



FLORIDA COMMISSION FOR THE TRANSPORTATION DISADVANTAGED (CTD)

CTD MEDICAID NON-EMERGENCY TRANSPORTATION (NET) PROGRAM

POLICY AND PROCEDURES MANUAL

September 2004

**CTD MEDICAID NON-EMERGENCY TRANSPORTATION (NEMT) PROGRAM
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PURPOSE

This manual has been prepared to describe the administration of the Florida Commission for the Disadvantaged (CTD) Medicaid Non-Emergency Transportation (NET) Program. It also describes the responsibilities of the Commission for the Transportation Disadvantaged (CTD), the Agency for Health Care Administration (AHCA), Subcontracted Transportation Providers (STPs), the policies and procedures that STPs will follow in providing services to Medicaid and MediKid beneficiaries, the reporting and billing requirements, and the standards by which STPs will be evaluated. In addition, **“BEST PRACTICE”** guidelines have been imbedded throughout the manual so that providers can incorporate these strategies into their daily operation to maximize both efficiency and effectiveness.

CHAPTER 1
ROLES AND RESPONSIBILITIES

INTRODUCTION

This chapter describes the roles and responsibilities of the participants in the Florida Commission for the Transportation Disadvantaged (CTD) Non-Emergency Transportation (NET) Program. The participants are:

- A. Commission for the Transportation Disadvantaged (CTD);
- B. Agency for Health Care Administration (AHCA);
- C. Official Planning Agencies (OPAs);
- D. Local Coordinating Boards (LCBs);
- E. Subcontracted Transportation Providers (STPs); and
- F. Medicaid and MediKids beneficiaries.

A. COMMISSION FOR THE TRANSPORTATION DISADVANTAGED (CTD)

The role of the CTD will be a management role for the Medicaid Non-Emergency Transportation program. The CTD will enter into agreements with STPs for services in each county.

In its role of manager of the program, the CTD is responsible for providing:

- 1. Uniform contracting, billing and reporting systems;
- 2. Safety and performance standards;
- 3. Payment system to reimburse providers at least monthly;
- 4. Systems for monitoring and providing technical assistance to providers;
- 5. Reports of services and complaints to AHCA on a monthly, quarterly and annual basis;
- 6. Suggestions on improving the cost-effectiveness and efficiency of the program; and
- 7. Compliance with state and federal regulations.

B. AGENCY FOR HEALTH CARE ADMINISTRATION (AHCA)

AHCA is the state agency authorized to administer the Medicaid and MediKids programs. Medicaid's Non-Emergency Transportation Program has been provided through the Community Transportation Coordinators (CTCs) since 1979. In 2004, AHCA entered into an agreement with the CTD to administer and operate the Medicaid Non-Emergency Transportation (NET) Program for Medicaid and MediKids beneficiaries.

AHCA is responsible for providing:

- 1. Access to beneficiary eligibility information;
- 2. Reimbursement to the CTD;
- 3. Policy and contract clarification;
- 4. Timely review of materials submitted;

5. Medicaid and MediKids transportation training;
6. Technical assistance;
7. Data, statistics and other reports; and
8. Periodic contract monitoring.

Medicaid staff have been participants in the administration of the coordinated transportation system through AHCA's representative on the CTD, and through the local area staff's participation on the Local Coordinating Boards throughout the state. Medicaid will continue these roles under the agreement.

C. OFFICIAL PLANNING AGENCIES (OPAS)

Official Planning Agencies (OPAs) may enter into a contract with the CTD to perform several functions. OPAs, whether they be responsible for a metropolitan area, rural area, or a regional one, support the Local Coordinating Boards, are responsible for developing a local Transportation Disadvantaged Service Plan, recommend the appointment of the Community Transportation Coordinator to the CTD, and are involved in the annual evaluation of the Community Transportation Coordinator. OPAs may also enter into a contract with the CTD to perform an annual monitoring of the STPs to ensure compliance of program standards.

D. LOCAL COORDINATING BOARDS (LCBs)

The membership of Local Coordinating Boards (LCBs) represent many agencies and organizations, including AHCA. The LCB for each area serves as the eyes and ears of the local coordinated system, providing advice and direction. Issues and concerns, including complaints and grievances should be addressed locally through the Local Coordinating Board. LCBs are responsible for assisting in the resolution of grievances against STPs. (See Service Denial Process).

E. SUBCONTRACTED TRANSPORTATION PROVIDERS (STPs)

The Subcontracted Transportation Providers (STPs) will play the most important role of the program by offering quality, cost-effective services for Medicaid beneficiaries. The term "STP" is used to describe the entity under contract with the CTD to offer non-emergency transportation services to Medicaid beneficiaries.

STPs are responsible for the following activities:

1. Provide 'gatekeeping' services by implementing appropriate intake and assessment procedures;
2. Provide service to Medicaid beneficiaries in compliance with their contract with CTD;
3. Report encounter data on service provision and complaints, as required;
4. Routinely monitor against safety and driver standards;
5. Monitor subcontractors, if appropriate;
6. Maintain accurate records regarding service provision, monitoring, training and complaint resolution;

7. Provide training to staff on Medicaid contract requirements;
8. Provide access to records when requested by AHCA or CTD; and
9. Maintain compliance with county, local and state requirements.

F. MEDICAID AND MEDIKIDS BENEFICIARIES

Each Medicaid and MediKids beneficiary has the responsibility to provide appropriate information when requesting services. They must provide accurate information to enable the provider to assign the most appropriate method of transport, in the most timely manner. The term “beneficiary” is used to describe an individual who is eligible for Medicaid or MediKids.

The beneficiary has a right to be treated with respect, and must reciprocate by giving adequate notice of the need for scheduling a trip, being available at the assigned pick up time, and giving timely notification if the trip is to be cancelled. It is expected that beneficiaries call to cancel appointments at least 24-hours in advance. Beneficiaries who are disruptive to other passengers may be scheduled for another route, or another driver if available. Beneficiaries have a right to privacy, and all records containing their medical condition must be maintained in a confidential manner.

CHAPTER 2

COVERED SERVICES

INTRODUCTION

This chapter describes the services to be provided eligible beneficiaries under the CTD Non-Emergency Transportation (NET) Program.

COVERED SERVICES

In accordance with federal regulations (42 CFR 431.53), NET services are defined as,

“... medically necessary transportation for any recipient and personal care attendant/escort, if required, who have no other means of transportation available to any Medicaid compensable service for the purpose of receiving treatment, medical evaluation, or therapy.”

FREE SERVICES

STPs may not authorize trips for Medicaid beneficiaries if non-Medicaid beneficiaries are provided the same services free of charge. The only exceptions are services provided by agencies that receive federal funds from Title V (Maternal and Child Health) of the Social Security Act, such as County Health Departments or Children’s Medical Services; or Part B or C of the Individuals with Disabilities Education Act.

Examples of entities providing free services are Community Mental Health Clinics or eye clinics that routinely offer their patients free van service to their facility. STPs may not pay for these services, nor count them in their encounter data reporting as Medicaid trips.

Non-emergency transportation services must be provided to eligible Medicaid recipients for Medicaid compensable medical appointments by utilization of the modes of transportation specified below.

1. Multiload Vehicles
2. Wheelchair Vehicle
3. Stretcher Vehicle
4. Public Transportation
5. Over-the-Road Bus
6. Private and Volunteer Transportation
7. Escort Services
8. Commercial Air Carrier Transportation

NURSING HOME AND MENTAL HEALTH FACILITY NET SERVICES

The STP must allow nursing homes and mental health facilities to arrange and schedule transportation for beneficiaries residing in their facility directly without a formalized contract with the STP for the facility's place of business. At a minimum, nursing home and mental health facilities shall be allowed to:

1. Provide transportation to a resident through vehicles owned and operated by the nursing home or mental health facility after determining that the most appropriate mode of transportation can be provided by such vehicles: and
2. Contact the STP to arrange for transportation services on behalf of the beneficiary residing in the facility if the nursing home or mental health facility is unable to provide the most appropriate mode of transportation.

The STP must authorize and supply transportation for Medicaid beneficiaries when:

1. AHCA has begun a closure or decertification of a nursing facility and transportation is needed for the Medicaid beneficiary to be transported from one nursing facility to another or to an alternate living arrangement; or
2. The beneficiary has a change in level of care that results in the facility not being certified or equipped to provide medically required or specialized services and transportation is needed from one nursing facility to another nursing facility.

COVERED SERVICES LIMITATIONS

STP is prohibited from:

1. Using fee-for-service ambulance transport in lieu of cost-effective and appropriate non-emergency transportation;
2. Limiting Medicaid beneficiaries to a specific number of medical trips for any specific time period if such limitation would effectively prevent the beneficiary from receiving necessary medical care; and
3. Limiting Medicaid beneficiaries to specific providers within a geographical range, establish trip zones, or use similar limitations for the purpose of restricting the distance required to receive medical services if such limitation would effectively prevent the beneficiary from receiving necessary medical care.

EXCLUDED SERVICES

- A. The STP is not required to provide of the following excluded services:

1. Stretcher Van Oxygen Administration. Stretcher van providers are not required to be equipped to provide and administer oxygen to a beneficiary during a transport. Oxygen provided and administered by the beneficiary is appropriate for NET if no other medical equipment or medical care is required en route. Stretcher van providers are also not required to be equipped to maintain a ventilator or care for a beneficiary who is ventilator-dependent during a transport. If a beneficiary has a battery-operated ventilator and an individual who has been trained to provide ventilator care will travel with the beneficiary to a doctor's office or to other medically necessary health care services, the beneficiary is eligible for NET if no other medical equipment or care is required en route. In questionable cases, the need for transport by a stretcher vehicle may require verification or documentation by a medical professional.
2. Ground Ambulance Transportation. NET services do not include ground ambulance transportation unless the ground ambulance is under contract as a stretcher or wheelchair transportation provider as specified in the Wheelchair Van Section, or the Stretcher Van Section. Ground ambulance transportation is also excluded if a local governmental ordinance mandates non-emergency stretcher transportation services be provided in a ground ambulance vehicle.
3. Air Ambulance Transportation. NET services do not include air ambulance transportation.
4. Basic Life Support (BLS) and Advance Life Support (ALS) Transportation. For the purpose of this Agreement, NET services do not include the arrangement, coordination or delivery of transportation services for beneficiaries who require the administration of any level of life support services (ALS or BLS) during transport.

