Specialty Care Transport (SCT): A transport is considered a “specialty care transport” when a specially trained paramedic is required to ride on the vehicle and provide service. Thus, personnel trained beyond the paramedic definition would be considered allowable staff based on medical necessity and Medicare ambulance guidelines. If the training the Medic has received is beyond the scope of a paramedic and is reasonable and necessary based on Medicare ambulance guidelines, the Medic would be considered allowable on the SCT as long as the Medic is authorized to perform the services in your state, and the health plan has agreed to pay for these services.

Subscriber: A “Subscriber” or “Member” is an individual who resides and/or works in the Service Area and is eligible for covered Transportation Services in the health benefits plan offered by the contracted Payer and who has been accepted for enrollment into a Payer’s health plan and is covered by such health plan at the time services are rendered. Also see CMS definition of an “Enrollee” contained in the Chapter 5, Quality Management Program.
**Explanation of Benefits (EOB):** A written statement from an insurance company or third party Payer, which lists the amounts paid (or not paid/denied) based upon the subscriber’s benefit contract.

**Health Insurance Portability and Accountability Act (HIPAA):** An Act enacted by the federal government on August 21, 1996, with the intent to assure health insurance portability, reduce health care fraud and abuse, guarantee security and privacy of health information and enforce standards for health information.

**Health plan:** An individual or group plan that provides or pays the cost of medical care. Includes Group Health Care Plans, Health Insurance Company, Health Maintenance Organization (HMO), Preferred Provider Organization (PPO), Independent Practice Association (IPA), Managed Care Organization (MCO), self-insured groups, third party administrators/payers, unions and employer groups.

**Medical Necessity:** Medically Necessary health care services are those necessary to preserve and maintain a subscriber’s health in accordance with acceptable standards of medical practice and received in an appropriate setting. The health plan’s Medical Director shall determine whether a particular health care service rendered to an Enrollee is Medically Necessary for the purpose of determining whether such health care services are covered services and not for the purpose of practicing medicine or determining a course of treatment, which course is to be determined by the Participating Physician. Such Payer determination means that Covered Transportation Services are deemed:

1. Appropriate and necessary for the symptoms, diagnosis or treatment of the Member’s condition, disease, illness or injury
2. Provided for the diagnosis, care and treatment of the Member’s condition, disease, illness or injury;
3. Within standards of good medical practice within the medical community;
4. Not primarily for the convenience of the Member, PTP or another health care provider; and
5. The most appropriate supply or level of service which can be safely provided to the Member.

**Payers:** A health plan (as defined above) or other payer which has directly or indirectly contracted with NMN for the services of Provider and which is responsible for paying for Covered Transportation Services rendered to Subscribers or employees.

**Protected Health Information (PHI):** PHI is information that has been electronically maintained or transmitted by or to NMN or health plan. It includes any information that identifies members including name, address, medical, enrollment and claims information.

**Provider:** A provider of health care or transportation services as defined in Section 1861 (u) of the Social Security Act (SSA), a provider of medical or other health services as defined in Section 1861 (s) of the SSA, and any other person or organization who furnishes or bills and is paid for health care in the normal course of business.

**Rural Air Ambulance Services:** The term “rural air ambulance service” means fixed wing and rotary wing air ambulance service in which the point of pick up of the individual occurs in a rural area (as defined in Section 1886 (d)(2)(D) or in a rural census tract of a metropolitan statistical area (as determined under the most recent modification of the Goldsmith Modification, originally published in the Federal Register on February 27, 1992 (57 Fed. Reg. 6725).
Chapter 8

GLOSSARY

In addition to the definitions provided by CMS in Chapter 5 of this manual, relating to Grievances and Appeals, as follows are definitions not covered above.

Benefit Plans: The evidence of coverage issued by the Payer that describes its obligations to arrange for the delivery of Covered Services to Subscribers who are eligible for such services. Each Benefit Plan shall identify those health care services, which are Covered Services available to Members and shall enumerate all applicable maximums, limitations and exclusions with respect to Covered Services to Members.

Coordination of Benefits Transaction (COB): A transaction sent from any entity (usually an insurer) to a health plan (another insurer) for the purposes of determining the relative payment responsibilities of the health plan of either of the following for health care:

- Claims
- Payment information

Covered Transportation Services: “Covered Transportation Services” means those transportation services, including but not limited to ambulance, ambulette, Livery services and air ambulance, that are subject to the programs provided for in the Agreement and are included in a Payer Plan, as defined in the applicable Payer Plan Notice found in Chapter 2 of this Provider Manual.

Electronic Data Interchange (EDI): Transfer of electronic information between two parties to carry out financial and administrative activities.

Emergency Services: The term “emergency” means services provided after the sudden onset of a medical condition manifesting itself by acute symptoms of such severity (including severe pain), that a prudent layperson, who possesses an average knowledge or medicine and health, could reasonably expect that the absence of immediate medical attention could reasonably be expected to result in any of the following:

- Placing the patient’s health in serious jeopardy or in the case of a behavioral condition placing the health of such person or others in jeopardy, or;
- Serious impairment to bodily functions; or
- Serious dysfunction of any bodily organ or part of such person; or
- Disfigurement.

Examples of conditions considered medical emergencies are difficulty in breathing, convulsions, unusual or excessive bleeding, unconsciousness, and/or severe pain.

Any ambulance trip that does not meet these criteria would be determined to be a non-emergency service. This includes all scheduled runs (regardless of origin and destination), as well as transports to nursing homes or to the patient’s residence. Transports to and from ESRD facilities for patients experiencing acute renal failure would be appropriately considered emergency ambulance services.)
Chapter 7
VALUE ADDED SERVICES

CVF Productions
Performing Arts & Multi-Media Studies

I. Web-site Development & Design – you can save 10% or more on web-site
development and design as a National MedTrans Network provider through
CVF Productions… $315.00 up to 5 pages (normally $350)

II. Web Hosting - CVF Productions is extending an offer to all National MedTrans
Network providers for hosting of your web-site which includes up to 20 GB
Transfer, 2 GB storage and Control Panel for only… $9.99 per month

For more information go to: www.cvfproductions.com
Or call: 727-242-6092

------------------------------------------------------------

The Winfield Group
Insurance Agency
3 Corporate Drive Suite 200
Clifton Park, NY 12065

Tri-State specialist for all your ParaTransit, and Livery Insurance needs.

For more information go to: www.winfieldgroup.com
Or call: John R. Tomassi
jtomassi@winfieldgroup.com
P 518.371.0075
F 518.371.0675
CREDENTIALING CHECKLIST

Provider: ___________________________ Type:  ☐ AIR  ☐ LANCE  ☐ LETTE  ☐ LIVERY

☐ Application (complete & signed) ___________________________

☐ Answered No to All Liability Questions? ___________________________

☐ Vehicle VIN List ___________________________

☐ Contract (complete & signed) ___________________________

☐ EMS DOH and/or State of NY DOT ___________________________

☐ TLC ___________________________

☐ Liability Face Sheet ___________________________

☐ NMN listed as Additional Insured? ___________________________

☐ W9 ___________________________

☐ Medicare Privilege Letter or EOB ___________________________

☐ Medicaid Privilege Letter of EOB ___________________________

☐ QA Program ___________________________

☐ EE Training Program ___________________________

☐ Ambulance Protocols ___________________________

☐ Sample Invoice ___________________________

☐ Site Visit (completed) ___________________________

☐ Primary Source Verification ___________________________

CREDENTIALING COMMITTEE REVIEW

Approved Effective: ___________________________

Approved Provisionally Subject to: ___________________________

Denied Reason: ___________________________

Signature of QM Chairperson of Credentialing Committee
___ Est. duration for Medications (if applicable)
___ Medications are kept at appropriate temperatures in separate refrigerator (no food or drink in refrigerator)
___ Medications are dated and not expired
___ Extra Supply of Oxygen
___ Any additional notes: _______________________________

☐ Livery/Ambulette Check:
   ___ Registration, Ins. Card, other Required Permits, etc. are on board
   ___ First Aid Kit
   ___ Condition of Vehicle: ________________________________
   ___ Condition of Equipment: ____________________________

☐ Ambulance / Air Ambulance Check:
   ___ Meds Secured (if applicable)
   ___ Condition of Equip. _________________________________
   ___ Condition of Vehicle: ______________________________
   ___ Meds are all current (none are expired?)
   ___ Is Equipment organized / Easily Accessible? ___________
   ___ # of Oxygen Tanks / Current or Expired? ______________
   ___ Is last Checkout Sheet available / compare with findings.

