursement is considered to be payment in full.

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065 2-1-07

## 410-136-0045 Copayment for Standard Benefit Package

A client receiving the Standard Benefit Package may be subject to copayments for Medical Transportation services. See General Rules, 410-120-1235 for additional information.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065

2-1-07

## 410-136-0050 Out-of-State Transportation

(1) Division of Medical Assistance Programs (DMAP) may authorize and make payment for out-of-state transportation when each of the following three conditions are met:

(a) The medical service to be obtained out-of-state is covered under the client's benefit package;

(b) The service is not available in-state;

(c) The service has been authorized in advance by the DMAP Out-of-State Coordinator.

(2) DMAP may also authorize out-of-state transportation when DMAP deems it to be cost-effective.

(3) The least expensive mode of transportation that meets the medical needs of the client will be authorized.

(4) Reimbursement will not be made for transportation out-of-state to obtain medical services that are not covered under the client's benefit package, even though the client may have Medicare or other insurance that covers the service being obtained.

(5) If the client is enrolled in a Prepaid Health Plan (PHP) and the Plan has authorized the service, DMAP may authorize and make payment for out-of-state transportation if the criteria set forth in subsections (1)(a) and (b) of this rule are met.

(6) If a Prepaid Health Plan arranges and authorizes services out-of-state and those services are available in-state, the PHP is responsible for all transportation, meals and lodging costs for the client and any required attendant (OAR 410-141-0420).

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065
2-1-07

**410-136-0060 Taxi Services**

(1) The Division of Medical Assistance Programs (DMAP) will make payment for taxi services, when those services have been authorized by the Branch.

(2) Reimbursement will be made for the most cost-effective route from point of origin to point of destination and billing is limited to the actual meter charge. The DMAP definition of meter charge includes:

(a) A flag rate that does not exceed 110% of the usual and customary charges for the services within the area;

(b) Actual patient miles traveled at a rate that does not exceed 110% of the usual and customary charges for the services within the area;

(c) "In route" waiting time, e.g., red lights, railroad tracks, medical interval, etc.

(3) Charges for assistance or "waiting time" incurred prior to the time the client enters the taxi or assistance after the client exits the taxi are not reimbursable.

(4) Meter charges that include "waiting time" billed to DMAP for a medical interval must be clearly documented in the provider records. Medical interval is defined as any delay in a transport already in progress for events such as:

(a) Nausea, vomiting after dialysis or chemotherapy; or

(b) Pharmacy stop to obtain prescription; or

(c) Other medically appropriate episode.

(5) When client circumstance requires an escort or attendant or when a second client is transported from the same point of origin to the same destination, no additional charge beyond the meter charge is allowed. If more than one client is transported from a single pickup

point to different destinations, or from different pickup points to a single destination, only the meter charge incurred from the first pickup point to the final destination may be billed. No additional flag rate or duplicated miles traveled may be billed.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065

2-1-07

## 410-136-0070 Wheelchair Car/Van Service

(1) The Division of Medical Assistance Programs (DMAP) will make payment for wheelchair car/van services, when those services have been authorized by the branch office.

(2) Payment for wheelchair services will not be made for transportation of ambulatory (capable of walking) clients.

(3) Wheelchair car/vans may also provide stretcher car services if allowed by local ordinance and when those services have been authorized by the local branch office.

(4) A stretcher car/van must be capable of loading a stretcher (gurney) into the vehicle.

(5) Reclining wheelchairs are not considered stretchers (gurneys) and must not be billed as stretcher car/van services.

(6) Payment for stretcher car/van services will not be made for transporting wheelchair clients.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065

2-1-07

## 410-136-0080 Additional Client Transport

(1) Ambulance, Wheelchair Car/Van, Stretcher Car, Taxi, and Contract Services (Ambulatory). If two or more Medicaid clients are transported by the same mode (e.g. Wheelchair Van) at the same time, the Division of Medical Assistance Programs (DMAP) will reimburse at the full base rate for the first client and one-half the appropriate base rate for each additional client. If two or more Medicaid clients are transported by mixed mode (e.g. Wheelchair Van and Ambulatory) at the same time, DMAP will reimburse at the full base rate for the highest mode for the first client and one-half the base rate of the appropriate mode for each additional client.