B. The STP is not responsible for the coverage of:

1. The cost of transporting a Medicaid beneficiary back to Florida when that beneficiary has traveled outside of Florida and requires hospitalization and/or subsequent nursing facility care, unless a Medicaid beneficiary has traveled for the purpose of receiving a Medicaid compensable service;
2. Transportation for therapeutic home visits to or from a hospital, hospice, nursing home, ICF/DD, state or other private or public institution;
3. Transportation of a beneficiary from one hospital to another, one nursing facility to another, or from a hospital to a nursing facility, solely based on the preference of the beneficiary or a member of the beneficiary's family;
4. Transportation of deceased Medicaid beneficiaries;
5. Transportation of family members to visit a hospitalized or institutionalized Medicaid beneficiary;
6. Transportation of a Medicaid beneficiary to receive medical training;

7. Transportation of Medicaid beneficiaries to a pharmacy for the purpose of having a prescription filled;
8. Transportation of a Medicaid beneficiary to a medical facility or physician's office for the sole purpose of obtaining a medical recommendation or to pick up medical records;
9. Transportation of a Medicaid beneficiary for socialization and/or therapeutic field visits to locations other than the facility where such services are received;
10. Transportation services that are available to the general public free of charge;
11. Transportation that is already covered by a per diem rate and included in a corresponding cost report. Transportation services are included in an ICF/DD's per diem;
12. Salaries, fees, or other compensation for professional health care attendants; or
13. Transportation of a Medicaid beneficiary to a service covered by a Home and Community-Based Service (HCBS) waiver and transportation is provided and can be billed to the waiver or is included in the reimbursement for the waiver service.

CHAPTER 3

SERVICE ACCESS

INTRODUCTION

This chapter provides information describing how eligible beneficiaries may access the services provided under the CTD Non-Emergency Transportation (NET) Program.

AVAILABILITY OF SERVICES

A non-emergency Medicaid transportation provider must be available to furnish transportation services to Medicaid beneficiaries for urgent (not emergency) care, 24 hours-a-day, seven days-a-week. Urgent care is defined as *“an unscheduled episodic situation in which there is no threat to life or limb but the recipient must be seen on the day of the request under currently accepted standards of care. Treatment cannot be put off until the next day. Hospital discharge shall also be considered as urgent care. This requirement shall also apply to appointments established by medical care providers allowing insufficient time for routine three (3) day scheduling. Valid requests for urgent care transport shall be acknowledged for scheduling within three (3) hours of the time the request is made.”*

BEST PRACTICE:

Some providers contract with a separate operator to provide after-hours service. This reduces the possibility of overtime pay and drivers working too many hours. This operator could be a company that is in the business of providing this level of service to the general public. In rural counties where operators are limited, providers have implemented a call forward system where their phones are forwarded to another number where a staff person is available to arrange services. Answering services is another way of receiving these type requests. One provider has even made arrangements with the local sheriff’s office to receive the calls and then contact the provider representative.

ACCESS TO SERVICES

Beneficiaries and their representatives must be provided full and easy access to Medicaid transportation services. Full access includes the provision of Telephone Devices for the Deaf and access to non-English speaking services, where necessary and requested.

The STP will implement an eligibility screening process by which beneficiaries are screened as to the most appropriate and cost-effective mode of transportation to be used. The elements outlined in the CTD Medicaid NET Intake Form (See Appendix) must be used by all providers in making this determination.

GEOGRAPHICAL CONSIDERATIONS FOR ACCESSING SERVICES

The STP is responsible for the provision of transportation services to eligible Medicaid beneficiaries to or from a stated point of origin or to or from specific Medicaid compensable services at the request of the beneficiary or person acting on behalf of the beneficiary. Transportation outside the area customarily used for health care services by the beneficiary's immediate community is to be provided only when sufficient medical resources are not available in the area or when a health care provider has referred the beneficiary to medically necessary health care services outside of the immediate community.

The STP is responsible for out-of-state NET services to and from Florida Medicaid enrolled health care providers. The STP must utilize the policies and procedures elaborating on how services by ground or air beyond sixty (60) miles of the Florida border shall be coordinated and purchased.

Residence and Closest Medical Facility

The STP is not responsible for providing transportation when the health care provider is located outside a beneficiary's community/vicinity if other similar and appropriate health care providers that offer the same or similar services appropriate for the beneficiary's needs and who will accept the beneficiary as a patient are located closer to the beneficiary's residence.

The STP may request a written referral signed by the referring medical provider and attesting to the need for travel outside the beneficiary's region of residence. Beneficiaries who are denied NET services must be given a written notice of the reason for denial and appeal rights. See Beneficiary Appeals Notice Section. The referral form should be uniform throughout the state and will be subject to approval by the Commission.

Service Area

- a. The STP may provide service to residents of other service areas in response to requests of the STP responsible for those service areas, if an agreed upon rate is determined by both parties.
- b. Other service areas include:
 1. Medical facilities or services available in other communities or contiguous areas not available in the beneficiary's service area but routinely used by residents of the service area who need medical care not provided within their service area; and
 2. Medical facilities or services outside the service area that are closer to the beneficiary's residence than the same type of services within their service area.
- c. The STP may arrange destination and return trips outside the STP's contracted service area when required services are not available within the contracted service area, but are within the state or designated border areas.

BENEFICIARY EDUCATION FOR ACCESSING SERVICES

To inform and educate beneficiaries, each STP is required to provide current Medicaid beneficiaries with the following information within 30 days of execution of the service agreements:

1. STP contact information by county
2. Process to apply for Medicaid NET services
3. CTD Medicaid NET Intake Form
4. CTD Medicaid NET beneficiaries rights and responsibilities
5. CTD Medicaid NET No-Show and Cancellation Policy
6. CTD Medicaid NET Complaint Resolution and Fair Hearing Policy
7. CTD Medicaid NET Denial of Service process

OUTREACH

Outreach efforts will include notifying the beneficiary that there are several initial points of entry for referrals for this service; the CTD may be contacted and refer calls to its contractors for the determination of transportation eligibility and the subsequent arrangement of services.

A program information flyer informing beneficiaries of important phone numbers, and the policies and procedures for requesting services must be made available for distribution to the public. Beneficiaries may contact their local STP for non-emergency transportation information. They may also contact the CTD directly at 1-800-983-2435 or through the Florida Relay System.

ACCESSIBILITY INFORMATION

The STP will ensure oral interpretation services are available free of charge to non-English speaking beneficiaries. This applies to all non-English languages, not just those that the State identifies as prevalent. The beneficiary will not be charged for interpretation services. The STP will notify beneficiaries that oral interpretation is available for any language and written information is available in prevalent languages, and how to access those services.

Written material will be available in alternative formats and in an appropriate manner that takes into consideration the special needs of those who, for example, are visually limited or have limited reading proficiency. All beneficiaries and potential beneficiaries will be informed that information is available in alternative formats and how to access those formats.

The CTD will place all educational materials and information on its web page at www.dot.state.fl.us/ctd.

CHAPTER 4

SERVICE DELIVERY PROCESS

INTRODUCTION

This chapter describes the gatekeeping policies and procedures to be used in determining the eligibility, authorization and mode of transportation necessary for eligible beneficiaries to utilize the services provided under the CTD Non-Emergency Transportation (NET) Program.

GATEKEEPING

For this program, “*Gatekeeping*” is defined as “*the verification that a caller is actually an eligible Medicaid recipient, that Medicaid transportation is needed, and that the appropriate type of transportation is authorized.*” Gatekeeping is the process that:

- a. determines beneficiary eligibility;
- b. assesses beneficiary need for NET services (authorization);
- c. determines the most appropriate transportation method to meet the beneficiary's need, including any special transport requirements for beneficiaries who are medically fragile or who have physical or mental impairments; and
- d. identifies those activities that are limited or excluded from consideration.

GATEKEEPING POLICY

- a. The STP shall comply with the following gatekeeping responsibilities:
 1. Accept requests for transportation directly from beneficiaries, adult family members on behalf of minor beneficiaries, guardians responsible for beneficiaries, and licensed health care professionals on behalf of beneficiaries.
 2. Assure that the beneficiary is a resident of a county in Florida and is currently Medicaid eligible. Beneficiary eligibility shall be obtained by contacting a MEVS Vendor or similar provider, or through FAXBACK with the Medicaid fiscal agent where a fax is sent through an automated system and a report is transmitted back containing beneficiary or provider requested eligibility information.
 3. Attempt to determine if transportation resources exist within the home regularly and/or specifically for the trip requested, and may deny transportation if available through resources in the beneficiary's household. “Household” is defined to include all persons residing at a common address.
 4. Determine if there is a reason why the beneficiary's own transportation cannot be utilized (such as the vehicle is broken, out of gas, etc.) and, if it cannot be utilized, may assist in transportation.

