DRAFT Nevada CSR Manual

MTM
Medical Transportation Management, Inc.

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Section 1

Welcome to MTM

WHO are we?
We are MTM- Medical Transportation Management, Inc. - leaders in the non-emergency medical transportation management industry.

WHAT do we do?
We arrange rides for Participants of health plans and state run programs like Medicaid. The rides are provided by the most appropriate means, which includes public transportation, sedan, taxi, multi-passenger van, Para-lift or wheelchair lift and non-emergency stretcher. We are the Medicaid Transportation Broker for the State of Idaho.

WHEN do we arrange rides?
MTM arranges the ride after the appointment has been scheduled by the Participant and in accordance with their plan's specific days-notice policy. The Participant must call to arrange a ride as soon as they are aware of the need for transportation; a two day advance notice is requested. The urgent nature of the appointment, along with the number of times the Participant has been educated on the days-notice policy, could determine whether the Participant is required to reschedule their appointment.

WHERE do we arrange rides?
We arrange rides for clients in 26 states and the District of Columbia within each client's program service area and with specific distance limits. Rides are for medical appointments, and if offered by the plan, non-medical appointments.

HOW is transportation arranged?
All appointments are arranged through "call intake" and "screening." Trip information is entered into MTM's proprietary NET Management System. Each "trip request" is arranged using the most appropriate means of transportation based on the participant's medical condition and cognitive abilities. This could include assigning bus, sedan, wheel chair lift, or stretcher van as needed. The trip is then sent in an electronic download format or faxed via the NET Management System to the transportation provider.

WHY do we do what we do?
MTM has a sincere desire to ensure sure that everyone gets to their medical appointments in a timely, safe manner. That is what motivates MTM to provide quality transportation service of the highest caliber. MTM's mission statement says it best-

Medical Transportation Management, Inc (MTM)
Department Summaries

MTM's mission is to be the premier manager of non-emergency transportation services, providing safe, reliable transportation for our passengers and the best value for our clients.

MTM carries out its proven processes through eight core departments:

1. Accounting and Finance
2. Business Solutions Group (BSG)
3. Client Services (CS)
4. Customer Service Center (CSC)
5. Network Management (NM)
6. Quality Management (QM)
7. Technology Infrastructure (TI)
8. Utilization/Care Management (UCM)

Accounting and Finance Department

The Accounting and Finance Department manages all financial aspects of MTM's transportation program and consists of the following: Accounting and Finance, Trip Reconciliation, and Bus/Reimbursement. This department works to ensure efficient payment of transportation providers by working directly with them to ensure accurate and timely completion of trip reconciliation. Additionally, the department mails, processes and accounts for all bus tokens and passes mailed to participants.

Business Solutions Group (BSG)

MTM has a highly trained technology department responsible for MTM's NET Management System, including the identification and delivery of business information and business system solutions, including, but not limited, to management reports, data and information analysis, and business process improvement. This department is responsible for the IT and information services requested by our clients, transportation providers and other partners/subcontractors. Business Solutions performs all database management functions including coordination of production, data processing, and reporting for clients and MTM staff, Electronic Data Interchange (EDI), system enhancements, data analysis, and HIPAA compliance related to data transmission.

Client Services (CS)

The hallmark of MTM's business is our exceptional Client Services Department. This department works in collaboration with all MTM corporate departments and will work with the State of Idaho Department of Health and Welfare to ensure MTM is fully compliant with all requirements governing the transportation benefit. Client Services staff stays apprised of state Medicaid requirements through a continuous internal training process. The department's primary responsibility is the management of the program, which includes being a ready resource to our clients and making changes to staffing, processes, and procedures when necessary to meet contract requirements and client expectations.

Customer Service Center (CSC)

MTM bases our CSC call statistics on NCQA (National Committee of Quality Assurance) standards. We operate six Customer Service Centers with locations in St. Louis and Laurie, Missouri, Pulaski, Virginia, St. Paul, Minnesota, Anderson, South Carolina and Washington DC. Through these customer service centers, we process over 1.6 million incoming calls, scheduling roughly 4 million trips annually. We hire and train professional-minded Customer Service Representatives (CSRs) to offer the highest-quality service. We provide ongoing training and monitor CSR performance to ensure compliance to client protocols and MTM standards. We provide high-quality trip reservation (or call intake) with industry-leading Cisco Systems CallManager call processing application. Through this system, we monitor Customer Service Center operations and provide minute-by-minute data for trending analysis and staffing adjustments.