(2) NOTE: Reimbursement will not be made for duplicated miles traveled.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065

2-1-07

**410-136-0100 Deceased Client**

Reimbursement will be determined as follows:

(1) When death of the client occurs before the arrival of the provider, no payment will be made by the Division of Medical Assistance Programs (DMAP).

(2) When death of the client occurs after the transport has begun but before the destination is reached, payment is limited to the appropriate base rate and mileage.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065

2-1-07

## 410-136-0120 Transportation of Inpatient Client from Hospital to Other Hospital (or Facility) and Return

The Division of Medical Assistance Programs (DMAP) will not reimburse for the transport or return of an inpatient client from the admitting hospital to another hospital (or facility) for diagnostic or other short-term services when the return of the patient occurs within the first 24-hour period. The transportation provider must bill the admitting hospital directly for these transports.

Stat. Auth.: ORS 409.010 & ORS 409.110
Stats. Implemented: ORS 414.065

2-1-07

## 410-136-0140 Conditions for Payment

(1) To qualify for reimbursement by The Division of Medical Assistance Programs (DMAP), a provider of ambulance, air ambulance, wheelchair car, stretcher car, taxi, secured transport or other medical transportation services must meet the following conditions:

(a) Establish rates to be charged to the general public, customarily charge the general public at those rates and routinely pursue payment of unpaid charges with the intent of collection unless prohibited by federal rules and/or regulations from charging for services. Any volunteer, community resource or other transportation service that operates without charge or provides services without charge to the community will not be reimbursed by DMAP when those same services are provided to DMAP clients;

(b) If providing ground or air ambulance services, be in compliance with Oregon Revised Statutes 682.015 through 682.991 (and any rules and regulations pertinent thereto) and must be licensed by the Oregon Health Division of the Department of Human Services (DHS) to operate as ground or air ambulance;

(c) An ambulance service provider located in a contiguous state which regularly provides transports for DMAP clients must be licensed by the Oregon Health Division of DHS as well as by the state in which it is located;

(d) Be in compliance with all statutes, required certifications or regulations promulgated by any local or state government entity.

(2) In the absence of any local regulatory body, a provider must be enrolled with DMAP as a provider of the level of service provided. If providing wheelchair transports, a provider in an unregulated area must be enrolled as a wheelchair transport provider and bill DMAP using the specific codes defined in the Procedure Codes Section of the Medical Transportation Services Provider Guide.

[Publications: The publication(s) referenced in this rule are available from the agency.]

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065

2-1-07

## 410-136-0160 Non-Emergency Medical Transportation

(1) The Division of Medical Assistance Programs (DMAP) will make payment for prior authorized non-emergency medical transportation including client-reimbursed travel, that does not require the services of an Emergency Medical Technician when the client's branch office or DMAP has determined the transport is medically appropriate.

(2) DMAP will not make payment for transportation to a specific provider based solely on client preference or convenience. For purposes of authorizing non-emergency medical transportation, the medical service or practitioner must be within the local area. Local area is defined as "in or nearest" the client's city or town of residence. If the service to be obtained is not available locally, transportation may be authorized to a practitioner within the accepted community standard or the nearest location where the service can be obtained or to a location deemed by DMAP to be cost-effective.

(3) A Branch may not authorize and DMAP will not make payment for non-emergency medical transportation outside of a client's local area when the client has been non-compliant with treatment or has demonstrated other behaviors that result in a local provider or treatment facility’s refusing to provide further service or treatment to the client. In the event supporting documentation demonstrates inadequate or inappropriate services are being (or have been) provided by the local treatment facility or practitioner, DMAP may authorize transportation outside of the client's local area on a case-by case basis.

(4) For a client who is threatening harm to providers or others in the vehicle, or whose health conditions create health or safety concerns to the provider or others in the vehicle, or whose other conduct or circumstances place the provider and others at risk of harm, the State may impose certain reasonable restrictions on transportation services to that client, including but not limited to the following:

(a) Restricting the client to a single transportation provider, or

(b) Requiring the individual to travel with an escort.