5. Attempt to determine whether any person who does not reside in the beneficiary's household can reasonably provide transportation. "Reasonably" is defined to mean both willing and able. The STP shall not demand the use of transportation resources available through any party residing outside the beneficiary's household.
 6. Require the use of public transportation, where available and appropriate, for beneficiaries who are able to understand common signs and directions. For additional information on requirements for public transportation see Service Standards Section.
 7. Determine if the beneficiary is ambulatory, requires a mobility device, or requires a stretcher for transport. Beneficiaries who must use a mobility device for ambulation or must remain in a lying position shall be transported in vehicles appropriate to their level of need.
 8. Allow for extenuating circumstances in applying the seventy-two (72) hour or less advance application requirement for transportation. Such extenuating circumstances shall include, but not be limited to, such situations as the requirement for post-operative or follow-up appointments in less than seventy-two (72) hours; urgent care requirements as claimed by the beneficiary, adult family members on behalf of a minor, elderly or disabled beneficiaries, guardians responsible for beneficiaries, and licensed health care professionals on behalf of beneficiaries who are residents of a nursing facility or other residential care facility, or who are otherwise unable to communicate for themselves; hospital and emergency room discharges; and transportation to appointments made to replace missed appointments that were not caused by the beneficiary's negligence.
 9. Provide transportation only to a Medicaid compensable service.
 10. Refuse to reimburse the cost of transportation provided for a beneficiary by any relative or member of the same household, exclusive of foster parents.
 11. Some nursing facilities, group homes and personal care homes have one or more vehicles, which are intended to facilitate the general administration of the facility and not necessarily to provide for resident transportation. The STP cannot deny service based on the mere existence of a vehicle. The availability of a vehicle for resident transportation must be determined on a case-by-case basis. If the vehicle is not available for resident transportation at the time required, as represented by the nursing facility manager or director of nursing, as applicable, such vehicle must be excluded from considerations of other available transportation.
 12. Consider information presented by or on behalf of a beneficiary relative to the need for NET services upon each such request for transportation, notwithstanding previous NET denials.
 13. Require that a beneficiary and associated escort be picked up from, and returned to, a common address.
- b. The STP are not responsible for providing transportation when a similar and appropriate health care providers of a similar type that offer the same or similar services appropriate

for the beneficiary's needs and who will accept the beneficiary as a patient are located closer to the beneficiary's residence.

- c. The STP and/or its STPs shall not arbitrarily deny services, but may require as a condition for approval of NET services, a written referral signed by a licensed health care provider attesting to the medical necessity for out-of-area service.

DETERMINATION OF SERVICE PROCESS

The STP must make a determination of need for services by meeting the following basic requirements:

1. The beneficiary's eligibility has been verified;
2. The beneficiary has declared that he or she is a current resident of the subcontract provider/provider's service area;
3. The beneficiary's Medicaid ID number and address have been recorded for reporting purposes;
4. The beneficiary has declared that he or she needs non-emergency transportation;
5. The beneficiary has been determined to have a valid service need;
6. The beneficiary intake information has been obtained;
7. The trip is determined to be within the service locality, or that the needed medical service is not available in the locality; and
8. The transportation mode is the most cost-effective possible.

The STP must advise the beneficiary that:

1. The beneficiary, under penalty of law, shall provide accurate and complete information to determine need for NET services;
2. When requested, the beneficiary must provide, as a condition for receiving service and being determined eligible for the service, information related to the need for services;
3. It is the beneficiary's responsibility to call and cancel an appointment at least twenty-four (24) hours in advance; and
4. Only transportation to or from a health care service provider for a Medicaid covered service is allowable.

BENEFICIARY REQUEST FOR SERVICES

The beneficiary must contact the STP with jurisdiction over the beneficiary's area of residence to request NET services prior to close of office business hours, three (3) workdays or more prior to a non-urgent, scheduled appointment. The three (3) workdays or more advance scheduling includes the day of the call but not the day of the appointment. Advance scheduling will be

mandatory for all NET services except urgent care and follow-up appointments when the timeframe does not allow advance scheduling.

The STP is responsible to provide same-day transportation services when the beneficiary has no other available means of transportation and requests services for urgent care. Valid requests for urgent care transport shall be acknowledged for scheduling within three (3) hours of the time the request is made.

BENEFICIARY INTAKE AND ASSESSMENT

The STP must obtain from the beneficiary, or an individual acting on behalf of the beneficiary, sufficient information to allow a decision regarding the beneficiary's need for NET services. This determination must take into consideration the beneficiary's ability to provide for his or her transportation outside of the NET program, pursuant to the gatekeeper policy established by the Commission as well as the beneficiary's needed level of transportation.

The STP must:

1. Complete an Intake Form
2. Verify the beneficiary's eligibility for Medicaid;
3. Determine if the beneficiary has access to transportation resources other than Medicaid-funded transportation;
4. Determine whether the transportation is for the purpose of receiving a Medicaid-covered service;
5. Select the appropriate mode of transportation based on the beneficiary's physical and mental condition;
6. Select the least costly transportation carrier, assessing whether the beneficiary can access mass transit; and
7. Arrange the transportation with the appropriate transportation carrier.

VALIDITY OF INFORMATION

If the STP has cause to doubt the validity of the information provided by or on behalf of the beneficiary, the STP may require documentation of that information as a condition of providing transportation

BEST PRACTICE:

At the time a telephone request for Medicaid-NET services is being made, the CTC may contact the medical provider/service to confirm that a medical appointment exists for the requestor and that the medical provider/service is a Medicaid-covered provider/services.

MEDICAID, MEDIKIDS AND MEDICAID NET ELIGIBILITY

To qualify for Medicaid NET services, an individual must meet specific eligibility requirements such as age, citizenship or resident alien status, and Florida residency. The individual must have a Social Security Number or proof of having applied for one. Each Medicaid and MediKids eligible beneficiary receives an individual identification card. The beneficiary is instructed to retain the card even during periods of ineligibility. If the beneficiary becomes ineligible for Medicaid and later becomes eligible, the same card is used.

WHO DETERMINES MEDICAID ELIGIBILITY?

Eligibility for Medicaid is determined by the Florida Department of Children and Families, or by the federal Social Security Administration (SSA) for certain categories of elderly and disabled individuals.

MEDICAID ELIGIBILITY DETERMINED BY THE DEPARTMENT OF CHILDREN AND FAMILIES

The Department of Children and Families determines eligibility for the following groups who have income and resources within established limits: low-income families with children and their caretakers, pregnant women, children in foster care, special-needs adoptees, low-income persons who are age 65 and older, low-income persons who are permanently and totally blind or disabled, and low-income persons in need of hospice or institutional care. Information about public assistance and other Medicaid eligibility requirements is available from a Department of Children and Families service center. Presumptive eligibility for pregnant women (PEPW) is determined by qualified provider agencies designated by the Department of Children and Families, including County Health Departments, Regional Perinatal Intensive Care Centers, and other agencies that have been approved upon request.

MEDICAID ELIGIBILITY DETERMINED BY SSA

The Social Security Administration determines eligibility for Supplemental Security Income (SSI), a federal cash assistance program that provides financial assistance to needy aged, blind and disabled individuals. SSI beneficiaries are automatically eligible for Florida Medicaid.

MEDIKIDS

MediKids is a health insurance program for children age one to five years old that is administered by the Agency for Health Care Administration. MediKids is a component of the Florida KidCare Program enacted by the 1998 Florida Legislature. MediKids enrollees are eligible for all Medicaid benefits except home and community-based waiver services. They receive services from Medicaid providers or providers contracted with Medicaid HMOs.

MEDIPASS

MediPass is a primary-care, case-management program designed to assure Medicaid beneficiaries access to medical care, decrease inappropriate service utilization, and control costs. Transportation services do not have to be authorized by the MediPass provider. However, the STP may verify if the medical service that the beneficiary is being transported to receive was

authorized by the MediPass provider. Remember, only those transportation services to Medicaid-reimbursable services are covered.

MEDICAID NET SERVICES ELIGIBILITY DETERMINED BY STP

The STP, through its Gatekeeping policies and procedures, determines the need for Medicaid NET services. Medicaid NET is the transportation of last resort when no other means of transportation is available.

MEDICAID IDENTIFICATION NUMBER AND CARD

The primary identification card for Medicaid is a gold plastic card with a magnetically encoded stripe, similar to a credit card. Possession of a Medicaid ID card does not mean a beneficiary is eligible for Medicaid services. The beneficiary is instructed to retain the card even during periods of ineligibility. If the beneficiary becomes ineligible for Medicaid and later becomes eligible, the same card is used. That is why a provider must verify a beneficiary's eligibility each time the beneficiary receives services. The Medicaid ID card provides direct access to the Florida Medicaid Management Information System (FMMIS) Medicaid eligibility and benefit files.

The eight-digit number on the front of the Medicaid identification card is the card control number used to access the beneficiary's file and verify eligibility. It is not the beneficiary's ten-digit Medicaid identification number that is entered on reports of service provision.

The card control number is one of the beneficiary identifiers that the provider may use to access the beneficiary's eligibility information on the Medicaid computer files. Other identifiers that the provider may use to access eligibility information are a combination of the beneficiary's name, date of birth, and social security number, or the ten-digit Medicaid identification number.

WHO IS ELIGIBLE FOR MEDICAID NET SERVICES

The categories of eligible beneficiaries authorized to utilize Medicaid NET services include:

- a. Low Income Families and Children;
- b. Foster Care Children;
- c. Sixth Omnibus Budget Reconciliation Act (SOBRA) Children and Pregnant Women;
- d. Supplemental Security Income (SSI) Related Medicaid Beneficiaries;
- e. Institutional Care Program (ICP) Residents - Beneficiaries who are eligible for transportation services for placement in a facility while their eligibility determination is being processed (e.g., nursing home residents, etc.);
- f. Title XXI MediKids - A Title XXI health insurance program that provides certain children, who are not Medicaid eligible, with Medicaid benefits;

- g. Medically Needy - A Medically Needy beneficiary is an individual who would qualify for Medicaid but has income or resources that exceed normal Medicaid guidelines. On a month-by-month basis, the individual's medical expenses are subtracted from income; if the remainder falls below Medicaid's income limits, the individual may qualify for Medicaid through the end of the month;
- h. Presumptively Eligible Pregnant Women - This program allows staff at County Health Departments, Regional Perinatal Intensive Care Centers, and other qualified medical facilities to make a presumptive determination of Medicaid eligibility for low-income pregnant women. This presumptive determination allows a woman to access prenatal care while Department of Children and Families eligibility staff make a regular determination of eligibility. Outpatient or office services related to the pregnancy are reimbursed by this program; transportation services are available to support these visits; and
- i. Newborn Enrollment - A child whose mother is enrolled in a Medicaid HMO is automatically covered by the HMO for at least the birth month and the two months immediately following birth, unless the mother disenrolls the child from the HMO.