Network Management (NM)

MTM's Network Management Department identifies, recruits, and credentials transportation providers in the service area in order to obtain the highest quality transportation network that is capable of sustaining our client's needs. This includes public transit, sedans, wheelchair equipped vehicles, and stretcher vans. MTM has a proven methodology for identifying, recruiting and contracting qualified transportation providers. We have successfully applied these processes and currently contract with over 500 transportation providers throughout our national service area. Once a network is in place, our experienced Network Management staff monitors the network for adequate coverage of vehicles and modes (sedan, wheelchair lift, etc.). The department also monitors all required documentation such as licensure, background checks, certifications, insurance requirements, and vehicle inspections to ensure these remain current.

Quality Management Department (QM)

MTM's Quality Management Department oversees and monitors all aspects of MTM's operations across all departments to ensure our clients receive the highest quality of service achievable. The Quality Management Department executes MTM's formal Quality Management Program and Work Plan. The scope of the QM Program includes: credentialing of providers, audits, and site reviews to ensure provider compliance with MTM Provider Guidelines, management of participant, client, and provider complaints/grievances, fraud and abuse investigation and reporting, incident and accident monitoring and reporting and prevention, systematic oversight of Customer Service Centers, and subcontracted entities, as well as monitoring and evaluation of administrative services.

MTM's Compliance Program speaks directly to our dedication to the services we provide. MTM monitors systems of compliance through internal mechanisms focused on examining business processes, which evaluate MTM's ability to comply with internal and external requirements. MTM's focus is on a discipline of continuous improvement. The Compliance Program conducts ongoing internal audits to discover actual activity within the organization, which enables objective decision-making and alerts managers to direct resources towards the right issues. Because of this, we learn about potential problem areas before they become issues and identify how to improve our processes. Corrective actions are then implemented in a timely manner in order to increase the effectiveness of controls within a process.

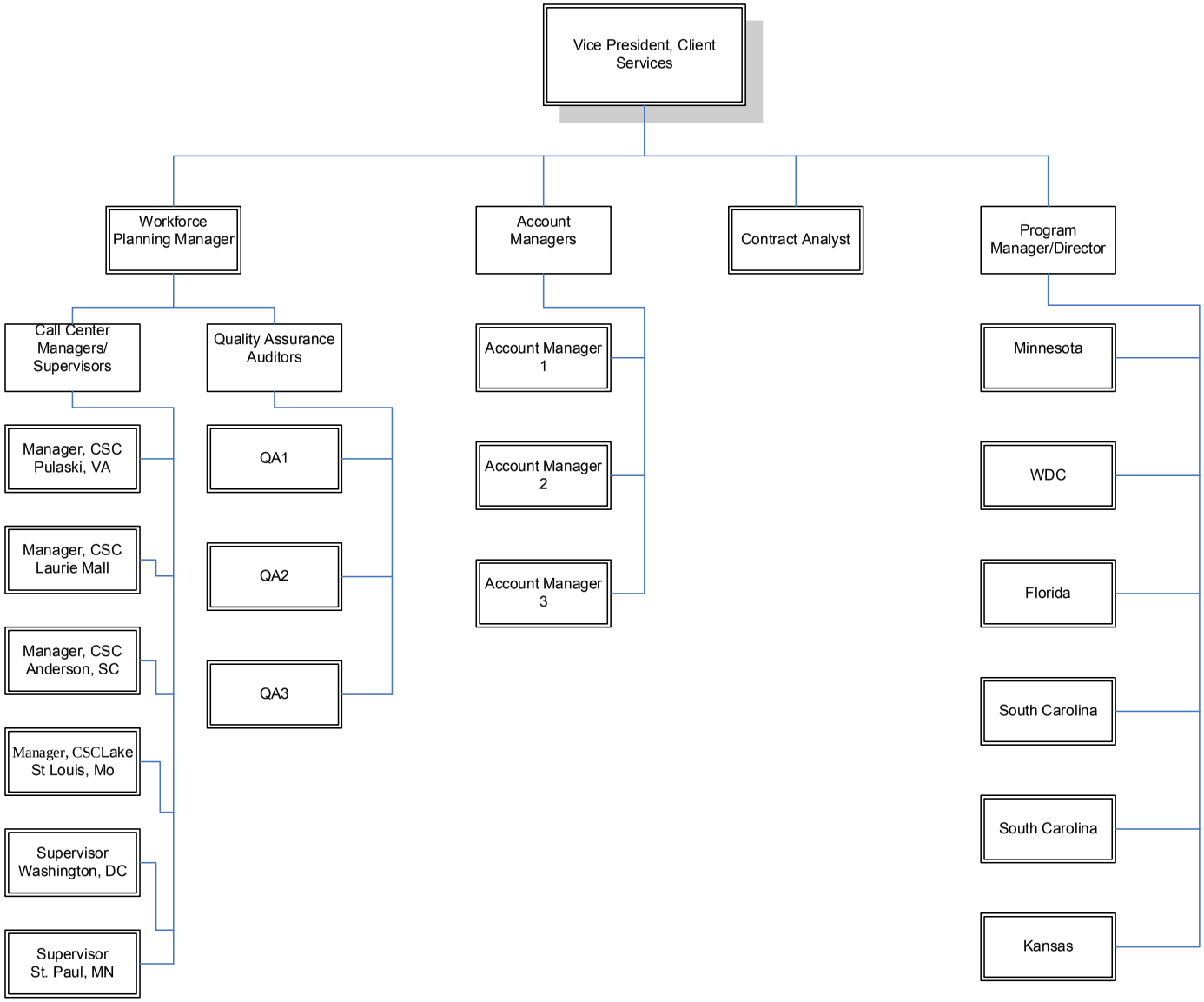
Technology Infrastructure (TI)