(5) If a managed care client selects a Primary Care Physician (PCP) or Primary Care Manager (PCM) outside of the client's local area when a PCP or PCM is available in the client's local area the client is responsible for the transportation to the PCP or PCM and this is not a covered service.

(6) The client will be required to utilize the least expensive mode of transportation that meets the medical needs and/or condition. Ride sharing by more than one client is considered to be cost effective and may be required unless written medical documentation in the branch record indicates ride sharing is not appropriate for a particular client. When more than one Medical Assistance client ride-shares to medical appointments, DMAP will reimburse mileage to only one client. The written documentation will be made available for review upon request by DMAP.

(7) The provider must submit billings for non-emergency ambulance transports provided to clients enrolled in Fully Capitated Health Plans (FCHP) to the FCHP. The Plan will review for medical appropriateness prior to payment. Depending on the individual FCHP the FCHP may or may not require authorization in advance of services.

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065

7-1-07

**410-136-0180 Base Rate**

(1) Ambulance -- All Inclusive. The Division of Medical Assistance Programs (DMAP) reimbursement for ambulance base rate includes any procedures/services performed, all medications, non-reusable supplies and/or oxygen used, all direct or indirect costs including general operating costs, personnel costs, neonatal intensive care teams employed by the ambulance provider, use of reusable equipment, and any other miscellaneous medical items or special handling that may be required in the course of transport. Reimbursement of the first ten miles is included in the payment for the base rate.

(2) Wheelchair Car/Van -- Stretcher Car (including stretcher car services provided by an ambulance). DMAP reimbursement of the first ten miles of a transport is included in the payment for the base rate. A service from point of origin to point of destination (one-way) is considered a "transport."

Stat. Auth.: ORS 409.010
Stats. Implemented: ORS 414.065

2-1-07

**410-136-0200 Emergency Medical Transportation (With Need for an Emergency Medical Technician)**

(1) A service will qualify for Division of Medical Assistance Programs (DMAP) reimbursement as an emergency ambulance transport when a sudden, unexpected medical condition creates a medical crisis requiring immediate transportation (with need for an Emergency Medical Technician) to a site, usually a hospital, where appropriate Emergency Medical Service is available.

(a) An Emergency Medical Service, including the prudent layperson standard, is defined under OAR 410-120-0000. For purposes of this rule, emergency medical transportation is treated as an Emergency Medical Service if the DMAP Member's medical condition that requires transport meets the prudent layperson standard.

(b) Notwithstanding the other provisions of this rule, DMAP Clients with the CAWEM benefit package are governed by OAR 410-120-1210(3)(e)(B) that does not apply the prudent layperson standard.

(2) When transport occurs, the client must be transported to the nearest appropriate facility able to meet the client's medical needs.

(3) Authorizations of, and billings for, emergency ambulance services provided to clients enrolled in Fully Capitated Health Plans (FCHPs) must be submitted to the FCHP. The FCHP will review for Emergency Medical Condition using the prudent layperson standard as defined in OAR 410-141-0000(42)(Emergency Medical Condition) prior to payment.

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065

2-1-07

## 410-136-0220 Air Ambulance Transport

The Division of Medical Assistance Programs (DMAP) will make payment for an air ambulance transport when at least one of the following conditions is met:

(1) The client's medical condition is such that the length of time required to transport, current road conditions, the instability of transport by ground conveyance, or the lack of appropriate level of ground conveyance would further jeopardize or compromise the client's medical condition; or

(2) The non-emergent service has been authorized by the client's branch office or DMAP, after a written recommendation has been obtained by the attending physician indicating medical appropriateness.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065

2-1-07

**410-136-0240 Secured Transports**

(1) The Division of Medical Assistance Programs (DMAP) will reimburse for secured transports when the following conditions are met:

(a) The provider must be able to transport children and adults who are in crisis or at immediate risk of harming themselves or others due to mental or emotional problems or substance abuse;

(b) DMAP must recognize the provider as a provider of secured transports. This requires written advance notice to DMAP (prior to or at the time of enrollment) that the provider has met the requirements of the secure transport provider protocol as established in OARs 309-033-0200 through 309-033-0970;

(c) When medically appropriate (to administer medications, etc. in-route) or in those cases where legal requirements must be satisfied (i.e., a parent, legal guardian or escort is required during transport), one additional person will be allowed to escort at no additional charge to DMAP. The DMAP reimbursement is considered to be payment in full for the transport.