WHO IS INELIGIBLE FOR MEDICAID NET SERVICES

The categories of ineligible beneficiaries are:

- a. HMO beneficiaries - Beneficiaries who are members of a Medicaid HMO that provides transportation;
- b. Beneficiaries who have their own means of transportation;
- c. Qualified (Medicare) Individuals Level 1 (QI1) and Level 2 (QI2) beneficiaries are not eligible for any Medicaid service except for Medicaid payment of their Medicare premiums, deductibles and coinsurance;
- d. HMO QMB and QMBR beneficiaries are not eligible for any Medicaid service except for Medicaid payment of their Medicare premiums, deductibles and coinsurance;
- e. HMO SLMB beneficiaries are not eligible for any Medicaid service except for Medicaid payment of their Part B Medicare premium;
- f. HMO Beneficiaries with legal alien status have access to emergency services only and are not eligible for non-emergency transportation services;
- g. Vehicle ownership or access;
- h. Qualified Medicare Beneficiaries (QMB) and Qualified Medicare Beneficiaries Renal Dialysis (QMBR);
- i. Special Low Income Medicare Beneficiaries (SLMB); and
- j. Legal Aliens

MEDICAID NET ELIGIBILITY VERIFICATION PROCESS

To determine Medicaid NET eligibility, the STP must:

- a. Review and document beneficiary eligibility to receive transportation services provided by the contract.
- b. Determine that the individual is currently eligible for services by relying upon the eligibility information supplied by one of the following:
 1. Presentation of a valid medical card (Medicaid Gold Card) when smart card systems are in place and set to read the Medicaid Gold Card and capable of obtaining beneficiary eligibility information;
 2. Documentation from a Medicaid Eligibility Verification System (MEVS) vendor;
 3. Documentation by FAXBACK with the Medicaid fiscal agent, or
 4. Documentation by other CTD approved sources.
- c. Regularly verify that the beneficiary is eligible for transportation services. Screening shall ensure:
 1. Verification from the requesting beneficiary that they have no other available means of transportation to medical services;
 2. That the requested transportation is not covered by other programs or funding;
 3. That the requested transportation is to the nearest Medicaid provider of covered services unless authorized by the referring physician.
 4. That authorization for requested transportation shall only be granted for eligible Medicaid services required by the beneficiary,
 5. That private and volunteer transportation or gas vouchers are utilized where appropriate to ensure cost-effective transportation. When private or volunteer mileage reimbursement, or gas vouchers, are utilized, the STP shall have on record: the driver's license, current vehicle registration and obtain documentation of, or proof of, insurance of the vehicle operator. When documentation of the above-listed information is accepted in lieu of copies of the documents, the STP shall obtain copies of these documents as soon as practicable; and
 6. That requested transportation is necessary to the destination and to return from services as authorized under the Agreement.

AUTHORIZATION

Trips may only be reported for reimbursement when the services are for the purpose of transporting a beneficiary to receive a Medicaid-compensable service, when such services are medically necessary, and the distance is reasonable.

MEDICAL NECESSITY

Medicaid reimburses for transportation services if they do not duplicate another provider's services and are determined medically necessary by meeting all of the following criteria: Individualized, specific, consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the recipient's needs; not experimental or investigational; reflective of the level of services that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available statewide; and furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider. The fact that a provider has prescribed, recommended, or approved medical or allied care, goods, or services does not, in itself, make such care, goods or services medically necessary or a covered service.

The fact that a medical provider has prescribed, recommended, or approved medical or allied care, goods, or services does not, in itself, make such care, goods or services medically necessary or a covered service.

REASONABLENESS

Medicaid transportation, which is furnished to ensure a beneficiary's access to medically-necessary services, is allowable only when services are:

- a. The most appropriate mode of transportation,
- b. The most cost effective method of transportation possible, and
- c. Within a reasonable distance of the beneficiary's address.

Reasonableness is not a criterion that can be used to deny transportation to necessary medical care, but it is used to limit transportation to qualified and available medical providers within the beneficiary's service area.

Requests for beneficiaries to be transported out of their service areas are appropriate when the services are scheduled with qualified medical providers whose equivalent services are not available in the service area. Providers may request a written referral from the beneficiary's medical provider stating the need for the additional distance. Transportation providers may require new beneficiaries to select the closest medical provider. Beneficiaries who are receiving routine office procedures or having blood work, lab services or other procedures that do not require a physician in attendance will be transported to the nearest medical provider or facility.

LOCALITY

Medicaid requires that a beneficiary be transported to sources of medical care within the beneficiary's locality, except when the required medical care is not available within that locality.

Locality refers to the county or city in which the beneficiary resides and to immediately adjacent communities. Transportation providers may require the beneficiary utilize the closest provider when the beneficiary is traveling across county lines, and a Medicaid provider within their own city is willing to accept the beneficiary at the closer location. This applies to a city if the transportation across the city boundary is excessive.

This limitation does not apply to beneficiaries enrolled in an HMO when the HMO's nearest treating provider of the necessary medical service is outside the beneficiary's locality. Medicaid does not reimburse transportation for MediPass beneficiaries who choose a primary care provider outside their locality when one is available within their locality.

BEST PRACTICE:

One CTC contacted dialysis centers and worked with them and the local Medicaid office to shift several clients to a closer facility. The Medicaid staff support this effort based on the "nearest medical provider" policy. The ability to influence dialysis scheduling was critical to shifting Medicaid clients to a scheduled service.

MODE OF TRANSPORTATION

LEVELS OF TRANSPORTATION

When determining the most appropriate mode of transportation for a beneficiary, a basic consideration must be the beneficiary's current level of mobility and functional independence. Modes other than public transportation must be used when the beneficiary:

- a. Is able to travel independently but, due to a permanent or temporary debilitating physical or mental condition, cannot use the mass transit system; or
- b. Is traveling to and from a location that is inaccessible (not within 3/4 mile of scheduled route) to mass transit.

The STP will determine the most appropriate mode of transportation needed by the beneficiary. This determination may be based on information provided by the beneficiary or, if a functional assessment process is in place, the results of a functional assessment process.

ALLOWABLE MODES OF MEDICAID NET TRANSPORTION

A. MULTILOAD VEHICLES

A multiload vehicle is a multiple passenger vehicle, typically used for NET services. It is appropriate only for ambulatory or non-ambulatory persons who can enter and exit a vehicle with minimal to no assistance. Assistance means that additional equipment and time are required. Multiload vehicles may include buses, vans, sedans and taxis.

B. WHEELCHAIR AND STRETCHER VEHICLES

Services other than multiload vehicle or public transportation may be required when one of the following conditions is present:

1. The beneficiary has a disabling physical condition which requires the use of a wheelchair, walker, cane, crutches or brace and is unable to use a multiload vehicle, commercial taxi or public transportation;
2. An ambulatory beneficiary requiring radiation therapy, chemotherapy or dialysis treatment, which results in a disabling physical condition after treatment, causing the beneficiary to be unable to access transportation without physical assistance;
3. The beneficiary is unable to ambulate without personal assistance of the driver in entering or exiting the beneficiary's residence and medical facility; or the beneficiary has a severe, debilitating weakness or has a physical or mental disability as a result of illness or health care treatment and requires personal assistance.
4. NET services do not include ground ambulance transportation unless the ground ambulance is under contract as a stretcher or wheelchair transportation provider. Ground ambulance transportation is also excluded if a local governmental ordinance mandates non-emergency stretcher transportation services be provided in a ground ambulance vehicle.

The STP is not precluded from using more intensive modes of transportation if such use is determined to be appropriate. Wheelchair and stretcher van services are considered intensive transportation modes due to a higher level of service required to accommodate the beneficiary's need based on the beneficiary's specific limitation. One of the above limiting conditions must exist before transportation modes other than multiload vehicle or public transportation are considered; however, the existence of a limiting condition does not necessarily mean that a more intensive mode of transportation is required. While the above conditions may demonstrate the possible need for wheelchair or stretcher services, the functional ability and independence of the beneficiary should also be considered in determining the mode of transportation required. The key to the use of more intensive modes of Medicaid NET services is that such services be adequate to meet the health needs of the individual.

A wheelchair vehicle is a motorized vehicle equipped specifically with certified wheelchair lifts or other equipment designed to carry persons in wheelchairs and scooters, or with mobility impairments. Wheelchair vehicles may be used for the provision of ambulatory transportation services to maximize capacity.

Wheelchair services can only be used in non-emergency situations and are limited to use by:

1. Beneficiaries who can sit upright and have no acute medical problems that require them to remain in a lying position;
2. Beneficiaries who are continually confined to a wheelchair;
3. Beneficiaries with severe mobility handicaps that prevent them from using private, public or taxi transportation;
4. Beneficiaries who are semi-ambulatory or homebound, and can accomplish limited ambulatory movement with the assistance of a special ambulatory aid (like a walker or cane); or
5. Beneficiaries who use a mobility device.

A stretcher vehicle is an enclosed vehicle that accommodates a litter and is equipped with locking devices to secure the litter during transit. Stretcher service is required for beneficiaries who are non-ambulatory and need assistance to be transported to and from the vehicle and the health care provider in a reclining position. No flashing lights, sirens, or emergency equipment are required. Stretcher services can only be provided in non-emergency situations and are limited to use by:

1. Beneficiaries who need to remain in a lying position but do not require the administration of life support;
2. Beneficiaries who have severe mobility disabilities that render them unable to sit in an upright position for prolonged periods of time; or
3. Beneficiaries who have begun self-administered home oxygen prior to transport may continue administration during transport. However, no new regimen of oxygen therapy may be started during transport, nor may the attendant employed by the transportation service administer oxygen.