Comments: ____________________________________________

____________________________________________________________________

Site Visit Representative:
   (Print Name) ___________________________ (Signature) ________________________

Provider’s staff who assisted with Site Visit: (Print Name) _______________________
   (Signature) ___________________________ Title: ______________________________

Date of Site Visit: ______________________________

For Credentialing Committee Use Only:

Comments on Site Visit: ________________________________

____________________________________________________________________

By: (Signature) __________________________

Comm. Rep: (Print Name) __________________________
Provider Assessment Tool

Provider Name: ______________________________ Type: □ Air □ Lance □ Lette □ Livery

Enter √ = yes, N = no, NA = not applicable, * = see comments

☐ Sample Invoice (attach copy)
☐ Audit of 3 Drivers/Pilots

1. Employment Application
   - Do they screen for Background info? Y / N
   - Do they fingerprint or somehow check driver/pilot’s criminal history? Y / N

2. A copy of Drivers License on file? Y / N

3. A copy of Certifications on file? Y / N

☐ Phone system - # of lines? ____ Battery back-up? Y / N
☐ Copy of Current Registrations on fleet of vehicles
☐ HIPAA Compliance Policy
☐ Back-up Power Available?
☐ Fire Extinguisher
☐ Smoke Detectors

☐ # of Vehicles not being utilized at time of Site Visit: __ Livery __ Lette __ Lance

☐ Vehicles reported by rep to be in use: __ Livery __ Lette __ Lance

☐ # of Vehicles appropriately equipped with Crash Carts/Defibrillators (if applicable)

☐ Has Oxygen Tank(s) (if applicable)
☐ Compliance with Bio-Hazard Disposal?
☐ Copy of Narcotic Policy (if applicable) and inspection of conformity with policy?
☐ Maintenance Schedule & protocol, or last 3 service receipts (circle which one).

☐ Back-up Supplies:
  ____ Items in secure location
• Medicare/Medicaid Privilege Letter or EOB showing Provider ID#

• A copy of the Provider’s QA Program or a statement of the guidelines followed
• A copy of Provider’s Employee Training Program or a statement of the guidelines followed

*Taxi & Limousine Commission (TLC), Dept. of Health (DOH), Dept. of Transportation (DOT)

NMN will review the Provider’s application along with Documentation for Provider and Drivers/Pilots for completeness utilizing the Credentialing Checklist at the end of this chapter, and forward the file to the Credentialing Department or Plan for Credentialing determination and notification.

All completed materials are forwarded to:

National MedTrans Network, Inc.
990 South 2nd St., Suite 1
Ronkonkoma, NY 11779
Attn: Credentialing Department
reviewed, and if they satisfy NMN/Plan’s participation criteria, NMN will notify each approved site of their acceptance into the NMN Network. Similarly, if upon review the documentation does not meet NMN/Plan’s participation criteria, the Provider will be notified of same.

**Methods of Transportation/Levels of Care**

If an approved Provider decides to add a new method of transportation or level of care, it must contact the Credentialing Department. The Provider will update the applicable portion of the Provider Assessment Tool. This information will be presented to the Credentialing Committee. If the Credentialing Committee determines there is a need for the additional service in that geographic area, the Credentialing Department will request supporting documentation for the added service. Once adequate documentation is received, the Credentialing Department will update the Provider’s list of credentialed services. New services become effective upon approval by the NMN’s Credentialing Committee.

**Drivers/Pilots’ Documentation Requirements**

At the time of initial Credentialing the Drivers/Pilots must meet the individual requirements as listed in the application and contract, attach all required documents and return the information to the NMN Credentialing Department. When a new driver/pilot joins a Provider, he or she will complete the same documents and provide the same information.

In addition to the Provider application and contract, the following information is required:

- A copy of current state driver’s/pilot’s license issued by the DMV or FAA for the appropriate classification
- A copy of current applicable certification, e.g. Pilot certification, 19A certification by service type – DMV, TLC, EMT, CDL
- An Attestation from the Provider stating that the application for employment used by the Provider screens for criminal background information on Drivers, Pilots and Staff when required by any regulatory agencies.

**Providers’ Documentation Requirements**

- A copy of current Vehicle Liability face sheet (*NMN must be listed as additional insured*)
- A copy of current Malpractice Liability face sheet (*NMN must be listed as additional insured, if applicable*)
- Copies of Ambulance Protocols (*if applicable*) other than what’s required by State Regulations
- Copies of TLC, EMS DOH or NY DOT, or appropriate State Certificates as applicable to level of transports*
- W9
Chapter 6
CREDENTIALING

Mission

The NMN Credentialing Program’s mission is to ensure that all health plan subscribers have access to appropriate, safe, and cost-effective transportation services through the review and evaluation of Providers by the Credentialing Committee aimed at meeting the accreditation, regulatory and quality assurance needs of the health plans. The Credentialing Committee is responsible to accept or deny Provider Applicants into the NMN Network.

Overview

As a condition of participation in the NMN network, a Transportation Provider (“Provider”) must complete an Application and be approved by NMN’s Credentialing Committee in accordance with standards approved by NCQA or Health Plans (“Plans”). Similarly, in order to maintain credentialing, and thus be approved for payment of services, providers must notify the NMN Credentialing Department, in writing, whenever they make changes to billing, location of operation or contact information including but not limited to: equipment, vehicles, territory, licenses, relocation, additional sites, or additional services to those already credentialed. Such changes will be subject to review by NMN, and approvals may be withheld based on NMN's sole determination of lack of geographic need. NMN will not pay for services rendered but not approved by NMN or performed by providers not credentialed by NMN.

Upon receipt of the application and signed agreement, a Provider will be screened by the Credentialing Department and if all criteria have been met, and all required documentation received, they will be scheduled for review at the next available Credentialing Committee Meeting. The Credentialing Committee’s decision to accept or deny the Provider will be communicated in writing to the provider within a reasonable time following the review by the Credentialing Committee.

Site Visits

For a Transportation Provider to be considered for participation in the NMN Network, the Provider must contact NMN to request an Application and a Participation Provider Agreement or respond to NMN’s request to complete an Application and an Agreement. (In some cases a Provisional Agreement will be accepted until such a time when the Participating Provider Agreement can be finalized and executed.) When completed and returned to NMN, this tool will be presented to the Credentialing Committee for a determination of geographic need. If the Credentialing Committee determines there is a geographic need for the requested Provider, the Credentialing Department will send a representative to perform a site visit. Once the Provider Assessment Tool is returned to NMN, the requested documents, Application and Provider Assessment Tool will be
**Provider Satisfaction Surveys**

Provider Satisfaction Surveys will be mailed to a pre-determined segment of the provider population or to all providers, semi-annually in writing. The content of the Provider Satisfaction Survey shall be approved by the QM Committee prior to mailing. The results of the Provider Satisfaction Surveys will be reported to the QM Committee, as well as to any healthplans requesting this information.

**Member Satisfaction Surveys**

Member Satisfaction Surveys will be conducted by phone with a sampling of members/subscribers, on a semi-annual basis. The content of the Member Satisfaction Survey shall be approved by the QM Committee prior to calls being placed to the members/subscribers. In some cases, plan approval may also need to be obtained prior to performing a member satisfaction survey, in accordance with the contractual obligations of the plan. The results of the Member Satisfaction Surveys will be reported to the QM Committee, as well as to any healthplans requesting this information.
Subscriber Claims/Authorization Denial Appeals

NMN is not always contracted to perform the appeal function for a contracted Health Plan. The Plan may retain the responsibility for the final decision on the denial determination and Appeal process. Nonetheless, all Appeals either to a claims denial or an authorization denial must be received at NMN within one hundred eighty (180) days after receipt of notification of the adverse determination.

When appropriate as per contractual requirements, NMN will acknowledge the filing of an Appeal within five (5) business days of receipt and a determination notice will be issued within thirty (30) calendar days of receipt of the appeal request, except as otherwise contractually dictated by the health plan.

An Expedited Appeal determination will be issued within the shorter of the two; two (2) business days of receipt of the necessary information or seventy-two (72) hours after the initiation of the appeal process. Expedited appeal is available for determinations involving an adverse determination in which the referring provider asks for an immediate appeal or there is indication that a delay in making a decision could seriously jeopardize the member’s life, health, or ability to regain maximum function, or could subject the subscriber to severe pain in the opinion of their provider.

Notice of Appeal decisions are issued to the member and the requesting provider in writing. Upheld non-certification notices will include:

- Detailed reasons for the determination in easily understandable language
- A reference to the criteria or benefit provision upon which the appeal determination was based
- A description of any pursuant appeal rights.

All Appeals delegated to NMN are reviewed by a professional who did not participate in the original review decision and who is not a subordinate of the review professional.
Subscriber Grievances:

If a subscriber has a Grievance (or reports an incident expressing dissatisfaction which per the above definitions is thereby considered a grievance), and the grievance is reported to NMN, NMN’s representative will report the issue to the health plan within 1-2 business days. NMN will call the provider if appropriate and obtain the provider’s comments. All of the information collected (from patient, provider and NMN) is transferred onto an Incident Report and faxed to the plan. The plan is almost always responsible to contact the enrollee to obtain further details on the grievance or respond to the enrollee regarding the grievance investigation, but may on occasion ask NMN for assistance. If the plan has requested NMN intervention with the enrollee, then and only then shall NMN’s representative contact the enrollee. A copy of the Incident Report is placed in the Provider’s file and one in the Grievance binder maintained by the QM Department, for review at the quarterly QM meeting.