MTM's Technology Infrastructure (TI) department is responsible for the technology systems infrastructure and operational support of MTM business operations including TI service desk, network (LAN & WAN) administration, system health monitoring, telephony system management, system/business continuity, and information security/privacy. The department serves internal and external clients to ensure all systems function optimally. Our dependable technology infrastructure was no accident. It required strategic planning and a dedicated staff to support it, along with a commitment to implement qualified improvements. MTM invests in the company's technological infrastructure to ensure our clients receive the best service possible. For example, in 2001, MTM invested just over $1 million upgrading our telephone system to increase efficiency and reliability. This upgrade consisted of implementing Cisco Systems CallManager call-processing application. It utilizes state-of-the-art Voice over Internet Protocol (VoIP). VoIP enables MTM to provide more cost-effective trip request processing than customer service centers that operate over traditional telephone lines.

Utilization/Care Management (UCM)

MTM was founded on the principles of increasing health care access by providing quality transportation services to special needs groups. From this knowledge, MTM designed the transportation management industry's first Utilization/Care Management Department. This department gives case managers a single point of contact when scheduling NET/NEMT transportation. The Care Managers work one-on-one with health-plan care managers, social workers, and facility staff in booking critical trips for their participants. Care Managers coordinate trips for dialysis, chemotherapy, high-risk obstetrical care, behavioral health services, transplants, hospital discharges, and other specialized services. The Care Manager may also coordinate meals and lodging as a participant's needs or circumstances dictate.

In addition to the above departments, MTM has a fully staffed Human Resources and Administration Department to assist in the hiring, employee training programs, ensuring employee rights and confidentiality are maintained and benefits administration for MTM employees. This department also provides important administrative functions to ensure the smooth operation of MTM.


Vice President, Client Services
Workforce Planning Manager
Account Managers
Contract Analyst
Program Manager/Director
Call Center Managers/ Supervisors
Quality Assurance Auditors
Manager, CSC Pulaski, VA
Manager, CSC Laurie Mall
Manager, CSC Anderson, SC
Manager, CSCLake St Louis, Mo
Supervisor Washington, DC
Supervisor St. Paul, MN
QA1
QA2
QA3
Account Manager 1
Account Manager 2
Account Manager 3
Minnesota
WDC
Florida
South Carolina
South Carolina
Kansas

Customer Service Center

HIPAA Guidelines

Under the Health Insurance Portability and Accountability Act of 1996, MTM is obligated under federal law, including, without limitation, to maintain the confidentiality of information, including personal healthcare information of all recipients.

Listed below are some areas that can prevent any disclosure of personal information.