Stretcher van providers are not required to be equipped to provide and administer oxygen to a beneficiary during a transport. Oxygen provided and administered by the beneficiary is appropriate if no other medical equipment or medical care is required en route.

Stretcher van providers are also not required to be equipped to maintain a ventilator or care for a beneficiary who is ventilator-dependent during a transport. If a beneficiary has a battery-operated ventilator and an individual who has been trained to provide ventilator care will travel with the beneficiary to a doctor's office or to other medically necessary health care services, the beneficiary is eligible for services if no other medical equipment or care is required en route.

In questionable cases, the need for transport by a stretcher vehicle may require verification or documentation by a medical professional.

C. PUBLIC TRANSPORTATION (MASS TRANSIT)

In some areas of Florida, public transportation may be a viable and cost-effective alternative to more traditional and expensive forms of non-emergency transportation available to the Vendor and/or its STPs. Public transportation is transportation available, through the payment of a rider fee, to the general public. Public transportation may be provided by transit companies, county or

city governments or federally funded transportation authorities. This type of transportation may be used to provide a full trip or portion of a trip to or from a health care service.

D. OVER-THE-ROAD BUS

An over-the-road bus is traditionally used to traverse long distances such as cross-county and cross-state travel.

E. PRIVATE VOLUNTEER TRANSPORTATION

Volunteer travel is provided by individuals or agencies that receive no compensation or payment other than minimal reimbursement for mileage for the provision of these transportation services. The STP may arrange transportation with the volunteer or organization directly, including scheduling appointments and notifying beneficiaries of arrangements. Additionally, the STP shall be responsible for payment of the minimal mileage of the volunteer transportation. The STP may develop volunteer services as part of its effort to provide NET services in accordance with the contract. Use of volunteer transportation does not alleviate the STP's responsibility to assure the safety, comfort and appropriate mode of transportation consistent with the beneficiary's health care status. The STP must ensure that all volunteers and vehicles used to provide volunteer transportation are properly licensed and insured.

F. COMMERCIAL AIR CARRIER TRANSPORTATION

Commercial air carrier transportation may be provided where appropriate to provide the necessary transportation to eligible Medicaid beneficiaries. If a beneficiary is in need of transportation outside of the state or must be transported a long distance due to the location of specialized medical services, the STP for the beneficiary's area of residence shall work directly with the beneficiary and the AHCA to determine that such services are not available in the beneficiary's locality and shall schedule the commercial air carrier transport and purchase such services as needed. Prior authorization is required for commercial air carrier transportation.

LIMITATIONS AND EXCLUSIONS

The following transportation services are excluded from the Medicaid NET program:

- a. Beneficiary Out-of- State Travel
- b. Transporting Relatives of Private Volunteers
- c. Unavailability of a Medical Provider at a Scheduled Appointment Time
- d. Therapeutic Home Visits
- e. Hospital To Hospital Transfer
- f. Transportation Due To Beneficiary Preference
- g. Transportation of a Deceased Beneficiary
- h. Transportation of Family Members
- i. Receipt of Medical Training
- j. Pharmacy Services
- k. Office or Facility Visitation Other Than Medical Appointment

- l. Socialization and Therapeutic Field Visits
- m. Transportation Already Covered By HCBS Waiver

Florida has the following waiver programs:

- 1) Adult Cystic Fibrosis Waiver
 - 2) Aged/Disabled Adult Waiver
 - 3) Assisted Living for the Elderly Waiver
 - 4) Channeling Waiver
 - 5) Consumer Directed Care Waiver
 - 6) Developmental Services Waiver
 - 7) Model Waiver
 - 8) Nursing Home Diversion Waiver
 - 9) Project AIDS Care (PAC) Waiver
 - 10) Supported Living Waiver
 - 11) Traumatic Brain and Spinal Cord Injury Waiver
- n. Service That Is Available To the General Public Free Of Charge
 - o. Transportation Already Covered By A Per Diem
 - p. Compensation to Professional Health Care Attendants

CHOOSING THE MOST APPROPRIATE VEHICLE

Medicaid transportation must be provided in the most appropriate vehicle according to a beneficiary's mental or physical condition at the time of transport. Consideration must be given to the beneficiary's current level of mobility and functional independence. Public transportation should be used whenever possible, but the following conditions override the use of mass transit:

- 1. The beneficiary is able to travel independently, but due to a debilitating physical or mental condition, cannot use mass transit, or
- 2. The beneficiary is traveling to a location inaccessible to mass transit, or accessibility is not within $\frac{3}{4}$ mile of a scheduled route.

The STP shall determine the most appropriate mode of transportation needed by the beneficiary. This determination may be based on information provided the beneficiary, or if a functional assessment process is in place, the results of a functional assessment process.

BEST PRACTICE:

Public Transportation (Mass Transit) should be selected for beneficiaries who have access to a bus system and can reach their medical appointment by bus in a reasonable time period. Mass transit would, in most cases, present the most cost-effective mode where it is available, and it is expected that it will be used when appropriate. Passengers can be issued single tickets for occasional trips, multiple tokens or passes for high users.

CHAPTER 5

MEDICAID NET OPERATIONS

INTRODUCTION

This chapter describes the transportation operations policies and procedures to be used to provide services under the CTD Non-Emergency Transportation (NET) Program.

BENEFICIARY DROP-OFF AND PICK-UP

Medicaid and MediKids beneficiaries must be dropped off at the medical service provider's location on or before the appointment time. Pickup windows for initial and return trips will be provided in accordance with the local transportation service plan.

TRIP CANCELLATIONS AND NO-SHOWS

If a beneficiary fails to provide a cancellation notice to the STP at least 24-hours in advance of a scheduled trip, then the beneficiary is classified as a "no-show". In addition, cancellations at the door will be considered a "no-show." The STP will provide the CTD a listing of the "no-show" beneficiaries. The no-show beneficiary listing will include the beneficiary's name, phone number, date and time scheduled for transport, and trip destination.

The STP, the CTD, or the AHCA may contact the beneficiaries and counsel them on proper usage of NET services and provide technical assistance. The STP shall track the beneficiaries contacted as no-shows and counseled and keep a record of the technical assistance provided. The STP may take action against beneficiaries (i.e. "lock-in") that have reoccurring no-shows and do not respond to counseling and technical assistance. Such action shall be approved by the CTD Contract Manager prior to implementation.

If the no-show beneficiary provides acceptable, verifiable evidence to the STP or the CTD that the no-show was due to unforeseen and unavoidable circumstances, the missed trip will not be counted as a no-show unless such evidence does not prove the beneficiary was unable to meet the scheduled pick-up time due to unforeseen and unavoidable circumstances.

MISUSE OF MEDICAID NET SERVICES

In situations where it appears that a beneficiary may be misusing Medicaid NET services, either by over utilization or for purposes other than to receive medical care, the STP will inform the CTD and AHCA. An investigation may be warranted by the appropriate authorities to determine if misuse is actually taking place. In addition, the beneficiary must be warned by the Medicaid representative that no Medicaid transportation will be authorized unless the medical necessity for it is documented. The beneficiary must be contacted by letter and informed of the correct procedures to follow in using Medicaid transportation.

FREQUENT CANCELLATIONS

In cases where a beneficiary routinely and continually cancels appointments, the STP should notify the CTD and AHCA, and contact the beneficiary to determine the beneficiary's reasons for cancellation. Documentation of medical appointments can be required if, after counseling, the beneficiary continues to cancel appointments.

The STP may apply the Medicaid NET "No-Show" policy when a beneficiary is a repeated "no-show." The "no-show policy" allows for 'lock-in' where prior authorization is required for each trip, allowing sufficient time to verify with the medical provider the need for medical transport; or restricting the beneficiary to certain days or times of day for travel. See Section 5.2 for no-show reporting requirements.-

No Medicaid beneficiary may be suspended due to excessive no-shows without AHCA's approval.

BEST PRACTICE:

In cases where a beneficiary routinely and continually cancels appointments the provider may contact the beneficiary and try to determine the beneficiary's reasons for cancellation. Documentation of medical appointments can be required if, after counseling, the beneficiary continues to cancel appointments.

ABUSIVE BENEFICIARY BEHAVIOR

Verbal or written reports or complaints received from STPs indicating threatening, violent, or abusive treatment by beneficiaries will be documented and investigated. If substantiated, the beneficiary will be counseled and informed that the provider can refuse to transport the beneficiary. The STP may solicit the assistance from the area Medicaid office when counseling beneficiaries. STPs may require an escort accompany abusive beneficiaries when being transported.

BEST PRACTICE:

Beneficiaries' threatening, violent, or abusive behavior, will be investigated. If substantiated, the beneficiary should be counseled and informed that the provider can refuse to transport the beneficiary. STPs may also contact law enforcement and pursue additional measures when needed.

BEST PRACTICE:

At intake and screening, the provider should identify what alternative transportation may be available to Medicaid beneficiaries who may qualify to receive cost-free transportation. The provider and local planning or medical facility staff can work together to identify any other free or alternative transportation resources that may be available, including faith based organizations.

OUT OF AREA SERVICES

Florida Medicaid pays for medical services out of the state for beneficiaries who are authorized to receive that care. A Florida attending physician may refer a patient to obtain needed services that cannot be provided in Florida. The Florida attending physician must request and obtain prior authorization before the beneficiary receives out-of-state services. The majority of these services are of two different types; the first is an urgent situation, where time is critical and transfers are normally from hospital to hospital and ambulance services are required. The second is not as time-sensitive, but the out-of-state distance makes the use of the provider's inventory impractical. The provider, then, must assist the beneficiary in their service area to access a common carrier. Carriers such as Greyhound, Amtrak, or even commercial air maybe more cost-effective than using the provider's limited resource by offering a dedicated vehicle and driver. Alternative methods such as gas vouchers or rental cars may also be explored for cost-effective long distance trips.