If a subscriber complains to the health plan, and the health plan reports the matter to NMN, the matter is investigated as detailed above, and the appropriate NMN representative will ensure the matter is responded to the plan within 2-5 business days. Every attempt will be made to respond to the grievance within 48 hours and unless there are circumstances out of one’s control, a response to a grievance will not exceed 5 business days.

In the event of an “Escalated Grievance” in accordance with the above sub-definition, 911 may need to be called or may warrant an immediate response to the Plan or within the targeted 24 hour time frame, but should not exceed 48 hours.

Upon receipt of the Grievance by the QM Department, the issue(s) will be reviewed and investigated by at least 1 member of the QM Committee. Upon completion of the review by the QM Committee member, NMN’s determination will be forwarded to the provider in writing along with a corrective action plan (if applicable). An entry is made into the Incident Log and the log is brought before the QM Committee on a quarterly basis for the purpose of noting trends or to review providers whose performance has come into question.

Grievances should be faxed to (516) 873-6548 Attn.: Quality Management, or if the matter is not time sensitive, it can be mailed to:

National MedTrans Network, Inc.
990 South 2nd St., Suite 1
Ronkonkoma, NY 11779

For Provider Claims Appeals, please refer to Chapter 4, Claims/Billing Overview.
**Assignee**: A non-contracted physician or other non-contracted provider who has furnished a service to the enrollee and formally agrees to waive any right to payment from the enrollee for that service.

**Complaint**: Any expression of dissatisfaction to a Medicare health plan, provider, facility or Quality Improvement Organization (QIO) by an enrollee made orally or in writing. This can include concerns about the operations of providers or Medicare health plans such as: waiting times, the demeanor of health care personnel, the adequacy of facilities, the respect paid to enrollees, the claims regarding the right of the enrollee to receive services or receive payment for services previously rendered. It also includes a plan’s refusal to provide services to which the enrollee believes he or she is entitled. A complaint could be either a grievance or an appeal, or a single complaint could include elements of both. Every complaint must be handled under the appropriate grievance and/or appeal process.

**Effectuation**: Compliance with a reversal of the Medicare health plan’s original adverse organization determination. Compliance may entail payment of a claim, authorization for a service, or provision of services.

**Enrollee**: A Medicare Advantage eligible individual who has elected a Medicare Advantage plan offered by an MA organization, or a Medicare eligible individual who has elected a cost plan or HCPP. *For the purposes of this Manual, an enrollee shall also mean any eligible individual enrolled with a commercial healthplan or worker’s comp plan.*

**Grievance**: Any complaint or dispute, other than one involving an organization determination, expressing dissatisfaction with the manner in which a Medicare health plan or delegated entity provides health care services, regardless of whether any remedial action can be taken. An enrollee or their representative may make the complaint or dispute, either orally or in writing, to a Medicare health plan, provider, or facility. An expedited grievance may also include a complaint that a Medicare health plan refused to expedite an organization determination or reconsideration, or invoked an extension to an organization determination or reconsideration time frame.

In addition, grievances may include complaints regarding the timeliness, appropriateness, access to, and/or setting of a provided health service, procedure, or item. Grievance issues may also include complaints that a covered health service procedure or item during a course of treatment did not meet accepted standards for delivery of health care.

**Definition of an “Escalated” Grievance**: Any and all Incidents/Grievances that involve the immediate safety of a patient/member, or a real or perceived danger to a member, or involves behavior by a provider or provider’s employee that is unlawful towards the member, such as physical or sexual misconduct.

**Independent Review Entity**: An independent entity contracted by CMS to review Medicare health plans’ adverse reconsiderations of organization determinations.

**Inquiry**: Any oral or written request to a Medicare health plan, provider, or facility, without an expression of dissatisfaction, e.g., a request for information or action by an enrollee.

In accordance with the above CMS definitions, as follows is the process applied to reporting of Grievances/Appeals:
In accordance with Chapter 3, “Provider Obligations – Incident Reporting”, if an incident and/or accident occurs involving the welfare of a subscriber, the provider MUST file such a report, the same day the incident occurred with National MedTrans Network.

Incidents involving waiting time having to do with a pick-up delay beyond 30 minutes in an urban area or an hour in a suburban area would require both a phone call to National MedTrans and a completed incident report. Either the Provider or an NMN representative will complete the “Incident Report” form within 1-2 business days of the occurrence. (A copy of the Incident Report form can be found at the end of Chapter 3.) NMN will call the plan or subscriber if appropriate and obtain their comments. All of the information collected (from patient, provider and NMN) is transferred onto an Incident Report and faxed to the plan. A copy is placed in the Provider’s file and one in the Grievance binder maintained by the QM Department, for review at the quarterly QM meeting.

Upon receipt of the completed Incident Report by the QM Department, the issue will be scheduled for review by the QM Committee. Upon completion of the review by the QM Committee, if so recommended by the Committee, NMN’s determination will be forwarded to the provider in writing along with a corrective action plan (if applicable). A “notice of unacceptable performance” may be made to the provider in writing. Continued poor performance may affect the Provider’s receipt of referrals from National MedTrans and may lead to grounds for termination from the network.

**Subscriber Grievance/Appeals Definitions:**

The following definitions are published by the Center for Medicare and Medicaid Services in Chapter 13 of the Medicare Managed Care Manual. These definitions will apply to Managed Medicare Plans as well as all other commercial health plans.

**10.1 - Definition of Terms**

 *(Rev. 88; Issued: 09-21-07; Effective/Implementation Dates: 09-21-07)*

Unless otherwise stated in this Chapter, the following definitions apply:

**Appeal:** Any of the procedures that deal with the review of adverse organization determinations on the health care services an enrollee believes he or she is entitled to receive, including delay in providing, arranging for, or approving the health care services (such that a delay would adversely affect the health of the enrollee), or on any amounts the enrollee must pay for a service as defined in 42 CFR 422.566(b). These procedures include reconsideration by the Medicare health plan and if necessary, an independent review entity, hearings before Administrative Law Judges (ALJs), review by the Medicare Appeals Council (MAC), and judicial review.

Disputes involving optional supplemental benefits offered by cost plans and health care prepayment plan (HCPPs) will be treated as appeals no later than January 1, 2006, (earlier at the cost plan’s or HCPP’s discretion). Prior to this rule change for 2006, they have been treated as grievances. Cost plans and HCPPs need to educate enrollees about this procedural change.
Health Plan notifications
THE QM COMMITTEE IS RESPONSIBLE TO REPORT TO HEALTH PLANS ON RECOMMENDED ACTIONS.

Evaluation
An annual QM Program evaluation is performed so that a work plan can be developed for the ensuing year. The QM Committee reviews the QM Program evaluation and work plan with recommendation to the Management Committee for final approval and implementation.

Network Performance Standards

• All vehicles will be inspected and approved by the appropriate transportation authority.

• Transportation procedures will be standardized as much as is practical among all providers.

• All medical equipment will be maintained so as to meet industry recommended performance guidelines.

• All professionals/drivers/pilots will be licensed and registered/certified as appropriate.

• All participating Providers will maintain sufficient staffing to enable them to efficiently and expeditiously handle the expected patient volume.

• Scheduled transports will be in accordance with NMN guidelines.

• Office hours will be typically 8am to 5pm, or as needed in order to accommodate subscribers’ needs.

• These policies may be amended from time to time by the QM Committee or the NMN Management Committee.

Provider Complaints
If a provider has a complaint involving a member’s compliance, behavior, or refusal of treatment/transport, or if a provider has an objection to an NMN policy, NMN’s QM Department should be notified as soon as possible by phone and depending on the significance of the issue, the provider should submit the matter in writing. Written notification must be made within thirty (30) days of the event.
UM/Provider Specialist
The UM/Provider Specialist is a designated individual whose primary responsibility is to meet the regulatory and operational needs of the health plans, by providing quality and utilization data to the QM Chairperson. Data includes, but is not limited to, utilization by provider type, grievance stats by incident type, etc. The UM/Provider Specialist is also responsible to coordinate audits of the UM processes to evaluate compliance with applicable law, URAC and industry standards and company objectives.

Site Compliance Officer
The Site Compliance Officer performs on-site evaluations of participating transportation provider’s operational environment to ensure services are rendered in accordance with NMN quality standards. Data collected is submitted to the Credentialing Supervisor, unless all criteria are not met, in which case the data is submitted to the QM Chairperson for evaluation and an opinion as to whether or not the Provider should be allowed into the network. Such opinion is communicated to the Credentialing Supervisor.

Credentialing Supervisor
The Credentialing Supervisor supports the process of selecting and evaluating providers. He/She reports quality deficiencies discovered during the credentialing process and solicits input from the QM Chairperson, sharing such input with the Credentialing Committee for action or for a decision to admit the Provider or terminate the Provider from the NMN network.