(2) The provider must submit a copy of all rates charged to the general public to DMAP, Provider Enrollment, at the time of enrollment. The provider must submit any changes to those rates to DMAP in writing within 30 days of the change. The notification must indicate the rate changes and effective date. If subsequent review by DMAP discloses that the written notice is not accurate, DMAP may recoup payments.

(3) DMAP will authorize reimbursement on an individual client basis in keeping with the DMAP rules regarding level of transport needed, eligibility, cost effectiveness and medical appropriateness. In the event the provider gave transport on an emergent basis, DMAP will authorize when appropriate after provision of service.

(4) In keeping with the guidelines set forth in 410-136-0300 Section (12) (c), DMAP will reimburse for court ordered medical transportation

for an OHP Plus client who is otherwise eligible for OHP medical transportation services.

(5) The DMAP Medical Care identification (ID) does not guarantee eligibility. The Provider is responsible for verifying client eligibility prior to providing services. This includes determining if DMAP or a managed care plan is responsible for reimbursement. The Provider assumes full financial risk in serving a person who is not confirmed eligible by DMAP as eligible for the service provided on the date(s) of service.

(6) Refer to OAR 410-120-1140 Verification of Eligibility (also see the DMAP General Rules Supplemental Information guide for instructions).

(7) The DMAP Medical Care ID is printed on paper and is the size of a business card. The ID lists the client's name, prime number and the date the ID was issued.

(8) The provider must transport the client to a Title XIX eligible or enrolled facility recognized by DMAP as having the ability to treat the immediate medical, mental and/or emotional needs of a client in crisis.

(9) DMAP must assume that a client being returned to place of residence is no longer in crisis or at immediate risk of harming him/herself or others, and is, therefore, able to utilize non-secured transport. In the event a secured transport is medically appropriate to return a client to place of residence, the branch must obtain written documentation stating the circumstances and the treating physician must sign the documentation. The branch must retain the documentation in the branch record (along with a copy of the order) for DMAP review.

Stat. Auth.: ORS 409.010, 409.050, 409.065, 409.110

Stats. Implemented: ORS 414.065

4-1-09 (T) 9-25-09 (P)

## 410-136-0260 Neonatal Intensive Care Transport

(1) The Division of Medical Assistance Programs (DMAP) will make reimbursement for a neonatal intensive care transport when the conditions listed below are met and the transport has been prior authorized by the Department of Human Services (DHS) branch/DMAP and meets all other eligibility requirements.

(2) The DMAP Medical Care identification (ID) does not guarantee eligibility. The Provider is responsible for verifying client eligibility prior to providing services. This includes determining if DMAP or a managed care plan is responsible for reimbursement. The Provider assumes full financial risk in serving a person who is not confirmed eligible by DMAP as eligible for the service provided on the date(s) of service.

(3) Refer to OAR 410-120-1140 Verification of Eligibility (also see the DMAP General Rules Supplemental Information guide for instructions).

(4) The DMAP Medical Care ID is printed on paper and is the size of a business card. The ID lists the client's name, prime number and the date the ID was issued.

(5) The provider must be recognized by DMAP as a provider of neonatal intensive care transports. This requires advance written notice to DMAP that the provider has met each of the following conditions:

(a) The conveyance vehicle must:

(A) Have the ability to generate 110 volts for a minimum of two hours;

(B) Carry two size 80 (or equivalent) oxygen tanks;

(C) Have lock-down for isolette;

(D) Have the ability to regulate oxygen tanks at 50 PSI;

(E) Have sufficient capacity to transport isolette and four team members;

(F) Have immobilized compressed air and oxygen.

(a) The transport destination point must be recognized by DMAP as a tertiary neonatal intensive care hospital unit.

(6) If subsequent review by DMAP discloses that the written notice is not accurate, payments may be recouped.