The provider may require medical provider certification when the beneficiary or the beneficiary's representative requests:

- a. Out-of-county transport;
- b. Wheelchair or stretcher transport;
- c. Weekend or night transportation services;
- d. An exception to the provider's evaluation on the most appropriate mode of transportation;
- e. Exception to the advance reservation policy; or

PA FORM AND DOCUMENTATION

The beneficiary's attending physician in Florida must complete a prior authorization, Form PA 01 (See Appendix) and certify in writing that the requested service(s) is not available in Florida. The physician must attach documentation that justifies the need for the service, such as medical history, lab reports, etc., and must also include the name and address of the out-of-state facility, and the name and phone number of the out-of-state facility's contact person.

The transportation provider should contact AHCA to verify that, in fact, out-of-state approval has been secured for the patient to access these services.

OUT-OF-COUNTY COORDINATION

When a beneficiary requires transportation from one county to another, the STP of the originating (sending) county must:

- a. determine the medical necessity and the most appropriate mode of transportation;
- b. authorize the transport;
- c. if necessary, contact the STP in the county of destination for possible coordination; and,

- d. arrange and schedule the return transportation to the originating county.

BEST PRACTICE:

Providers should try to utilize already scheduled inter-county transportation in order to eliminate expensive demand-response, out-of-county trips. Providers that access similar highway corridors could coordinate their long distance transportation and encourage multi-loading.

OUT-OF-COUNTY SERVICE ROUTES

The STP may limit out-of-county trips to specific days of the week (i.e., Tampa on Mondays and Wednesdays; Orlando on Tuesdays and Thursdays). The STP can require documentation from the beneficiary’s medical provider of the medical necessity that makes it imperative to authorize out-of-county transportation that does not correspond to the established schedule.

The STP is responsible for notifying beneficiaries and area medical providers of an established out-of-county service route so that beneficiary appointments can be scheduled accordingly.

COMMON LONG DISTANCE CARRIERS

As an alternative resource to contain the costs of long-distance travel to receive medical services, the STP should use common carriers (e.g., Greyhound) for beneficiaries whose physical and mental condition permits such use. The STP can purchase the ticket from the carrier, and provide additional transportation necessary to the station or depot of the common carrier. The common carrier will likely be more cost-effective than dedicating a driver and vehicle from existing resources to provide the trip.

OUT OF AREA TRANSPORTATION REQUEST FORM

The CTD has developed a consistent form that must be used to authorize out of area trips. The form requires that the beneficiary’s medical provider justify the need for out-of-area transport. The physician is knowledgeable about the patients condition, and the lack of availability of service in the patient’s service area. If the trip is for services out-of-state, the physician will have obtained authorization from Medicaid, and the approved Form PA 01 or other authorization letter from Medicaid may be attached as documentation (See Appendix).

ESCORT SERVICES

The CTD contract requires the STP to allow an escort, when the beneficiary’s condition warrants one. An escort is an individual whose presence is required to assist a beneficiary during transport and at the place of treatment. The escort leaves the vehicle at its destination and remains with the beneficiary. An escort must be of an age of legal majority recognized under Florida law. The Vendor’s STPs must allow, without charge to the escort or beneficiary, one (1) escort to accompany a beneficiary or group of beneficiaries who are blind, deaf, mentally disabled, or under twenty-one (21) years of age, when the beneficiaries are transported to receive

Medicaid covered services. Escorts are justified when, due to age or disability, a Medicaid beneficiary needs the accompaniment and support of another individual to be able to travel to receive necessary medical services. An escort does not include the employee (driver or attendant).

BEST PRACTICE:

Providers have had success in requiring the passenger or individual responsible for arranging the transportation to secure the escort when needed. An innovative approach to assisting passengers on transit systems is the Bus Buddy Program.

BAKER ACT BENEFICIARIES

The Baker Act refers to action taken by the state to protect those individuals who are classified as being a danger to themselves or others. When a Baker Act beneficiary requires transportation to a non-Medicaid compensable receiving facility or institution, the county is responsible for providing the transportation. If a Baker Act beneficiary requires Medicaid compensable services that cannot be furnished at the receiving facility prior to institutionalization, then Medicaid can reimburse for transportation to the required medical services.

MEDICAL APPOINTMENTS IN BORDER STATES

Trips for transporting beneficiaries to receive services from a medical provider in those states bordering Florida (Georgia or Alabama), are allowed if the beneficiary normally goes to that border provider for medical treatment. The provider may subcontract with Georgia or Alabama operators for this service. STPs must enable beneficiaries to receive out-of-state transportation when the beneficiaries have been approved to receive out-of-state medical services. Ensure that Form PA 01 is completed and submitted with out-of-state requests that exceed 60 miles from the Florida border.

CHAPTER 6

SERVICE DENIAL PROCESS

INTRODUCTION

This chapter describes the policies and procedures to be used in denying services under the CTD Non-Emergency Transportation (NET) Program.

APPROVED AND DENIED REQUESTS

If the request is approved, the provider notifies the beneficiary. The provider and beneficiary must be eligible on the date of service, and the provider must have an executed contract with the CTD. See Chapter 5 for the appropriate records which must be retained for each trip.

A provider may deny a trip request in certain circumstances. If a trip request is denied, the beneficiary has the right to appeal the decision. The beneficiary may appeal the decision through the Local Coordinating Board (LCB) grievance process, and may appeal the LCB decision through the CTD and through the Division of Administrative Hearings appeals processes.

STPs may deny a request when the beneficiary:

- a. Refuses to cooperate in determining the status of Medicaid NET eligibility;
- b. Refuses to provide the documentation requested to determine need for Medicaid NET services;
- c. Is found to be ineligible for Medicaid NET services on the basis that the information provided cannot be otherwise confirmed;
- d. Exhibits uncooperative behavior or misuses/abuses Medicaid NET services (the STP must retain documentation of the incident and AHCA must be contacted to offer counseling to the beneficiary if the STPs is considering denying transport to a disruptive client);
- e. Is not ready to board Medicaid NET transport five (5) minutes after the vehicle has arrived; or
- f. Fails to request a reservation three (3) workdays or more in advance of appointment without good cause. For purposes of this section, “good cause” is created by factors such as, but not limited to, any of the following:
 1. Urgent care;
 2. Post-surgical and/or medical follow-up care specified by a health care provider to occur in fewer than three workdays;

3. Imminent availability of an appointment with a specialist when the next available appointment would require a delay of two weeks or more; or
4. The result of administrative or technical delay caused by the STP and required that an appointment be rescheduled.

When the STP denies eligibility of transportation services to a beneficiary, the STP must inform the beneficiary of his/her right to appeal by mailing an initial decision letter outlining the reason the STP is denying transportation services. This letter shall be mailed to the beneficiary no later than seven (7) calendar days following such decision to deny. The beneficiary has a right to pursue a complaint with the LCB's Grievance Committee, the CTD's Ombudsman program, and/or appeal through the Fair Hearings process. The beneficiary will be informed of the process of these levels of appeal and should be encouraged to pursue the local options before requesting a Fair Hearing. A beneficiary has 90 days from the date of the denial or reduction of services notice to request a Fair Hearing, but if he requests a fair hearing within 10 work days of the date of the reduction/denial notice, the provider must continue the service. Providers may not discontinue service until the hearings officer issues his determination, if the beneficiary has filed an appeal within the prescribed timeframe.

COMPLAINT RESOLUTION AND FAIR HEARING PROCESS

When the STP denies eligibility of transportation services to a beneficiary, the beneficiary must be informed of his/her right to appeal by sending, by mail, an initial decision letter outlining the reason the STP is denying transportation services. This letter shall be mailed to the beneficiary no later than seven (7) calendar days following such decision to deny.

The STP must utilize a formal beneficiary appeals process whereby a beneficiary may bring his/her complaint for resolution prior to the beneficiary beginning the formal Medicaid grievance procedures.

Beneficiary transportation cannot be limited or suspended during the review period while the appeal is being reviewed. Beneficiaries must be allowed to schedule and receive transportation services throughout the appeal process.

Complaint Resolution

The STP must maintain a toll-free access for receiving beneficiary complaints. The STP shall ensure that the beneficiary has followed the established complaint procedures.

The STP may utilize the CTD's Ombudsman Program to serve as a regulatory body for the voicing of complaints by beneficiaries. If the complaint is not resolved through the Ombudsman program, the beneficiary must be informed of his/her right to file a formal grievance with the Office of Administrative Appeals or other legal venues appropriate to the specific nature of the complaint.

Fair Hearing Policy

The Medicaid fair hearing policy and process is detailed in Rule 65-2.042, F.A.C. The STP's grievance system policy and appeal and grievance processes shall state that the beneficiary has the right to request a Medicaid fair hearing in addition to pursuing the STP's grievance process. A STP acting on behalf of the beneficiary and with the beneficiary's written consent may request a Medicaid fair hearing. Parties to the Medicaid fair hearing include the STP, as well as the beneficiary and his or her representative or the representative of a deceased beneficiary's estate.

The beneficiary or STP may request a Medicaid fair hearing within 90 calendar days of the date of the notice of action. The beneficiary or provider may request a Medicaid fair hearing by contacting Department of Children and Families at the Office of Public Assistance Appeals Hearings, 1317 Winewood Boulevard, Building 1, Room 309, and Tallahassee, Florida 32399-0700.