Meetings
The QM Committee meets at least quarterly, maintains a permanent record of its proceedings, and reports to the NMN Chief Executive Officer and the NMN Management Committee. Each meeting agenda may include:

- Status of annual work plan, and progress made toward achieving goals of the work plan
- Evaluation of selected transportation studies
- Review of complaints, concerns or issues
- Review of quality monitoring initiatives
- Review of changes to industry standards of care
- Discussion of identified problems involving quality of care or utilization
- Discussion of corrective actions for identified problems, including time lines and thresholds for corrective actions
- Assessment of results of any corrective action

Recording
The minutes of each meeting of the QM Committee are distributed to all appropriate NMN administrators and are maintained in a locked area in the NMN QM offices.
Chapter 5
QUALITY MANAGEMENT PROGRAM

Mission

The NMN Quality Management Program’s mission is to ensure that all health plan subscribers have access to appropriate, safe, and cost-effective transportation services through the implementation and evaluation of improvement initiatives identified by the Quality Management Committee in response to quality monitoring activities aimed at meeting the regulatory and quality assurance needs of the health plans.

Overview

The NMN Quality Management (QM) Program is established to measure quality and utilization and to work with the Credentialing Committee in developing credentialing criteria that ensures the quality of the providers joining the network. These objectives are accomplished through the development of protocols, policies and procedures consistent with State, Federal, URAC and other standards, and through ongoing monitoring of services to identify opportunities for improvement.

QM Program activities include the evaluation of complaints (Provider, Subscriber or Payer) concerning transportation services, satisfaction surveys, the oversight of action plans to improve or correct identified issues; and the communication of results of such plans to the appropriate management staff, Provider, Subscriber or Payer.

Staffing Structure of QM Committee

The defined organization structure of the QM Program provides for a well-rounded area of expertise and ensures that all participants provide effective monitoring of services and a quick response to identified issues or areas of concern.

QM Chairperson
The QM Chairperson is a Board Certified, Emergency Medicine Physician, appointed annually by the Management Committee. He/She is responsible for QM Committee activities and recommendations, and is accountable to the NMN Management Committee and assists the Credentialing Committee.

Director of Clinical Services
The Director of Clinical Services is a registered, licensed Emergency Medical Technician who integrates operational activities and the Provider’s day to day experiences with the development of protocols, policies and procedures to provide compliance oversight of the clinical processes.
Provider Claims Appeals

NMN, whenever delegated by the Health Plans to process claims, will process all claims submitted which are considered to be “clean claims”. Should a claim include incorrect data, or incomplete data, an explanation will appear on the remittance advice (RA).

If a claim was denied for a reason which cannot be corrected and resubmitted for routine reprocessing, an accurately completed CMS-1500 or UB-92 form, “Claims Appeal Letter”, as well as, additional information and documentation must be supplied.

Requests for a claim review must be made in writing within 120 days from the date of first denial. Appeals received more than 120 days from the date of first denial will not be accepted for review and therefore will remain denied. If a provider seeks to appeal the NMN rejection, a copy of the RA along with a copy of the claim with supporting documentation must be mailed to NMN within the 120-day limit from the date of denial. The necessary information for the appeal is then reviewed by the Claims Manager who will consult with the QM committee (or where applicable the health plan’s Appeals committee). A decision is rendered within 30 days of receipt of all information and the provider is notified in writing of the decision.

Send a copy of the RA, along with your letter and any additional information and documentation to:

National MedTrans Network, Inc.
990 South 2nd St., Suite 1
Ronkonkoma, NY 11779
Attn: Claims Manager

For Subscriber Claims/Authorization Denial Appeals, please refer to Chapter 5, Quality Management Program.
<table>
<thead>
<tr>
<th>Code</th>
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<th>Code</th>
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<td>NY203</td>
<td>ROUND TRIP</td>
<td>NY225</td>
<td>GROUP TO MEDICAL APPOINTMENT</td>
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<td>NY204</td>
<td>INSIDE COUNTY</td>
<td>NY226</td>
<td>DRUGSTORE STOP/EXTRA STOP</td>
</tr>
<tr>
<td>NY205</td>
<td>OUTSIDE COUNTY</td>
<td>NY227</td>
<td>NYC BRIDGE &amp; TUNNEL TOLLS</td>
</tr>
<tr>
<td>NY206</td>
<td>MILEAGE</td>
<td>NY228</td>
<td>GROUP RIDE O/W ZONE 1</td>
</tr>
<tr>
<td>NY207</td>
<td>ADDITIONAL RECIPS IN VEHICLE</td>
<td>NY229</td>
<td>GROUP RIDE O/W ZONE 2</td>
</tr>
<tr>
<td>NY208</td>
<td>REGULARLY RECURRING TRIP</td>
<td>NY230</td>
<td>GROUP RIDE O/W ZONE 3</td>
</tr>
<tr>
<td>NY209</td>
<td>ATTENDANT</td>
<td>NY231</td>
<td>GROUP RIDE O/W ZONE 4</td>
</tr>
<tr>
<td>NY210</td>
<td>ADD ON FOR LONG DISTANCE</td>
<td>NY232</td>
<td>GROUP RIDE O/W ZONE 5</td>
</tr>
<tr>
<td>NY211</td>
<td>ADD ON FOR EXCEPTIONS</td>
<td>NY233</td>
<td>GROUP RIDE O/W ZONE 6</td>
</tr>
<tr>
<td>NY212</td>
<td>GROUP INSIDE CMMA</td>
<td>NY234</td>
<td>SPECIFIC REIMBURSEMENT</td>
</tr>
<tr>
<td>NY213</td>
<td>GROUP OUTSIDE CMMA</td>
<td>NY235</td>
<td>SPECIFIC REIMBURSEMENT</td>
</tr>
<tr>
<td>NY214</td>
<td>GROUP RIDE ROUND TRIP</td>
<td>NY236</td>
<td>SPECIFIC REIMBURSEMENT</td>
</tr>
<tr>
<td>NY215</td>
<td>GROUP RIDE INSIDE COUNTY</td>
<td>NY237</td>
<td>PROVIDER SPECIFIC REIMBURSEMENT - MILEAGE</td>
</tr>
<tr>
<td>NY216</td>
<td>GROUP RIDE OUTSIDE COUNTY</td>
<td>NY250</td>
<td>NYS THRUWAY TOLLS</td>
</tr>
<tr>
<td>NY217</td>
<td>GROUP AMBULATORY PER PERSON</td>
<td>NY251</td>
<td>NYS BRIDGE AUTHORITY TOLL</td>
</tr>
<tr>
<td>NY218</td>
<td>GROUP 1 WAY WHEELCHAIR</td>
<td>NY252</td>
<td>CHAMPLAIN FERRY CROSSING</td>
</tr>
<tr>
<td>NY219</td>
<td>GROUP AMBULATORY ADD'L RECIP</td>
<td>NY253</td>
<td>TOLLS (OTHER)</td>
</tr>
<tr>
<td>NY220</td>
<td>GROUP WHEEL'R ADD'L RECIP</td>
<td></td>
<td>NY298 GROUP RIDE UNASSIGNED</td>
</tr>
</tbody>
</table>
Transporting Organs: An Ambulance Provider can be reimbursed for transporting organs to an organ transplant site, however, the Provider would have to bill the transplant site directly and that site would reimburse the ambulance provider and bill the health plan for acquisition costs for the organ procurement.

**AMBULETTE – Category of Service 0602**

**Note:** While these codes are recognized by Medicaid, not all codes have dollar amounts assigned to them for each county.