- ✓ Press CTRL + ALT + DELETE (CTRL + ALT + END if using one of the new black thin clients) to lock system when getting up from workstation. Do in the same manner and enter password upon signing back into system.
- ✓ Place any paper(s) with names or Medical numbers out of view or when leaving the workstation.
- ✓ Drop any paper(s) with names or Medical numbers on them in the metal boxes located throughout the CSC. Do not dispose of in the trash.
- ✓ Any issues or concerns regarding a recipient should not be discussed outside of business.
- ✓ Enter any personal information, regarding a recipient's medical illness or condition, in the system's Trip Remarks or Red Flag only. This information would not be necessary for view on a trip.
- ✓ Do not disclose any personal information, with or without a recipient's consent, to any party that does not deal with meeting the transportation request.
- ✓ Do not release a Medical number. If the caller is unaware of the Medical number or does not have the Medical number available, the file can be entered by name or telephone number. The caller must then confirm the address, telephone number and date of birth. The release of the Medical number would not be given to the caller at any time during the call if it were not provided.
- ✓ If either the recipient or the recipient's file states that they have a password, please ask caller for the password before arranging transportation. A password is to ensure the recipient's safety/privacy and has been created for a reason.
- ✓ Do not leave a message with anyone other than caller or person who made transportation arrangements initially or on an answering machine. Be vague informing them to call Medical Transportation concerning their arrangements when necessary.
- ✓ Retrieve any printed or copied items with names or medical numbers immediately.

MTM
Medical Transportation Management, Inc.

Customer Service Center-**Toll Free Transportation Numbers**

In the event that a caller comes in on an incorrect line, direct the caller to the correct MTM toll free number. If the caller does not match any of the accounts listed below, refer the caller to contact the customer service number on the back of their benefit card.

- **Advantage Care Select** (IN)
  (877) 203-5622
- **Albany County/DFA** (NY)
  (866) 208-7357
- **Arcadian Health Plan** (multi)
  (866) 232-6116
- **Blue Advantage Plus** (MO)
  (800) 872-0508
- **Care Improvement Plus** (multi)
  (888) 240-6435
- **Children's Mercy Family Health Partners** (MO, KS)
  (800) 890-6026
- **Children's Special Care** (MI)
  (877) 547-2488
- **Colorado Access** (CO)
  (866) 791-4079
- **District Medical Assistance Transportation Services** (DC)
  (866) 796-0601
- **Gateway Health Plan** (PA, OH)
  (866) 670-3063
- **Greene County** (NY)
  (877) 361-9791
- **Hamilton County (OH)**
  (877) 722-2285
- **Harmony Health of Illinois** (IL)
  (877) 248-1338
- **Harmony Health of Missouri** (MO)
  (866) 745-6714
- **Healthcare USA** (MO)
  (800) 688-3752
- **Humana** (LA)
  (800) 430-4146
- **Humana** (TX)
  (866) 628-0391
- **Kaiser Foundation** (CO)
  (888) 665-8125
- **Kansas (KS)**
  (888) 240-6497
- **Martin County CTC** (FL)
  (866) 836-7034
- **Mercy Medicare** (MO)
  (800) 756-3039
- **Minnesota Medicaid** (MN)
  (866) 467-1724
- **Missouri Care** (MO)
  (800) 695-5791
- **Molina Healthcare of FL** (FL)
  (888) 240-6596
- **Molina Healthcare of MO** (MO)
  (888) 867-9115
- **Molina National** (multi)
  (866) 867-3208
- **MTM Advantage** (MO)
  (866) 655-0778
- **MTM Business**
  (888) 561-8747
- **MTM Complaint Line**
  Transfer to ext. 8-1-0-5
- **OmniCare** (MI)
  (800) 947-2133
- **Orange County** (NY)
  (866) 591-4066
- **Puget Sound** (WA)
  (877) 722-2308
- **South Carolina** (SC)
  (866) 831-4130
- **STAT**
  (888) 592-7828
- **St. Louis Taxi Service** (MO)
  (866) 275-9783
- **Unison Medicaid** (OH)
  (800) 269-4190
- **Unison Medicare** (OH)
  (888) 881-8127
- **Vendor Queue (LSL)**
  (877) 892-3997
- **Vendor Queue** (DC)
  (866) 232-6124 ext. 8141
- **Viva Health Plan** (AL)
  (888) 318-6362
- **Wellcare** (IL, MO)
  (888) 332-8126

Updated: October 15, 2009

MTM Fax Numbers

- **Michigan Faxes**
  (877) 637-9950
- **New York & DC Faxes**
  (877) 406-0658
- **MTM Toll-Free Fax**
  (877) 637-9950
- **Vendor Turn-back Faxes**
  (866) 652-3128
- **Quality Management**
  (866) 343-0998
- **Network Management**
  (800) 459-6224
- **Human Resources**
  (636) 561-7979
- **Care Management**
  (877) 406-0658
- **Mileage Reimbursement**
  (800) 722-0129
- **MNET**
  (651) 645-9627
- **MTM Local Fax /CSC Fax**
  (636) 561-6055