The STP must:

1. Continue the beneficiary's benefits while Medicaid fair hearing is pending if:
 - a. The Medicaid fair hearing is filed within 10 workdays of the date on the notice of action (add 5 workdays if the notice is sent via U.S. mail) or the intended effective date of the plan's proposed action.
 - b. The Medicaid fair hearing involves the termination, suspension, or reduction of a previously authorized course of treatment;
 - c. The services were ordered by an authorized provider;
 - d. The authorization period has not expired; and
 - e. The beneficiary requests extension of benefits.
2. Ensure that punitive action is not taken against a provider who requests a Medicaid fair hearing on the beneficiary's behalf or supports a beneficiary's request for a Medicaid fair hearing. If the STP continues or reinstates beneficiary benefits while the Medicaid fair hearing is pending, the benefits must be continued until one of following occurs:
 - a. The beneficiary withdraws the request for a Medicaid fair hearing.
 - b. 10 workdays pass from the date of the STP's adverse decision and the beneficiary has not requested a Medicaid fair hearing with continuation of benefits until a Medicaid fair hearing decision is reached. (Add 5 workdays if the notice is sent via U.S. mail.)
 - c. A Medicaid fair hearing decision adverse to the beneficiary is made.
 - d. The authorization expires or authorized service limits are met.

The STP must authorize or provide the disputed services promptly, and as expeditiously as the beneficiary's health condition requires, if the services were not furnished while the Medicaid fair hearing was pending and the Medicaid fair hearing officer reverses a decision to deny, limit, or delay services.

The STP must pay for disputed services, in accordance with state policy and regulations, if the services were furnished while the Medicaid fair hearing was pending and the Medicaid fair hearing officer reverses a decision to deny, limit, or delay services.

CHAPTER 7

REPORTING AND BILLING

INTRODUCTION

This chapter describes how STPs will report Encounter Data and submit bills for services rendered under the CTD Non-Emergency Transportation (NET) Program.

ENCOUNTER DATA REPORTING

The STP must maintain an extensive secure database capable of collecting and holding, for each transport, the data elements outlined in this Section.

ACTIVITY DOCUMENTATION

The STP must retain, and make available for audit purposes, the following records for five (5) years after termination of the Agreement or for the duration any audit that extends past five (5) years.

The STP must:

- a. Maintain beneficiary eligibility data. Eligibility data shall be provided to the STP by MEVS or FAXBACK or other similar provider. The STP shall use this data to confirm eligibility of persons requesting or receiving transportation services.
- b. Protect the confidentiality of the beneficiary's records.
- c. Keep vehicle logs on file for every transport for five (5) years after the Agreement ends, in accordance with state law.
- d. Maintain encounter data for each one-way trip provided as specified below:
 1. STP's unique identification number assigned by the CTD;
 2. Date the service was provided in month, day, year format: MM/DD/YYYY;
 3. Beneficiary's last name, first name, and middle initial exactly as it appears on the gold, plastic Medicaid ID Card or other proof of eligibility;
 4. Beneficiary's 10-digit Medicaid ID Number. Do not provide the number on the Medicaid ID card. This is a card control number, not the beneficiary's Medicaid ID number;
 5. Total miles of trip provided;
 6. Total cost of trip provided;
 7. Pickup address including the street name and number, apartment number, and city;

8. Time that the beneficiary was picked up. Use military (24-hour clock) time. For example: 3:35 p.m. = 1535;
 9. Complete address of the provider destination including the street name and number, apartment number, and city;
 10. Identify trips that were not provided due to beneficiary no-shows;
 11. Medical necessity of the trip;
 12. Origin of transport code: physician's office (P), clinic (C), laboratory (L), hospital (H), nursing home (N), dialysis (D), or other diagnostic or therapeutic (O), or residence (R);
 13. Destination of transport code: physician's office (P), clinic (C), laboratory (L), hospital (H), nursing home (N), dialysis (D), or other diagnostic or therapeutic (O), or residence (R);
 14. Mode of transportation used: multiload vehicle (MV), public transportation (PT), private volunteer transport (VT), wheelchair (WC), Stretcher (ST), over-the-road bus (OB), or commercial air carrier (CA); and
- e. Enter encounter data requirements for each bus ticket or pass issued, in a format provided by the Commission.

REPORTS

- a. Encounter Data. The STP will prepare reports on encounter data as well as complaints filed and corrective action taken. Some may be summary reports for wide distribution. Others may be detailed reports for CTD and other technical audiences. Users may be the general public, legislators, legislative staff, policy makers, media, and budget analysts. The STP may be required to provide immediate response to ad hoc data requests of CTD staff.
- b. Project Reports. The STP shall utilize project reports established by the CTD. The STP shall utilize reporting formats that will be developed by the CTD. When reporting requirements are not established in the Agreement, the CTD shall provide the STP with instructions and submission timetables. The CTD reserves the right to modify reporting formats and submission timetables as a result of changing priorities or management direction.
- c. Annual Reports. The STP must submit to the CTD, by September 15th of each year, an annual operating report that summarizes all services provided for during the Agreement period. The annual operating report will be provided to the CTD via the electronic reporting mechanism available through the CTD's web page.

- d. Ad Hoc Reporting. The STP must provide reports to the CTD in response to requests for data on a periodic basis. Data should be provided to the CTD within one (1) business day, or longer, if agreed to by both the CTD and the Agency for Health Care Administration.
- e. Other Reports. The STP may be required to provide additional information in the annual, and monthly reports when specified by the CTD.

AUTOMATION REQUIREMENTS

The STP must have the capacity (hardware, software and personnel) sufficient to generate all data and reports needed for this project. The STP shall also have the necessary information technology needed to fully manage and report on the project described in this Agreement.

SYSTEMS COMPLIANCE

The following standards and criteria define systems compliance:

- a. Software and applications will not abnormally end or provide invalid or incorrect results as a result of date data;
- b. In all new applications and where possible in legacy applications, date elements in interfaces and data storage should specify century to eliminate date ambiguity. The standard format for data storage and calculations should follow the international standard date notation, which includes a four-digit year. Applications that use or require month and date representation should conform to the following format: YYYYMMDD where YYYY = full representation of the year, MM = month (between 01 and 12) and DD = day of the month (between 01 and 31). User interfaces (i.e., screens, reports, etc.) should accurately show four digit years. Where this is impossible (i.e., date elements represented without century), the correct century must be unambiguous for all manipulations and/or calculations involving that element.

BILLING THE CTD

CTD MEDICAID NET PAYMENT IS PAYMENT IN FULL

When the CTD pays the STP its monthly lump-sum pursuant to their contract, the STP must accept that payment as payment in full for the transportation of all beneficiaries transported during the reporting period. However, providers may collect a Medicaid authorized co-payment from each beneficiary for each trip in addition to the lump-sum billed to the CTD.

If a STP requests payment and a trip is subsequently rejected, he may not bill the beneficiary, the beneficiary's relatives or any person or persons acting as the beneficiary's designated representative, except as described in the following section.

BILLING THE BENEFICIARY

CTD MEDICAID NET CO-PAYMENTS

The STP, at its discretion, may require a co-payment of beneficiaries that is not greater than \$1.00 per each one-way trip or \$2.00 per each round trip whichever is less. Any change in beneficiary co-payment amounts must receive CTD approval prior to implementation of such increase or decrease.

BENEFICIARIES EXEMPT FROM CO-PAYMENT

The following categories of beneficiaries are not required to pay a co-payment:

- a. Children under 21 years of age;
- b. Pregnant women when the services relate to the pregnancy or to any other medical condition that may complicate the pregnancy or conditions or complications of the pregnancy extending through the end of the month in which the 60-day period following termination of pregnancy ends;
- c. Institutional care program (ICP) beneficiaries who are required to spend all of their income for medical care costs (except for a minimal amount that is required for personal needs) as a condition of receiving services in an institution and who are inpatients in long-term care facilities, hospitals, or other medical institutions.
- d. Beneficiaries who require emergency services after the sudden onset of a medical condition which left untreated would place the beneficiary's health in serious jeopardy;
- e. Beneficiaries when the services or supplies relate to family planning;
- f. Beneficiaries who are enrolled in Medicaid health maintenance organizations (HMOs) or prepaid health plans (PHPs) that provide transportation services; and
- g. Beneficiaries who are receiving hospice services.

If the STP intends to charge the beneficiary for the service because the trip is not allowed by Medicaid, the provider must inform the beneficiary in writing prior to service provision. A copy of this written notification to the beneficiary must be maintained in the STP's record .

A STP may not bill the beneficiary except under the following circumstances:

- a. The beneficiary is not eligible to receive Medicaid services on the date of service,
- b. The transportation service the beneficiary receives is not covered by Medicaid,
- c. The service to which the beneficiary is being transported is not reimbursable by Medicaid or does not meet the exceptions described in this MANUAL,
- d. The beneficiary is enrolled in an HMO or in MediPass and has been informed that the particular service for which he is being transported has not been authorized by the HMO physician or MediPass provider,
- e. The beneficiary is enrolled in an HMO or in MediPass and has been informed that the treating provider is not a member of the beneficiary's HMO network or the beneficiary's MediPass provider,

- f. The beneficiary has been informed that the provider does not accept Medicaid payment for the specific service to be rendered, and
- g. When the beneficiary is responsible for a co-payment for the service, the provider may bill the beneficiary for the co-payment.

BENEFICIARY’S INABILITY TO PAY

A STP cannot deny service to a beneficiary based solely on the beneficiary’s inability to pay a Medicaid co-payment amount. If the beneficiary is unable to pay at the time services are rendered, the STP may bill the beneficiary for the unpaid charge.

BEST PRACTICE:

Ask beneficiaries to sign or initial driver manifest recording whether co-payment was made.

Make notes on client files in the computer of those clients who owe co-payments. When beneficiaries call to make trip arrangements, remind them that they have an obligation to make payment. Many individuals have made payments.

Contact dialysis centers to seek assistance with the co-payment for their clients. Other types of facilities could be contacted as well.

CHAPTER 8

SERVICE MONITORING

INTRODUCTION

This chapter describes the requirements the STPs must meet in order to maintain their contract with the CTD Non-Emergency Transportation (NET) Program.