<table>
<thead>
<tr>
<th>Procedure</th>
<th>General Description</th>
<th>Procedure</th>
<th>General Description</th>
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</thead>
<tbody>
<tr>
<td>NY100</td>
<td>O/W TRIP INSIDE CMMA</td>
<td>NY125</td>
<td>GROUP PER PERSON WHEELCHAIR</td>
</tr>
<tr>
<td>NY101</td>
<td>O/W EVE/WKND/HOL</td>
<td>NY126</td>
<td>GROUP EXTRA RECIPIENT</td>
</tr>
<tr>
<td>NY102</td>
<td>O/W OUTSIDE CMMA</td>
<td>NY127</td>
<td>GROUP OUTSIDE CMMA</td>
</tr>
<tr>
<td>NY103</td>
<td>MILEAGE</td>
<td>NY128</td>
<td>GROUP OUTSIDE COUNTY</td>
</tr>
<tr>
<td>NY104</td>
<td>ROUNDTARP</td>
<td>NY129</td>
<td>GROUP ROUND TRIP</td>
</tr>
<tr>
<td>NY105</td>
<td>EXTRA RECIPIENT TRAVELING</td>
<td>NY130</td>
<td>ATTENDANT FOR GROUP RIDE</td>
</tr>
<tr>
<td>NY106</td>
<td>O/W TO RECURRING APPT.</td>
<td>NY131</td>
<td>GROUP RIDE: MILEAGE</td>
</tr>
<tr>
<td>NY107</td>
<td>ADD-ON LONG DISTANCE</td>
<td>NY132</td>
<td>TRIP: SPECIFIC REIMBURSEMENT</td>
</tr>
<tr>
<td>NY108</td>
<td>ADD-ON FOR DIFFICULT TRIP</td>
<td>NY133</td>
<td>TRIP: SPECIFIC REIMBURSEMENT</td>
</tr>
<tr>
<td>NY109</td>
<td>ATTENDANT</td>
<td>NY134</td>
<td>TRIP: SPECIFIC REIMBURSEMENT</td>
</tr>
<tr>
<td>NY110</td>
<td>ATTENDANT EVE/WKND/HOL</td>
<td>NY135</td>
<td>MILEAGE: SPECIFIC REIMBURSE</td>
</tr>
<tr>
<td>NY111</td>
<td>STRETCHER: INSIDE CMMA</td>
<td>NY136</td>
<td>MILEAGE: SPECIFIC REIMBURSE</td>
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<tr>
<td>NY112</td>
<td>STRETCHER: OUTSIDE CMMA</td>
<td>NY137</td>
<td>MILEAGE: SPECIFIC REIMBURSE</td>
</tr>
<tr>
<td>NY113</td>
<td>STRETCHER: HARD TO SERVE</td>
<td>NY138</td>
<td>MILEAGE: SPECIFIC REIMBURSE</td>
</tr>
<tr>
<td>NY114</td>
<td>STRETCHER: ROUND TRIP</td>
<td>NY139</td>
<td>STRETCHER: SPECIFIC REIMBURSE</td>
</tr>
<tr>
<td>NY115</td>
<td>STRETCHER: MILEAGE</td>
<td>NY140</td>
<td>STRETCHER: SPECIFIC REIMBURSE</td>
</tr>
<tr>
<td>NY116</td>
<td>DRUG STORE/EXTRA STOP</td>
<td>NY141</td>
<td>SPECIFIC REIMBURSEMENT</td>
</tr>
<tr>
<td>NY117</td>
<td>NYC BRIDGE/TUNNEL TOLLS</td>
<td>NY142</td>
<td>SPECIFIC REIMBURSEMENT</td>
</tr>
<tr>
<td>NY118</td>
<td>AS TAXI/LIVERY</td>
<td>NY143</td>
<td>SPECIFIC REIMBURSEMENT</td>
</tr>
<tr>
<td>NY119</td>
<td>AS TAXI/LIVERY: AMBULATORY</td>
<td>NY150</td>
<td>NYS THRUWAY TOLLS</td>
</tr>
<tr>
<td>NY120</td>
<td>MULTI-PURPOSE VEHICLE</td>
<td>NY151</td>
<td>NYS BRIDGE AUTHORITY TOLLS</td>
</tr>
<tr>
<td>NY121</td>
<td>AS TAXI/LIVERY: MILEAGE</td>
<td>NY152</td>
<td>CHAMPLAIN FERRY CROSSING</td>
</tr>
<tr>
<td>NY122</td>
<td>AS TAXI/LIVERY: OUTSIDE CMMA</td>
<td>NY153</td>
<td>TOLLS (OTHER)</td>
</tr>
<tr>
<td>NY123</td>
<td>AS TAXI/LIVERY: EXTRA RECIPIENT</td>
<td>NY199</td>
<td>UNASSIGNED</td>
</tr>
<tr>
<td>NY124</td>
<td>GROUP PER PERSON AMBULATORY</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**TAXI/ LIVERY/ VAN – Category of Service 0603, 0605, 0606**

**NYS MEDICAID TRANSPORTATION PROCEDURE CODES**

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**Note:** While these codes are recognized by Medicaid, not all codes have dollar amounts assigned to them for each county.

<table>
<thead>
<tr>
<th>Procedure</th>
<th>General Description</th>
<th>Procedure</th>
<th>General Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>NY200</td>
<td>ONE WAY INSIDE CMMA</td>
<td>NY222</td>
<td>GROUP AMBULATORY MILEAGE</td>
</tr>
<tr>
<td>NY201</td>
<td>EVENING, WEEKEND, HOLIDAY</td>
<td>NY223</td>
<td>GROUP WHEELCHAIR MILEAGE</td>
</tr>
<tr>
<td>NY202</td>
<td>ONE WAY OUTSIDE CMMA</td>
<td>NY224</td>
<td>ATTENDANT FOR GROUP RIDE</td>
</tr>
</tbody>
</table>
Rural Miles – The first 17 miles from rural point of pickup are determined to be rural for ground ambulance. Possible changes to rural ground mileage could occur based on Benefits Improvement and Protection Act (BIPA) guidelines. Air rural miles are all miles reported on the claim if zip code of point of pickup represents a rural designation. The reasonable and necessary requirement for rural air transport shall be deemed to be met when such services are requested by a physician or other qualified medical personnel who reasonably determine or certify that the individual’s condition is such that the time to transport by land poses a threat to the individual’s survival or endangers their health; or the service is provided pursuant to an established State or regional emergency medical services agency protocol that has been approved by the Secretary.

Basic Life Support (BLS) Ambulance billing for Advanced Life Support (ALS) – A BLS ambulance may bill for ALS services as long as either the EMT-Intermediate or Paramedic rides on the BLS to the subscriber’s destination.

Specialty Care Transport (SCT) – The definition of SCT allows a specially trained paramedic to ride on the vehicle and provide service. Thus, personnel trained beyond the paramedic definition would be considered allowable staff based on medical necessity and Medicare ambulance guidelines. If the training the Medic has received is beyond the scope of a paramedic and is reasonable and necessary based on Medicare ambulance guidelines, the Medic would be considered allowable on the SCT as long as the Medic is authorized to perform the services in your state, and the health plan has agreed to pay for these services.

Waiting Time –
For Ambulances, the waiting time code may be used only in unusual circumstances and only if the health plan has contractually agreed to it with NMN. It is reasonable to assume that the ambulance personnel would spend up to one-half hour in the processing of paperwork in the delivery of a patient to the hospital. Therefore, the waiting time code should be used only if the patient’s condition dictated a delay beyond that one-half hour. Procedural delays (i.e., those not related to patient’s condition) are not billable under this code.

For Ambulettes, Wheel Chair Coaches, Stretcher Coaches or Livery Services, a wait time of up to 15 min is included in the rate, thereafter a provider is not obligated to wait. If he/she chooses to wait, there will be no reimbursement, unless the health plan allows for it and/or has contractually agreed to it. On Round Trip calls, Providers are strongly recommended to request that they be listed as a “will call” so that once the patient is ready the health care provider calls for the pick up. In these instances, the Provider is requested to respond within 30 minutes of the call.
Unlisted ambulance service – There may be a need, on occasion, to report an unlisted ambulance service. Please use HCPC Code A0999 when reporting unlisted ambulance services.

Added Origin/Destination Codes –

<table>
<thead>
<tr>
<th>Code</th>
<th>Nomenclature</th>
</tr>
</thead>
<tbody>
<tr>
<td>G</td>
<td>Hospital-based dialysis facility (hospital or hospital-related)</td>
</tr>
<tr>
<td>J</td>
<td>Non hospital-based dialysis facility</td>
</tr>
<tr>
<td>I</td>
<td>Site of transfer (e.g., airport or helicopter pad) between modes of ambulance transport.</td>
</tr>
<tr>
<td>P</td>
<td>Physician’s office (includes HMO non-hospital facility, clinic, etc.)</td>
</tr>
<tr>
<td>X</td>
<td>(Destination code only). Intermediate stop at physician’s office enroute to the hospital (includes HMO non-hospital facility, clinic, etc.).</td>
</tr>
</tbody>
</table>

Medical Necessity -
(The following Applies to Ambulance Providers only):
The ambulance provider is required to obtain within 48 hours (410.40(d)(2) and 410.40 (d)(3) and retain (410.41(c)(1)) physician certifications on file and to make the certifications available upon request by CMS or the Health plan or Health plan intermediary. The purpose of the certification is to obtain specific information about the patient’s condition at the time that ambulance services are ordered that substantiates the need for ambulance transportation services. Certification for such transports may only be made by a physician (MD or DO). When the transport of a patient is from the scene of an accident, and no physician is involved until the patient reaches the hospital, any physician in the hospital who examines the patient or has knowledge of the case may certify the medical need for ambulance service. For non-emergency, unscheduled, ambulance transports section 410.40 (d)(3)(ii) states, “For a subscriber residing at home or in a facility who is not under the direct care of a physician, a physician certification is not required.”