Updated: January 3, 2007

Section 2

Customer Service Skills

Telephone Etiquette

- "ONE MOMENT PLEASE" is used in place of "HOLD" on all calls
- Use "Please" and "Thank You" when you are on the phones. This portrays good customer service and sounds good when a recorded call is pulled. It also helps to fill sound dead air. As a rule of thumb, anytime information is asked for, say "Please" and when it is given, say "Thank you."
- Do not refer to transportation as being a "free service", as members could take this as insulting. Instead say "This is a benefit provided through your insurance at no cost that is available for you".
- A warning must be given to a caller that is using profanity before disconnection occurs.
- When you are attempting scheduling of transportation, getting authorizations, verifying urgency, or anything that would cause the caller to be on hold for an extended period of time, please go back every **2 to 3 minutes** to inform the caller that you are still working on it and thank them for their patience. This avoids complaints and shows good customer service. It alleviates the stress and lets them know that someone is working in their behalf.
- Prior to transferring a call, always contact the party first. Never cold transfer.
    - The only time cold transferring is allowable is when a call is sent to the Complaint Line or Discharge Queue.
- Words of positive reinforcement can help to ensure the members know that they are appreciated and it is helpful to MTM with arranging transportation. It shows that we pay attention to what is being done right instead of always mentioning things are done incorrectly.
    - "Thank you for giving us sufficient notice. This helps in ensuring your ride."
    - "I appreciate you having all of your information ready for us. This really helps us out."

What is a CSR?

A Customer Service Representative is the first contact callers have with MTM. CSRs answer calls striving to give the best possible service on the first ring. A typical call might include scheduling a ride, canceling a ride, or changing specifics to a previously arranged ride. CSRs are given goals for calls per hour and length of handle time. Goals for CSRs within their 90 day introductory period are based relative to their tenure, while those who are beyond their introductory period have a standard goal. CSRs must have the ability to relate to a diversity of customer's requests and needs and to identify with circumstances. The need to acquire and maintain in-depth knowledge of, and adhere to, established CSC Protocols and Procedures is necessary. CSRs must also demonstrate a sincere personal commitment to promptness, reliability, and quality work. The CSR role is critical to MTM's entire business.

Customer Service Skills Training (Soft Skills)

Outstanding Customer Service is the best way to keep your Customers! Most importantly remember Customers are the reason we have a job!

What is Outstanding Customer Service?
Outstanding customer service is the ability of an organization to constantly and consistently exceed the customer's expectations. Providing excellent customer service is one way a business can distinguish itself from the competition.

What is the purpose of Outstanding Customer Service?
Outstanding customer service should be a standard on every call. Customers should never have to expect to get great customer service; rather it should be the standard. Imagine if you were not getting the quality of service you expect from a company. Most likely you will not use their services in the future. As Customer Service Representatives, it is important to remember that MTM's customers have choices too. If they are not happy with the service we provide, most likely MTM will lose their business. In addition, the customer that had a bad experience will tend to share with friends and family. This has the potential to cost MTM even more business.

Before we can provide good customer service, we must first understand what exactly our customers are expecting.

1. Customers want someone they can depend upon and whom they can trust to do the job correctly the first time.
2. Customers want someone who is knowledgeable and who can answer their calls quickly.
3. Customers want someone that takes care of their individual need.
4. Customers want someone to treat them with respect and courtesy.
5. Customers want someone who will listen to their needs and not interrupt them during a conversation.
6. Customers want someone who delivers on their promise.

Customer service begins with the initial contact and carries through to the end of the conversation. First impressions are formed at the beginning of the conversation with things like the way you speak, your word choices, the tone in your voice, and how well you listen. If the first impression is not favorable in the customer's eyes, you have laid the foundation for poor customer service.

10 Steps to take to provide Outstanding Customer Service

1. **Respond quickly to your customers**.
    a. Responding quickly provides the customer with a first good impression because you are being attentive to their needs.
        i. CSRs should always the phone on the 1st ring. Customer hate waiting even if it is only a few seconds.
    b. Never put your customer on hold immediately after greeting them. This will create the customer to get very frustrated.
    c. Ensure you announce your name at the beginning of the call.