Stat. Auth.: ORS 409.010, 409.050, 409.065, 409.110and ORS 414.065
Stats. Implemented: ORS 414.065

## 410-136-0280 Required Documentation

(1) For all claims submitted to the Division of Medical Assistance Programs (DMAP), the provider records must contain completed documentation (pertinent to the service provided) that include, but is not limited to:

(a) Client Name, ID Number and Date of Service;

(b) Emergency Technician Report. The report must indicate at least one or more of the conditions listed in OAR 410-136-0200;

(c) Medical appropriateness of air ambulance transport (as defined in OAR 410-136-0220);

(d) Point of origin, e.g., client address, Nursing Home name and address, location of accident, etc.;

(e) Destination point, e.g., hospital name, doctor name, address, etc.;

(f) Circumstances when billing includes charges for in-route waiting time for medical interval (as defined in OAR 410-136-0060) or unusual waiting time due to unforeseen traffic delay;

(g) Number of actual patient miles traveled;

(h) Justification for extra attendant beyond two (if ambulance or stretcher car) or beyond one (if wheelchair van);

(i) Provider copy of the DMAP 405T (or DMAP 406 or any equivalent) for all non emergency medical transportation;

(j) Second (or additional) destination point(s) address, etc.

(2) All required documentation must be retained in the provider files for the period of time specified in the general rules.

(3) A copy of the Medical Transportation Order must be attached to all billings submitted for secured transports.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065

2-1-07

**410-136-0300 Authorization**

(1) For the purposes of the Administrative Rules governing provision of Medical Transportation Services, authorization is defined to be authorization in advance of the service being accessed or provided.

(2) Retroactive authorization for medical transportation will be made only under the following circumstances:

(a) “After hours” transports to obtain urgent medical care. Medical appropriateness will be determined by branch or the Division of Medical Assistance Programs (DMAP) review;

(b) Secured transports provided to clients in crisis on weekends, holidays or after normal branch office hours. Medical appropriateness for secured transports will be determined by branch/DMAP review to ensure authorization is given and/or reimbursement made only for those transports that meet criteria set forth in 410-136-0240.

(3) Authorization of payment is required for the following:

(a) Non-emergency ambulance;

(b) Non-emergency air ambulance;

(c) Stretcher car (including stretcher car services provided by an ambulance);

(d) Wheelchair car/van;

(e) Taxi;

(f) Secured transport (including those arranged for and/or provided outside of normal branch office hours);

(g) Client reimbursed transportation (including medically appropriate meals, lodging, attendant);

(h) Fixed route public bus systems;

(i) All special/bid transports.

(4) Authorization will be made for the services identified above when:

(a) The transport is medically appropriate considering the medical condition of the client;

(b) The destination is to a medical service covered under the Medical Assistance program;

(c) The client medical transportation eligibility screening indicates the client has no resources or that no alternative resource is available to provide appropriate transportation without cost or at a lesser cost to DMAP;

(d) The transport is the least expensive medically appropriate mode of conveyance available considering the medical condition of the client.

(5) The DMAP Medical Care identification (ID) does not guarantee eligibility. The Provider is responsible for verifying client eligibility prior to providing services. This includes determining if DMAP or a managed care plan is responsible for reimbursement. The Provider assumes full financial risk in serving a person who is not confirmed eligible by DMAP as eligible for the service provided on the date(s) of service.

(6) Refer to OAR 410-120-1140 Verification of Eligibility (also see the DMAP General Rules Supplemental Information guide for instructions).

(7) The DMAP Medical Care ID is printed on paper and is the size of a business card. The ID lists the client's name, prime number and the date the ID was issued.

(8) Authorization must be obtained in advance of service provision. Branch telephone numbers can be found in the DMAP General

Rules. A provider authorized to provide transportation will receive a completed Medical Transportation Order (DMAP 405T or DMAP 406). All transportation orders, including any equivalent, must contain the following:

(a) Provider name or number;

(b) Client name and ID number;

(c) Pickup address;

(d) Destination name and address;

(e) Second (or more) destination name and address;

(f) Appointment date and time;

(g) Trip information, e.g., special client requirements;

(h) Mode of transportation, e.g., taxi;

(i) 1 way, round trip, 3-way;

(j) Current date;

(k) Branch number;

(l) Worker/clerk ID;

(m) Dollar amount authorized (if special/secured transport).