Long Trips – Providers will be entitled to a 25 percent bonus on the mileage rate for ground miles 51 and greater, only when the health plan has agreed to pay this bonus. Please refer to the Plan Information in Chapter 2
Medications – Medications should also be listed as a separate line item and must include the number of units administered. To the extent that the health plan reimburses for meds, NMN will reimburse for meds. Please refer to the Plan Information in Chapter 2. As follows are the codes acceptable for reporting medication administration:

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>90780</td>
<td>IV INFUSION FOR THERAPY/DIAGNOSIS, ADMINISTERED BY PHYSICIAN OR UNDER DIRECT SUPERVISION O</td>
</tr>
<tr>
<td>J0170</td>
<td>INJECTION, ADRENALIN, EPINEPHRIN UP TO 1 ML AMPUL</td>
</tr>
<tr>
<td>J0460</td>
<td>INJECTION, ATROPINE SULFATE, UP TO 0.3 MG</td>
</tr>
<tr>
<td>J1200</td>
<td>INJECTION, DIPHENHYDRAMINE HCL, BENADRYL, UP TO 50 MG</td>
</tr>
<tr>
<td>J1260</td>
<td>INJECTION, DOLASETRON MESYLATE, 10 MG</td>
</tr>
<tr>
<td>J1940</td>
<td>INJECTION, FUROSEMIDE, UP TO 20 MG</td>
</tr>
<tr>
<td>J2250</td>
<td>INJECTION, MIDAZOLAM HYDROCHLORIDE, PER 1 MG</td>
</tr>
<tr>
<td>J2270</td>
<td>INJECTION, MORPHINE SULFATE, UP TO 10 MG</td>
</tr>
<tr>
<td>J2275</td>
<td>INJECTION, MORPHINE SULFATE (PRESERVATIVE-FREE STERILE SOLUTION), PER 10 MG.</td>
</tr>
<tr>
<td>J2550</td>
<td>INJECTION, PROMETHAZINE HCL, UP TO 50 MG</td>
</tr>
<tr>
<td>J2912</td>
<td>INJECTION, SODIUM CHLORIDE, 0.9%, PER 2 ML</td>
</tr>
<tr>
<td>J2930</td>
<td>INJECTION, METHYL PREDNISOLONE SODIUM SUCCINATE, UP TO 125 MG</td>
</tr>
<tr>
<td>J3010</td>
<td>INJECTION, FENTANYL CITRATE, 0.1 MG</td>
</tr>
<tr>
<td>J3360</td>
<td>INJECTION, VALIUM, DIAZEPAM, UP TO 5 MG</td>
</tr>
<tr>
<td>J3475</td>
<td>INJECTION, MAGNESIUM SULFATE, PER 500 MG</td>
</tr>
<tr>
<td>J3490</td>
<td>NOT OTHERWISE CLASSIFIED DRUGS</td>
</tr>
<tr>
<td>J7030</td>
<td>INFUSION, NORMAL SALINE SOLUTION, 1000 CC</td>
</tr>
<tr>
<td>J7040</td>
<td>INFUSION, NORMAL SALINE SOLUTION, STERILE (500 ML = 1 UNIT)</td>
</tr>
<tr>
<td>J7042</td>
<td>5% DEXTROSE/NORMAL SALINE (500 ML = 1 UNIT)</td>
</tr>
<tr>
<td>J7050</td>
<td>INFUSION, NORMAL SALINE SOLUTION, 250 CC</td>
</tr>
<tr>
<td>J7051</td>
<td>STERILE SALINE OR WATER, UP TO 5 CC</td>
</tr>
</tbody>
</table>
mileage except if otherwise indicated in the Plan Notice as detailed in Chapter 2 of this Manual.

**AMBULANCE – Category of Service 0601**

For those health plans where separate charges are recognized for specialized (generally ALS) services (e.g., intubation, intravenous (IV) drug administration, and defibrillation), those separate payments recognize only the cost of specialized supplies. Personnel, reusable supplies, and capital equipment costs are all considered to be part of the basic ambulance service and are expected to be included in the transport and/or mileage charge. As follows are the codes acceptable for reporting transports:

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>A0130</td>
<td>NON-EMERGENCY TRANSPORTATION: WHEEL-CHAIR VAN / AMBULETTE</td>
</tr>
<tr>
<td>A0428</td>
<td>AMBULANCE SERVICE, BASIC LIFE SUPPORT, NON-EMERGENCY TRANSPORT, (BLS)</td>
</tr>
<tr>
<td>A0429</td>
<td>AMBULANCE SERVICE, BASIC LIFE SUPPORT, EMERGENCY TRANSPORT (BLS-EMERGENCY)</td>
</tr>
<tr>
<td>A0225</td>
<td>AMBULANCE SERVICE, NEONATAL TRANSPORT, BASE RATE, EMERGENCY TRANSPORT, ONE WAY</td>
</tr>
<tr>
<td>A0800</td>
<td>AMBULANCE TRANSPORT PROVIDED BETWEEN THE HOURS OF 7PM AND 7AM</td>
</tr>
<tr>
<td>Q3019</td>
<td>ALS VEHICLE USED, EMERGENCY TRANSPORT, NO ALS LEVEL SERVICES FURNISHED.</td>
</tr>
<tr>
<td>A0426</td>
<td>AMBULANCE SERVICE, ADVANCED LIFE SUPPORT, NON-EMERGENCY TRANSPORT, LEVEL 1 (ALS 1)</td>
</tr>
<tr>
<td>A0427</td>
<td>AMBULANCE SERVICE, ADVANCED LIFE SUPPORT, EMERGENCY TRANSPORT, LEVEL 1, (ALS1-EMERGENCY)</td>
</tr>
<tr>
<td>A0433</td>
<td>ADVANCED LIFE SUPPORT, LEVEL 2 (ALS 2)</td>
</tr>
<tr>
<td>A0430</td>
<td>AMBULANCE SERVICE, CONVENTIONAL AIR SERVICES, TRANSPORT, ONE WAY (FIXED WING)</td>
</tr>
<tr>
<td>A0431</td>
<td>AMBULANCE SERVICE, CONVENTIONAL AIR SERVICES, TRANSPORT, ONE WAY (ROTARY WING)</td>
</tr>
</tbody>
</table>

**Mileage** – Mileage is affected by a geographic cost modifier; therefore, mileage should be listed as a separate line item and is limited to loaded miles (patient onboard). Additionally, for Emergency Services, the codes shown below for BLS and ALS mileage are used for covered mileage that represents ambulance transport to the nearest appropriate facility. A code for non-covered mileage is available, however, primarily to facilitate supplemental insurance billing, for plans that allow for it.

As follows are the codes acceptable for reporting mileage:

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>A0425</td>
<td>GROUND MILEAGE, PER STATUTE MILE</td>
</tr>
<tr>
<td>A0021</td>
<td>AMBULANCE SERVICE, OUTSIDE STATE PER MILE, TRANSPORT MEDICAID</td>
</tr>
<tr>
<td>A0380</td>
<td>BLS MILEAGE (PER MILE)</td>
</tr>
<tr>
<td>A0390</td>
<td>ALS MILEAGE (PER MILE)</td>
</tr>
<tr>
<td>S0209</td>
<td>WHEELCHAIR VAN, MILEAGE, PER MILE</td>
</tr>
<tr>
<td>S0215</td>
<td>NON-EMERGENCY TRANSPORTATION; MILEAGE, PER MILE.</td>
</tr>
<tr>
<td>A0888</td>
<td>NON-COVERED MILEAGE</td>
</tr>
</tbody>
</table>
NMTN believes Providers should be paid fairly and promptly, however, there are occasions when the health plan may delay or suspend the claim for additional information, or cases where Coordination of Benefits (COB) is necessary, or circumstances beyond NMN’s control, such as forces of nature. In such instances, reimbursement to the Provider may be delayed.

**Claims Coding**

In order to expedite the processing and payment of transport claims, providers are requested to submit claims using the most current ICD-9 and HCPCS/CPT-4 codes and modifiers (if applicable). When submitting claims for transports that require pre-certification, the authorization number must also be included. If the claim is submitted on a CMS 1500 form, the authorization number should be listed in field 23. Any missing information may result in delayed reimbursement and/or the claim to be rejected and returned to the provider for corrections and re-submission.

Medicare Subscribers (includes Managed Medicare) – The Social Security Act authorizes payment for *ambulance* services only if the “patient’s condition is such that other methods of transportation is contraindicated.” Transportation by *ambulance* is covered under the Medicare program only if “(a) normal transportation would endanger the health of the patient…” If a patient can use normal transportation without endangering his or her health, there would be no justification for *ambulance* services and therefore no Medicare coverage for such services. Transportation by *ambulance* is subject to Medical Necessity and Physician Certification as detailed below under the “Medical Necessity” section.

Coordination of Benefits Transaction (COB) - When a Subscriber has more than one insurer, Provider must provide information for both insurers including Subscriber’s Name and health plan identification number. In cases of COB, it is likely that the claims turnaround-time will be delayed due to the fact that the primary health plan will need to process the claim and either pend or pay a portion of the claim. Following receipt of the Explanation of Benefits (EOB), the claim will need to be submitted to the secondary insurer or health plan.