2. **Offer assurance of help**
    a. Customers want to know that they have reached the correct department/person that is going to be able to assist them.
    b. Be sure to say to the customer, "I will be happy to help you with your request".

3. **Be courteous**
    a. Being courteous creates the foundation for a positive experience.
    b. Remember the Golden Rule "Treat your callers like you want to be treated".
    c. Using courteous words like please, thank you, you're welcome. These word choices show the customer you care.
        i. Use the word "yes" instead of "yeah" or "uh hum". Using yes sounds more professional, respectful and intelligent.
    d. Use the customer's name throughout the contact of the call. Using the customer's name personalizes the contact and makes the customer feel like they are not just another caller.
        i. If you cannot pronounce the last name, gain permission from the customer to use their first name.
        ii. When asking someone's name, repeat it immediately. Saying a name aloud helps to cement it in the memory. Use the person's name often over the course of the conversation and remember to smile.
    e. Never chew food or gum while on the phone with a customer. There is nothing worse than hearing someone chopping on food while you are trying to have a conversation with them.

4. **Avoid unnecessary hold times**
    a. Customers do not like to be put on hold for any length of time. However, it is sometimes necessary to place a caller on hold. Always get permission from your customer when you place them on hold.
    b. It is also important to always refresh with your customer. This will ensure them that you are still working on resolving the issue.

5. **Listen to your caller**
    a. It is important to listen to the caller's questions, comments, and/or concerns. Listening shows that you care about your caller. Most of the time if you listen to the caller up front, you do not have to ask additional questions in order to process their request.
    b. The most important thing is to never interrupt your caller.

6. **Empathize with your customer**
    a. When your customer becomes upset explain to the customer that you understand their frustration and you will do what you can to assist them.
    b. When your customer becomes upset, it is very important for you to stay calm. Do not take anything the customer says personally. Understand the customer is just upset and may say hurtful things the customer does not really mean. If a customer flusters or unnerves you, stay positive. Do not let the customer hear frustration in your voice.

7. **Make your customer happy**
    a. When speaking to your customer, have a smile in your voice.
    b. Do your best to help resolve the customer's request or complaint while following the company protocols. This can be very hard to do, but stay calm and explain the rule to the customer if you can't fulfill their request. If you can't help, inform your customer who can.
    c. Sometimes it is impossible to make a customer happy. If needed, seek additional help from a more experienced or higher level customer service agent or manager.

8. **Recap**
    a. Providing your customers with a recap of the call will let the customer know that you have set the trip up correctly. This includes recapping the trip date, location, transportation provider, any special needs
    b. Ask your customer if everything has been set up correctly to ensure there are no misunderstandings on either party.

9. **Thank the customer for their business**
    a. It is important to let the caller know that you value their business.

10. **Follow up with your customer**
    a. If necessary always follow up on your promises. If you informed a customer that you would call them back, then follow through.

CLAS Standards
(Cultural and Linguistically Appropriate Service)

Prepared for

MTM

To ensure that all people entering in contact with MTM receive equitable and effective treatment in a cultural and linguistically appropriate manner, MTM will adopt the National standards issued by the U.S. Department of Health and Human Services (HHS) Office of Minority Health (OMH) in 2001.

These standards are designated to address the needs of racial, ethnic and linguistic population groups that experience unequal access to health care services.

The standards are organized by themes:

- Culturally competent care (1 – 3)
- Language access Service (4 – 7)
- Organizational Support for cultural competence (8 – 14)

Within this framework, there are three types of standards of varying stringency:

- CLAS mandate: are those standards that are current Federal requirements for all recipients of Federal funds (Standards 4 - 7). These standards are based on **Title VI of the Civil Right Act of 1964**.
- CLAS guidelines: are activities recommended by OMH for adoption as mandated by Federal, State and national accrediting agencies (standards 1 – 3, 8 – 13)
- CLAS recommendations suggested by the OMH for voluntary adoption (14)

In an effort to provide the most adequate and fair treatment to members, clients and staff, MTM has adopted 10 of the 14 standards and adapted them to the line of business.

The Standards

MTM should ensure that participants receive from all staff members, effective, understandable, and respectful care that is provided in a manner compatible with their cultural health beliefs, practices, and in their preferred languages.

MTM should implement strategies to recruit, retain, and promote at all levels of the organization a diverse staff and leadership that are representative of the demographic characteristics of the service area.