(8) If the Medical Transportation Order indicates ‘on-going’ transports have been authorized, the following information is also required:

(a) Begin and end dates;

(b) Appointment time(s);

(c) Days of week.

(9) Additional information identifying any special needs of the individual client should also be indicated on the order in the “Comments” section. If the order is for a secured transport the name and telephone number of the medical professional requesting the transport, as well as information regarding the nature of the crisis is required.

(10) Authorization for non-emergency services after service provided:

(a) Occasionally a client may contact the provider directly “after hours” (i.e., when the branch office is closed) and order an urgent care medical transport. Only in this case, is it appropriate for the provider to initiate the Medical Transportation Order. All required information (except the branch number, worker/clerk ID and dollars authorized) must be completed by the provider before submitting the order to the branch for authorization. The provider must also indicate on the order the time and day of week the client called. The partially completed authorization order must be received at the appropriate branch office within 30 calendar days following provision of the service;

(b) After branch review (and if approved) the branch will complete the branch number, dollars authorized (if special or secured transport) worker/clerk ID and current date, and return the order to the provider within 30 calendar days. The provider may not bill DMAP until the final approved order is received;

(c) A provider requesting branch authorization for “after hours” rides may be at risk of non-payment if the branch determines the ride was not for the purpose of obtaining urgent medical services covered under the Medical Assistance Programs.

(11) For client reimbursed transportation and fixed route public bus systems, the client must contact the branch office in advance of the travel. Once the transportation has been authorized, money for bus tickets/passes or the actual bus tickets/passes will be disbursed at the branch level. If a client is requesting mileage reimbursement, the

branch is to provide assistance using the current guidelines and methodologies as indicated in the DHS Worker Guide.

(12) Authorization will not be made nor reimbursement provided:

(a) To return a client from any foreign country to any location within the United States even though the medical care needed by the client is not available in the foreign country;

(b) To return a client to Oregon from another state or provide mileage, meals or lodging to the client, unless the client was in the other state for the purpose of obtaining services or treatment approved by DMAP or approved by the client's Prepaid Health Plan with subsequent DMAP approval for the travel; or

(c) For any secured medical transport provided to a person:

(A) In the custody or control of any law enforcement agency;

(B) Who the Department has determined is an inmate of a public institution as defined in OAR 461-135-0950; or

(C) Whose OHP eligibility has been suspended by the Department pursuant to ORS 414.420 or 414.424.

(13) Authorization does not guarantee reimbursement:

(a) Check eligibility on the date of service by calling Automated Information System (AIS) or requesting a copy of the client’s Medical Care Identification;

(b) Ensure the service to be provided is currently a medical service covered under the Medical Assistance program;

(c) Ensure the claim is for the actual services and/or number of services provided.

(d) Per OAR 410-136-0280, for all claims submitted to DMAP, the provider record must contain completed documentation pertinent to the service provided.

(14) DMAP may not be billed for services and/or dollars in excess of the number of services and/or dollars authorized.

Stat. Auth.: ORS 409.010, 409.050, 409.065, 409.110
Stats. Implemented: ORS 414.065

4-1-09 (T)  9-25-09 (P)

**410-136-0320 Billing**

(1) Medical transportation services must be billed on the CMS-1500 or the 837P using the billing instructions and procedure codes found in the Medical Transportation Services Provider Guide.

(2) Completed CMS-1500s or 837Ps should be submitted to the Division of Medical Assistance Programs (DMAP).

[Publications: Publications referenced are available from the agency.]

Stat. Auth.: ORS 409.010 & ORS 409.110

Stats. Implemented: ORS 414.065

2-1-07

## 410-136-0340 Billing for Clients Who Have Both Medicare and Medicaid Coverage

(1) For services provided to clients with both Medicare and coverage through the Division of Medical Assistance Programs (DMAP), bill Medicare first, except when the items are not covered by Medicare.

(2) DMAP services not covered by Medicare should be billed directly to DMAP on either the DMAP-505, CMS-1500 or the 837P.

(3) DMAP may be billed directly (on a DMAP-505 or the 837P) for Aid Call.