All-Inclusive Services – In addition to the base rate for transport by ambulance, the term “all-inclusive” bundles into one code all the services and supplies associated with a patient’s transport. This code reflects all services rendered (including specialized services such as oxygen administration, defibrillation, intubation, and IV drug administration, but generally excluding the injectable drug and transtelephonic ECG monitoring), all supplies consumed (including routine supplies as well as supplies related to specialized services furnished, but generally excluding any injectable drugs administered) and mileage. The term “generally” is used here to indicate that you are not required to unbundled services which are included in your all-inclusive allowance. The base rate for ambulettes or wheelchair vans, is deemed to be all-inclusive, but excludes
Chapter 4
CLAIMS / BILLING INFORMATION

Claims Submission

All claims / invoices for transport services should be submitted to National MedTrans Network for adjudication and payment as soon as possible, but no later than thirty (30) days after the provision of Covered Transportation Services. (In some cases Provider may be required to submit the claim to the applicable Payer, in accordance with the instructions of NMN.) Wherever possible, a CMS Form1500, or the generally accepted successor form should be submitted, however, an invoice is acceptable if it has been pre-approved by NMN and/or the health plan. The following information is required:

1) Subscriber Name & Patient Name
2) Address
3) Subscriber’s Social Security # or Health Plan ID #
4) Date of Transport
5) To and from Points of Transports
6) Mileage
7) Diagnosis, if available
8) CPT coding for the appropriate Level of Care rendered.
9) Description of service rendered
10) Provider’s Name
11) Provider’s Address
12) Provider’s Phone #
13) Provider’s Tax ID #

Claims will be paid only for services performed by providers credentialed by NMN. It will be considered fraudulent to submit claims for, or assign services performed, to a non-credentialed provider, in order to circumvent this rule.

Any claims received more than thirty (30) days after date of service will be refused for payment.

Claims should be submitted to the following address unless otherwise notified.

National MedTrans Network, Inc.
990 South 2nd St., Suite 1
Ronkonkoma, NY 11779
Attn: Claims Department

NMN shall adjudicate and pay or deny Clean Claims in accordance with Payer policies and procedures within forty-five (45) days of receipt of payment of such Clean Claims from Payer.
HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA) Privacy Act:

In 1996, Congress passed the Health Insurance Portability and Accountability Act (HIPAA). This Act is comprised of two major legislative actions: Health Insurance Reform and Administrative Simplification. The Administrative Simplification provisions of HIPAA direct the federal government to adopt national electronic standards for automated transfer of certain health care data between health care Payers, plans, and providers. This enables the entire health care industry to communicate electronic data using a single set of standards, thus eliminating all nonstandard formats currently in use. It is also intended to intent to assure health insurance portability, reduce health care fraud and abuse, guarantee security and privacy of health information and enforce standards for health information.

All transportation providers are required to sign a HIPAA Business Associate agreement, which protects the privacy of the health plan subscribers. A copy of this agreement is included herewith for reference purposes. Any questions should be directed to our HIPAA compliance officer. NMN and Providers shall treat medical and insurance information of Members provided to it pursuant to this Agreement in confidence and handle such information in accordance with all applicable state and federal laws governing the confidentiality and security of medical and insurance information.
REPORTING DISCIPLINARY ACTIONS:

If a Provider or any of its transportation professionals (as defined in the Participating Provider Agreement) engage in any conduct or commit an act for which any professional organization may impose or in fact imposes disciplinary action or for which such license, certification, accreditation or authority may be or in fact is revoked or suspended, NMN in its sole and exclusive discretion, may, (1) terminate the Provider’s Agreement immediately if the sanction is directed at the Provider, or (2) require that the Provider not permit the professional against whom the sanction is directed to perform any Covered Transportation Services for any Member. PTP is required to notify NMN within twenty four (24) hours after the time that the Provider is made aware of any of the disciplinary action.

CLAIMS REPORTING:

Providers agree to comply with the format and timely filing guidelines as detailed in Chapter 4 of this Provider Manual.

NOTICES:

All notices, waivers and other communications, including changes in Federal Tax I.D. number, name, ownership and remittance address under this Agreement must be in writing within forty five (45) days and will be deemed to have been duly given when (a) delivered by hand (with written confirmation of receipt), (b) sent by facsimile (with written confirmation of receipt), provided that a copy is mailed by registered mail, return receipt requested, or (c) when received by the addressee, if sent by a nationally recognized delivery service (receipt requested), in each case to the appropriate addresses and facsimile numbers set forth below (or to such other addresses and facsimile numbers as NMN may designate):

National MedTrans Network, Inc.
990 South 2nd St., Suite 1
Ronkonkoma, NY 11779
Facsimile number: (631) 218-4457
National MedTrans Network, Inc.
Incident Report

Instructions:
1. Complete the form below. Please include the vehicle ID number and provide Driver’s/Pilot’s name wherever possible. Complete all areas except where indicated “for office use only”.
2. If additional pages are necessary, please attach a separate sheet of paper.
3. Sign and Print your name and fax it to National MedTrans at 631-218-4457.

Today’s Date: __________ Date of Incident: __________

Vehicle: __________ Vendor: __________ Plan: __________

Name of person reporting Incident: ________________________________

Patient’s/Passenger’s Name: ________________________________

Place of Incident: _____________________________________________

Description of Incident:
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Corrective Action Taken:
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Signature: ___________________/ Print: __________ Page ___ of ___

Of person who completed this incident report

******************************************************************************For Office Use Only******************************************************************************

Received: ___________________
Reviewed by: ___________________
Notes: ___________________

Incident Report Number: □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ (Date XX-XX-XX and # of complaint received to date, e.g. -01, 02, 03)
National MedTrans and a completed incident report. Complete the “Incident Report” form and fax it into National MedTrans Network at 631-218-4457 within 1-2 business days of the occurrence. Incident Reports will be kept in the Provider’s file. If the incident warrants, a notice of unacceptable performance may be made to the provider in writing. Continued poor performance may affect the Provider’s receipt of referrals from National MedTrans and may lead to grounds for termination from the network.
DRIVER / PILOT:

- A Certified Driver/Pilot will be furnished for each vehicle.

- Drivers/Pilots shall be only those competent operators who are regularly employed by the contractor, and they shall be licensed drivers/pilots in accordance with the laws of the applicable State. Provider is required to have checked the background of each driver/pilot for federal and state violations.

- Drivers/Pilots shall furnish any assistance required by the beneficiaries in moving from pick-up point into the vehicle and from the vehicle to the point of destination.

RECORD KEEPING:

Provider shall maintain complete, accurate and up to date medical and financial records in respect of Covered Transportation Services provided to Members hereunder ("Patient Records"), pursuant to an adequate filing system and in conformity with all applicable state and federal record-keeping requirements. Provider agrees to maintain and handle all Patient Records in a confidential manner, in accordance with all applicable state and federal laws and regulations governing the confidentiality and security of such records and the information contained therein. Additionally, Provider agrees to provide NMN and Payers copies of Patient Records at no charge, upon written request, within fifteen (15) days from the date of receipt of NMN's or a Payer's written request, or earlier if required by law. Provider also agrees to maintain Patient Records for a minimum of seven (7) years or longer if required by law, and further agrees that this requirement shall survive the termination of the Provider’s Agreement with NMN.

INCIDENT REPORTING:

Should an incident and/or accident occur involving the welfare of a Subscriber, the contractor MUST file such a report, the same day the incident occurred, to National MedTrans Network.

An incident involving a delay beyond 15 minutes of the scheduled pick-up time, but not greater than 30 minutes of the scheduled pick-up time, would simply require a phone call to National MedTrans advising of the delay, and would not require an incident report to be completed. However, a delay beyond 30 minutes in an urban area or an hour in a suburban area would require both a phone call to
Chapter 3
PROVIDER OBLIGATIONS

All Providers must meet or exceed the applicable Local, Regional, State, and Federal Rules, Regulations and Guidelines as required for the type of service provided. The vendor must demonstrate that they meet or exceed these requirements prior to performing services for National MedTrans Network, Inc. and must ensure continuing compliance for the duration of their contractual relationship.

PROVIDER:

For non-emergent calls, Providers will make all reasonable efforts to promptly schedule and perform Covered Transportation Services in accordance with NMN’s instructions. Covered Transportation Services will be scheduled and performed consistent with the needs of the subscriber and any orders of the referring entity. Providers will perform Covered Transportation Services in accordance with generally accepted medical policies and procedures.

For urgent or scheduled calls, the expectation is that a pick-up will be made within 15 minutes of scheduled time as per notification by either the health plan or NMN. If the provider is unable to make the pick-up within 30 minutes of the call for urban areas and within an hour for suburban areas, the provider must notify the network. The network will then make other arrangements for the pick-up. Waiting times of more than one hour where the network has not been notified, and therefore is unable to make other arrangements, is deemed un-acceptable and will be a condition for quality review of the provider and may necessitate implementation of a corrective action plan on behalf of the provider.