ANNUAL MONITORING

The STPs shall be monitored on an annual basis by the CTD and OPAs to assure that they meet the required health and safety standards for vehicle maintenance, operation, and inspection; driver qualifications and training; beneficiary problem/complaint resolution; and the delivery of courteous, safe, and timely transportation as outlined in their contract with the CTD. This monitoring will include:

A. SAFETY AND SERVICE STANDARDS

Providers must comply with the safety standards outlined in Chapter 14-90, F.A.C.; the entire listing of standards and the method of validation for each, are listed in the CTD's "*CTD Medicaid NET Evaluation QA Workbook*." The requirements include standards for operations and maintenance, annual inspection of vehicles, driver and operation requirements, accident information, equipment standards, and accessibility requirements.

B. BENEFICIARY ACCESS TO SERVICES

Annual monitoring of providers' compliance with their relationship with the beneficiaries will be conducted. Standards subject to annual review include provider's timeliness of phone response; customer service techniques; accurate and timely response to beneficiaries' requests for service; and educational efforts directed toward informing beneficiaries of instructions for requesting service, night and Holiday coverage arrangements, and their rights to appeal.

Providers will be assessed on the extent to which the beneficiary was appropriately screened for services, to ensure that the appropriate type of vehicle was used; and the provider's abilities to accommodate beneficiaries' needs for special transportation.

C. SUBCONTRACT MONITORING

Providers shall be responsible for annually monitoring any subcontractors for compliance with the contract's requirements. STPs will maintain all documentation relating the monitoring of such subcontractors.

PERFORMANCE IMPROVEMENT PLANS AND SANCTIONS

Performance Improvement Plan

Should the CTD find a provider out of compliance with their contract, it may issue a request for a Performance Improvement Plan (PIP). The CTD will identify the issues of non-compliance and recommend a date for correction. The provider must develop the PIP and return it to the CTD for approval within 15 days. The CTD may suggest changes, but if the provider does not meet the timelines with corrective action, the CTD may issue a sanction.

Sanctions

If the CTD finds that the provider is in violation of its contract, the provider may be subject to sanctions. Three sanctions are authorized: withholding payment, fines (5% maximum of monthly request), and termination.

APPENDIX A

GLOSSARY

ADA (Americans with Disabilities Act) -- Includes regulations for agencies and entities that provide services to persons with disabilities.

Business Day -- The business office must be open at a minimum between the hours of 8:00 a.m. and 5:00 p.m., Monday through Friday.

Climate Control System -- The heating or air conditioning system of the vehicle in question.

CMS (Centers for Medicare and Medicaid Services) -- The organizational unit of DHHS responsible for administering Title XIX of the Social Security Act, which is Medicaid.

DHHS -- The United States Department of Health and Human Services.

Deliverable -- Each documentation, report, MANUAL, and every other item that the STP is required to produce under the terms and conditions of this Agreement.

Dependent -- An individual under the age of eighteen (18). A dependent may be a Medicaid recipient.

Dispatching -- The act of designating a specific vehicle and driver to pick-up and deliver a Medicaid recipient.

Eligible (Medicaid Eligible) -- A person who is determined to be eligible for Medicaid services by the Social Security Administration, or Department of Children and Families.

Emergency Care -- Care that is medically necessary as a result of a sudden onset of a medical condition manifesting itself by acute symptoms of such severity that the absence of immediate attention could reasonably be expected to result in serious dysfunction of any bodily part or death of the individual.

Encounter Data - Data on transportation services provided to Medicaid recipients.

Escort -- An individual whose presence is required to assist a recipient during transport and while at the place of treatment. Escorts cannot be charged any cost for transportation when accompanying a recipient requiring assistance.

EVS (Eligibility Verification System) -- A system for verifying recipient eligibility for Medicaid services, usually by direct, on-line computer hook-up.

Fixed Route – Service in which the vehicle(s) repeatedly follows a consistent time schedule and stopping points over the same route, whereby such schedule, route or service is not at the user’s request.

Gatekeeping -- The verification that a caller is actually an eligible Medicaid recipient, that Medicaid transportation is needed, and the appropriate type of transportation is authorized.

Independent Contractor -- See transportation provider.

In State/Out-of-State Travel -- In-state travel refers to all NET services the STP is responsible to assure delivery within the boundaries of the State of Florida and within a line drawn outside the Florida border. Out-of-state travel refers to travel outside of the predetermined border limit.

Intake and Screening -- See Gatekeeping.

Medicaid ID Number -- A unique identification number assigned to each Medicaid recipient for eligibility card issuance and claims submittal purposes.

Medical Necessity -- Medicaid reimburses for transportation services if they do not duplicate another provider’s services and are determined medically necessary by meeting all of the following criteria: Individualized, specific, consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the recipient’s needs; not experimental or investigational; reflective of the level of services that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available statewide; and furnished in a manner not primarily intended for the convenience of the recipient, the recipient’s caretaker, or the provider. The fact that a provider has prescribed, recommended, or approved medical or allied care, goods, or services does not, in itself, make such care, goods or services medically necessary or a covered service.

Medicare -- The federal medical assistance program that is described in Title XVIII of the Social Security Act. It is not the same as Medicaid.

Minibus -- A multiple passenger van, and also includes buses, sedans, and taxi.

Monitoring – The CTD shall monitor the STP’s performance of duties under this Agreement by a variety of methods. Satisfactory, quality performance is required.

NET (Non-Emergency Transportation) -- In accordance with federal regulations (42 CFR 431.53), the Non-Emergency Transportation (NET) program offers transportation services for Medicaid recipients who need to secure necessary medical care and have no other means of transportation.

NET Trip -- A one-way transportation service from the recipient's place of origin to the place where a covered medical service will be provided to that recipient or the reverse or from one covered medical service to another.

NF -- Nursing facility or nursing home.

Non-Emergency Transportation Services -- These are non-emergency transportation services provided to Medicaid recipients by STPs and transportation operators that provide recipients with access to necessary medical services when the recipients have no other personal transportation available.

Operational Procedures MANUAL -- A MANUAL developed by the STP that presents the procedures for scheduling, after-hours services, urgent care, driver customer service standards, record keeping requirements for drivers, etc.

Public Transportation -- City, county or municipal subway, bus, rail, and other transportation services available in a number of locations in Florida.

Recipient -- An individual eligible for medical assistance in accordance with the State's Medicaid program who has been certified as such by the Social Security Administration and the Department of Children and Families.

Recipient Appeal -- Recipients have the right to appeal when the Provider has denied or terminated or suspended NET services to them.

Recipient Residency -- The county or service area within which the Medicaid recipient is regularly domiciled.

Reservation -- The verification of a trip for a recipient at a specific time and place for pick-up and delivery to a specific destination.

Scheduling -- The process through which a Medicaid recipient contacts the STP who assigns the trip to the most appropriate transportation provider. Normally, this must be done at least three (3) days before the NET service is required.

Scheduling Day/Hours -- Any day or time when the STP is expected, under the terms of this Agreement, to have personnel available for scheduling NET services. Designated hours during which scheduling of appointments can be done is a mandated function of the STP.

Service Agreement -- An Agreement between a CTD and a STP for the delivery of transportation services.

Social Security Administration (SSA) -- The federal agency that determines eligibility for SSI, including Medicaid benefits.

State -- State of Florida.

State Medicaid Plan -- The comprehensive written commitment by a Medicaid agency, submitted under section 1903(a) of the Social Security Act, to administer or supervise the administration of a Medicaid program in accordance with federal and state requirements.

Stretcher (Non-emergency) Van -- An enclosed vehicle that accommodates a litter and is equipped with locking devices to secure the litter during transit. Recipients using this vehicle must be non-ambulatory and need the assistance of at least two persons in order to be transported to and from the vehicle and health care provider in a reclined position. No flashing lights, sirens or emergency equipment are required.

Subcontractor -- A person, company or organization the CTD enters into a Contract with to provide the services delivered under this Agreement

SSI (Supplemental Security Income) -- A type of cash assistance received by individuals determined eligible by the Social Security Administration. Medicaid benefits are included in the eligibility determination made by the Social Security Administration.

TTY (Text Telephony) -- A specially designed telephone device equipped with a keyboard and small screen, which allows two-way conversation. This service may also be available in software to modem personal computer compatibility.

Transportation Operator -- Those entities that own and operate vehicles engaged in the direct delivery of transportation and provide services to recipients through the scheduling of the STP.

Transportation Service Agreement -- An agreement between the CTD and a transportation provider for the delivery of transportation services.

Urgent Care -- An unscheduled episodic situation in which there is no threat to life or limb but the recipient must be seen on the day of the request under currently accepted standards of care. Treatment cannot be put off until the next day. Hospital discharge shall also be considered as urgent care. This requirement shall also apply to appointments established by medical care providers allowing insufficient time for routine three (3) day scheduling. Valid requests for urgent care transport shall be acknowledged for scheduling within three (3) hours of the time the request is made.

Vehicle Identification Number (VIN) -- The unique number given to each vehicle produced by a manufacturer.

Vehicle Log -- A log which is kept by the vehicle driver that reports information on all trips with that vehicle: names of driver and recipients, times, pick-up and delivery points, and odometer readings.

Vendor -- An entity that is responsible for recruiting and contracting with transportation providers; payment administration; quality assurance of services; and administrative oversight and reporting.

Volunteer Transportation -- Transportation provided by individuals or agencies that receive no compensation or payment other than minimal reimbursement for mileage for the provision of these transportation services.

Wheelchair Van -- A van equipped with lifts and locking devices to safely secure a wheelchair while the van is in motion.

Work Day -- For purposes of establishing business hours and satisfying reporting requirements: a minimum of Monday through Friday between the hours of 8:00 a.m. and 5:00 p.m. with the exception of New Years Day, Memorial Day, July Fourth, Labor Day, Thanksgiving Day and the day after, and Christmas Day.