(4) DMAP may be billed directly (on a CMS-1500 or the 837P) for the following medical transportation services:

(a) Taxi;

(b) Secured Transport;

(c) Wheelchair Car/Van;

(d) Stretcher Car (including stretcher car services provided by an ambulance).

(5) Except for Aid Call, all services listed above require authorization by the appropriate Department of Human Services office.

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065

2-1-07

## 410-136-0350 Billing for Base Rate -- Each Additional Client

(1) Billings must be submitted to the Division of Medical Assistance Programs (DMAP) on a separate CMS-1500 or the 837P.

(2) Bill using the appropriate procedure code found in the Procedure Code Section of the Medical Transportation Services Provider Guide.

(3) All required billing information must be included on the claim for the additional client.

(4) Ensure a completed Transportation Order for the additional client has been forwarded by the branch for retention in the Provider Record.

[Publications: Publications referenced are available from the agency.]

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065

2-1-07

## 410-136-0360 Billing - Ambulance

The CMS-1500 or the 837P and the Division of Medical Assistance Programs (DMAP)-505 or the 837P forms are the required billing forms for medical transportation. Refer to the appropriate Department of Human Services (DHS) website for information on completion of both forms.

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065

2-1-07

## 410-136-0420 Emergency Medical Transportation Procedure Codes

(1) Ambulance Service -- Bill the following codes using Type of Service "E":

(a) Basic Life Support (BLS) -- Bill using the following procedure codes:

(A) A0429 -- Ambulance service, BLS, emergency transport (BLS-emergency);

(B) A0425 -- Ground mileage, per statute mile;

(C) A0424 -- Extra ambulance attendant, ALS or BLS (requires medical review).

(b) Advanced Life Support (ALS) -- Bill using the following procedure codes:

(A) A0427 -- Ambulance service, ALS, emergency transport, level 1 (ALS1-emergency);

(B) A0433 -- Ambulance service, ALS, emergency transport, level 2 (ALS2-emergency);

(C) A0425 -- Ground mileage, per statute mile;

(D) A0424 -- Extra ambulance attendant, ALS or BLS (requires medical review).

(c) Neonatal Intensive Care -- Bill using the following procedure codes:

(A) A0225 -- Ambulance service, neonatal transport, base rate, emergency transport, one-way;

(B) A0425 -- Ground mileage, per statute mile.

(d) Air Ambulance -- Bill using the following procedure codes:

(A) A0430 -- Ambulance service, conventional air services, transport, one-way (fixed wing);

(B) A0431 -- Ambulance service, conventional air services, transport, one-way (rotary wing).

(e) Aid Call (Ambulance Response and Treatment, No Transport) -- Bill procedure code A0998 for aid call.

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065

2-1-07

**410-136-0440 Non-Emergency Medical Transportation Procedure Codes**

(1) Ambulance Service – Refer to the supplemental guide for billing instructions.

(a) Basic Life Support (BLS) -- Bill using the following procedure codes:

(A) A0428 -- Ambulance service, BLS, non-emergency transport (BLS);

(B) S0215 – Ground mileage, per statute mile;

(C) A0424 -- Extra ambulance attendant, ALS or BLS (requires medical review).

(b) Advanced Life Support (ALS) -- Bill using the following procedure codes:

(A) A0426 -- Ambulance Service, ALS, non-emergency transport, level 1 (ALS1);

(B) A0433 -- Ambulance Service, ALS, non-emergency transport, level 2 (ALS2);

(C) S0215 – Ground mileage, per statute mile;

(D) A0424 -- Extra ambulance attendant, ALS or BLS (requires medical review).

(c) Air Ambulance -- Bill using the following procedure codes:

(A) A0430 -- Ambulance service, conventional air services, transport, one-way (fixed wing);

(B) A0431 -- Ambulance service, conventional air services, transport, one-way (rotary wing).

(d) Wheelchair Car/Van -- Bill using the following procedure codes:

(A) A0130 -- Non-emergency transportation, wheelchair car/van base rate;

(B) S0209 – Ground mileage, per statute mile;

(C) T2001 -- Extra Attendant (each).