On Round Trip calls, Providers are strongly recommended to request that they be listed as a “will call” so that once the patient is ready, the health care provider calls for the pick up. In these instances, the Provider is requested to respond within 60 minutes of the call. For further information on “Waiting Time”, please refer to the Claims Coding section of this manual.

Additionally, ambulance providers are required to obtain and retain physician certifications on file and to make the certifications available upon request by CMS or the Health plan or Health plan intermediary, as detailed below in the “claims” section of this Provider Manual. For non-emergency, unscheduled, ambulance transports, for a subscriber residing at home or in a facility who is not under the direct care of a physician, a physician certification is not required.
Eligibility Verification

1) Eligibility Verification can be obtained by calling National MedTrans Network directly at (800) 934-7704. *Eligibility is subject to Plan’s verification and accuracy of information and is not a guarantee of payment.*

Authorization

In some cases, authorizations are not required, depending on the Plan’s benefit design. In other cases the Plan authorizes the transport or empowers NMN to authorize the transport. Authorization is not a guarantee of payment. All prior authorizations are subject to the member’s continued eligibility on the actual date of service. *If the patient is not a member of the Health Plan on the date of service, the prior authorization is no longer valid, and the Health Plan will not cover the service.* The following services may require pre-authorization, and if so, these requirements will be included in the Payor Plan Notice sent to the provider:

- Scheduled Ground Ambulance
- All Air Ambulance transports
- Ambulette
- Livery

Subscriber (Member) Identification Cards

Subscribers are given an identification card. This card should be presented to the provider when the transport is a scheduled transport. This card is for identification purposes only and does not establish eligibility for coverage. See the sample member ID cards (if available) on the subsequent pages.
PAYER PLAN NOTICE

[Insert Plan Name]

Effective Date: ________________________________

Products: ________________________________

Fees: As set forth in the attached Fee Schedule

Transport Care Management: Providers must call (800) _________ to obtain approval for scheduled transports.

Authorization Requirements: ________________________________

Co-Payments: Co-Insurance: _________

Billable Modifiers: ________________________________

Drugs: ________________________________

Mileage: ________________________________

Long Trip Mileage: ________________________________

Additional Attendant: ________________________________

Specialty Care Transport: ________________________________

Service Area: ________________________________

(Attached rates are subject to change. Notifications to Providers of any changes to rates will be provided 30 days in advance of change.)
Chapter 2
PLAN INFORMATION

Upon finalization of an agreement with a plan, a Payer Plan Notice is mailed to all participating providers and is posted on the NMN website and accessed by a username and password supplied by NMN to the provider. The purpose of the notice is to alert the provider to the provisions of the newly contracted plan, including the effective date, plan’s requirements, transportation benefit design specifications, as well as, fees and payment policies.

The provider is requested to append the Payer Plan Notice to the original NMN agreement between the provider and NMN, as it is an official amendment to the provider’s agreement. Additionally, the provider should review the Payer Plan Notice and notify appropriate staff of the new plan’s provisions.

Wherever possible, additional plan information will be supplied to the provider to assist in the provider’s understanding of the type of plan that it is. This additional information is subject to marketing materials available from the plan, or what the plan will allow NMN to communicate, or what is deemed as “need to know” information for the provider by NMN.

As follows is the Payer Plan Notice Template:
Credentialing Committee

The Credentialing Committee (CC) consists of an organized advisory body to meet the regulatory and operational needs of the health plans, and approve or deny provider entry into the network. They are also responsible to develop and improve upon Credentialing Policies that represent standard industry practices for screening providers and their background, as well as site visit and other worktools used to assess the providers’ operational environment.

Subscriber Rights & Responsibilities

Health Plan subscribers (patients) have a right to:

✓ High quality transportation services provided in a decent, responsible and respectful manner

✓ Receive treatment information necessary to providing a safe transport

✓ Refuse treatment, to the extent permitted by law, and be clearly informed of the consequences of their refusal

✓ Voice an opinion about the transport or the staff and expect a professional and timely response, receive medical care in a dignified manner without discrimination due to race, color, religion, sex, age, national origin, sexual orientation or health plan coverage.

✓ Receive considerate and respectful care and treatment, regardless of their physical or emotional condition

✓ Privacy and confidentiality of their medical information and transport experience, except as otherwise provided by law or contract.

Provider Manual Updates

Updates and Revisions to this Provider Manual will be posted on the NMN website and if significant, a notification will be sent to the provider in writing regarding the nature of the update and/or revision.
**Governing Board**

As provided in the corporate By-Laws, NMN is governed by a Board of Directors composed of the Directors and designees of participating Transportation Providers and a public representative.

The Board is responsible for;

- Establishing corporate policies related to marketing, provider screening, quality management, financial management, risk-sharing, provider network development, and business development with health plans and other organizations.
- Providing for appropriate patient care management
- Providing for proper review and control of corporate assets and funds
- Timely and fair reimbursement to providers for services rendered.

**Committees**

The NMN management programs include a management operations committee, quality improvement committee, and a utilization management committee.

**The Management Committee**

The Management Committee is comprised of the two principals (owners), a managed care executive with health plan expertise, 6 representatives from network providers, and a certified public accountant. The 3 states (NY, NJ & CT) are divided into 2 geographical regions and a representative from each region is elected annually to serve. The Management Committee meets monthly to monitor the day to day operational policies and direction of the corporation and network, and to monitor all other committees of NMN.

**Quality Management Committee**

The Quality Management (QM) Committee consists of an organized advisory body including a certified EMS technician. The QM Committee’s purpose is to meet the regulatory and quality assurance needs of the health plans, assure the delivery of high quality services to patients, act on opportunities to improve care and services, meet the operational needs of the health plans, evaluate procedure review protocols, assess and quantify the quality and delivery of services, as well as, identify and resolve issues and provider/patient concerns.
Corporate Overview

National MedTrans Network, Inc. (NMN) is a privately owned, regional transportation provider network founded in 2005, and went live on 1/1/06 offering Payers a single source solution for their transportation needs. NMN is a utilization management and quality management organization founded by transportation providers in New York State, who recognized the need for a comprehensive transportation network with an objective management system that can coordinate and monitor patient care utilizing algorithms and the combined years of transport expertise that our regional providers offer.

NMN offers pre-certification and related utilization management programs, quality improvement and assessment programs, claims administration programs, equipment assessment and privileging programs, and other similar programs delegated to it or otherwise contracted for by Payers. All such programs are consistent with applicable state and federal laws and regulations, appropriate accrediting agency standards, and accepted medical standards.

NMN represents providers with a fleet of service vehicles including Ambulettes / Mobility Assistance Vehicles, Livery Vehicles and Ambulances, as well as, numerous Air Ambulance Jets & Helicopters. Many of our providers have been in business for over 20 years. With one phone call to our organization, our clients can obtain any combination of the following services:

- Ambulette
- Ambulance
- Air Ambulance
- Livery Services

NMN has developed a successful approach to managing transportation of patients safely and efficiently, while maximizing quality of care, appropriate utilization, as well as provider and patient satisfaction. The NMN approach to transporting patients includes a functional core delivery network, transport care management, quality assessment programs, privileging and retrospective utilization management. We coordinate all scheduling of appointments based on the level of care necessary to safely transport a patient, utilizing algorithms which provide for a fair rotation of our high quality network providers. All providers are screened through our Credentialing Process and Site Visits to ensure the highest quality of service for our patients. All providers are paid at a uniform fee schedule, without exception.

NMN is one of the first transportation networks to provide full service, single source solutions to New York, New Jersey and Connecticut area health plans. The regional focus, market experience, management systems and infrastructure, together with the financial investment of the principals and the participation of qualified, experienced providers, make NMN uniquely qualified to accept full risk or fee-for-service transportation contracts from managed care plans and self-insured groups, union and employer groups. The total members covered by these plans total several million.

Participation in the network is free, and driven exclusively by the organizations’ credentials and ability to accommodate transports. There is no competitive bidding process for work.
Chapter 1
GENERAL INFORMATION

Mission Statement

The Mission of National MedTrans Network, Inc. is to improve the safety and quality of patient transportation by screening, organizing, and managing transportation providers in a fair and collaborative manner.

Value Statement

We recognize the importance of shared personal and professional values in achieving our mission, increasing patient safety and demonstrating our commitment to our patients, providers and employees. The core values we operate from are:

- Commitment to improving healthcare safety during transports
- Integrity and honesty in our dealings with others
- Respect and caring for people
- Partnership and collaboration with those who share our values and goals
- Pride in our communities, our daily work, and our accomplishments
- Pursuit of constructive change and innovation
- Support and encouragement of personal and organizational achievements
- Fair, equitable and prompt reimbursement to our network providers
- Utilize information technology with providers to manage care, measure utilization and outcomes and provide feedback and education to providers.
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