(e) Stretcher Car/Van -- Bill using the following procedure codes:

(A) T2005 -- Non-emergency transportation, stretcher car/van base rate;

(B) T2002--- Ground mileage, per statute mile, stretcher car/van

(C) T2001 -- Extra Attendant (each);

(D) T2003 -- Non-emergency transportation, stretcher car service provided by ambulance base rate;

(E) T2049 -- Ground mileage, per statute mile, stretcher car/van by ambulance.

(f) Taxi -- Bill using A0100 (all-inclusive);

(g) Secured Transport (all-inclusive) – Bill using A0434. Attach a copy of the Medical Transportation Order to all billings submitted for secured transports.

(2) All non-emergency Medical Transportation requires authorization in advance of service provision.

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065

2-1-07

**410-136-0800 Prior Authorization of Client Reimbursed Mileage, Meals and Lodging**

(1) The regional transportation brokerage or the client's local branch office must authorize all reimbursement for client mileage, meals and lodging in advance of the client's travel in order to qualify for reimbursement. A client may request reimbursement up to 30 days after their medical appointment(s) provided the expenditure was authorized in advance of the travel and provided that the requested amount is $10 or greater. Reimbursement under the amount of $10 shall be accumulated until the minimum of $10 is reached.

(2) A client must demonstrate medical necessity before the Division of Medical Assistance Programs (DMAP) authorizes reimbursement for mileage, meals and/or lodging. DMAP will only reimburse to access medical services covered under the Oregon Health Plan.

Stat. Auth.: ORS 409

Stats. Implemented: ORS 414.065

2-1-07

## 410-136-0820 Qualifying Criteria for Meals/Lodging/Attendant

(1) Payment for meals may be made when a client (with or without attendant) is required to travel a minimum of four hours out of their geographic area, but only if the course of travel spans the recognized "normal meal time". The following criteria will be used:

(a) Breakfast allowance -- travel must begin before 6 am;

(b) Lunch allowance -- travel must span the entire period from 11:30 am through 1:30 pm;

(c) Dinner allowance -- travel must end after 6:30 pm.

(2) Payment for lodging for the night previous to a next-day appointment may be made when a client would otherwise be required to begin travel prior to 5 am in order to reach a scheduled appointment, or when travel from a scheduled appointment would end after 9 pm. If lodging is available below the Division of Medical Assistance Program (DMAP)current allowable rate, payment will be made for only the actual cost of the lodging.

(3) When medically necessary, payment for meals and/or lodging may be made for one attendant to accompany the client. At least one of the following conditions/circumstances must be met:

(a) The client is a minor child and, therefore, unable to travel without an attendant; or

(b) The client's attending physician has forwarded to the client's branch office a signed statement indicating the reason an attendant must travel with the client; or

(c) The client is mentally/physically unable to reach his/her medical appointment without assistance; or

(d) The client is or would be unable to return home without assistance after the treatment or service.

(4) No reimbursement will be made for the attendant's time or services.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065

2-1-07

## 410-136-0840 Common Carrier Transportation

When deemed cost effective and providing the client can safely travel by common carrier transportation, (e.g., inter/intracity bus, train, commercial airline) reimbursement can be made either directly to the client for purchase of fare or the branch may purchase the fare directly and disburse the ticket (and other appropriate documents) directly to the client.

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065

2-1-07

**410-136-0860 Overpayments -- Client Mileage/Per Diem**

(1) The following situations are considered to be overpayments:

(a) Client mileage and/or per diem monies were paid to the client directly for the purpose of traveling to medical appointments and reimbursement for the same travel was provided by another resource;

(b) Monies paid directly to the client for the purpose of traveling to medical appointments and the monies were subsequently not used by the client for the intended purpose;

(c) Monies were paid directly to the client for the purpose of traveling to medical appointments but the client ride-shared with another client who had also received mileage reimbursement;

(d) Monies were paid directly to the client for the purpose of traveling to medical appointments but the client subsequently failed to keep the appointment;

(e) Bus tickets/passes were provided to the client for the purpose of traveling to medical appointments but were sold or otherwise transferred to another person for use.

(2) All overpayments for client reimbursed travel relating to medical appointments will be recovered from the client by the Adult and Family Services Division's Overpayment Recovery Unit (ORU).

Stat. Auth.: ORS 409
Stats. Implemented: ORS 414.065

2-1-07