MTM should ensure that staff, at all levels and across all disciplines, receive ongoing education and training in culturally and linguistically appropriate service delivery.

MTM must offer and provide language assistance services, including bilingual staff and interpreter services, at no cost to each participant with limited English proficiency at all points of contact in a timely manner, during all hours of operation.

MTM must provide participants both verbal offers and written notices in their preferred language informing them of their right to receive language assistance services.

MTM must assure the competence of language assistance provided to LEP members by interpreters and bilingual staff. Family and friends should not be used to provide interpretation services (except on request by the member).

MTM should develop, implement, and promote a written strategic plan that outlines clear goals, policies, operational plans, and management accountability/oversight mechanisms to provide culturally and linguistically appropriate services.

MTM should conduct initial and ongoing organizational self-assessments of CLAS-related activities. They are encouraged to integrate Cultural and Linguistic Competence related measures into their internal audits, performance improvement programs, patient satisfaction assessments, and outcomes-based evaluations.

MTM should maintain a current demographic and cultural profile of the community as well as a needs assessment to accurately plan for and implement services that respond to the cultural and linguistic characteristics of the service area.

MTM should ensure that conflict and grievance resolution processes are culturally and linguistically sensitive and capable of identifying, preventing, and resolving cross-cultural conflicts or complaints by members.

MTM should ensure that data on the individual patient's/consumer's race, ethnicity, spoken and written language, are collected in health records, integrated into the organization's management information systems, and periodically updated.

MTM must make available easily understood patient-related materials and post signage in the languages of commonly encountered groups and/or groups represented in the service area.

MTM should develop participatory, collaborative partnerships with communities and utilize a variety of formal and informal mechanisms to facilitate community and patient/consumer involvement in designing and implementing CLAS-related activities.

MTM is encouraged to regularly make available to the public information about their progress and successful innovations in implementing the CLAS standards and to provide public notice in their communities about the availability of this information.

Quality Observation Scoring Guidelines

This guideline is reviewed annually
Last Updated on 12/17/09
Next Review date 12/17/10

The purpose of this scoring guide is to assist the Reviewer on how to properly score the Observation form located in the Quality Management System database. This document will outline each section within the Observation form and provide a description of how to score each component within each of those sections. Some components may be scored as NA even though not indicated in each section due to the specific call.

The observation scores should be used as a guide of the overall performance of the CSR in the area of Quality. The CSR will be scored on all components of the call intake process. The Quality Management System database will compile the CSRs scores.

The Call Center Managers will have access to each CSR's scores in the Quality Management System daily. The Call Center Managers will be responsible for sharing individual and center results to their Team Leads for coaching, training and performance improvement purposes.

Section 1 – Greeting

1.1 Immediate attention to customer – The CSR should provide a response to caller immediately upon answering the phone.

a. Did the CSR thank the member for calling?
b. Did the CSR state "Good Morning or Good Afternoon"?
    1. Scoring on this component will be 5 if met, 0 if not met

1.2 Proper Identification of Self- The CSR should immediately introduce themselves in the greeting of their contact.

a. Did the CSR use their first name in the greeting of their call in a manner in which the caller could understand?
    1. Scoring on this component will be a 5 if met, 0 if not met

1.3 Proper Identification of Company- The CSR should immediately identify the company (health plan) the caller is trying to reach. They should not answer the phone as MTM unless specified in protocols.

a. Did the CSR use the health plans name in entirety without using abbreviations?
    1. Scoring on this component will a 5 if met, 0 if not met

1.4 Not applicable per MTM process.

1.5 Responds appropriately to customer and situation- The CSR should be attentive immediately after the greeting in order to identify the caller's need.

a. Did the CSR gain information from caller immediately after greeting?
b. Did the CSR gain medical ID or other information if necessary in order to access account quickly?
    1. Scoring on this component will be a 5 if met, 0 if not met

1.6 Verifies with whom they are speaking

a. The CSR should follow HIPAA guidelines and must verify four of the five pieces of information to be compliant.
    i. Name of Recipient
    ii. Address
    iii. Phone number
    iv. Medical ID
    v. Date of Birth
    1. Scoring on this component will be a 5 if met, 0 if not met
    2. If CSR scores a 0 in this component, the entire observation will be scored as a 0 due to ensuring 100% compliance with HIPAA guideline.

Section 2- Assess

2.1 Starts with an open probe

a. Did CSR say "How may I help you today or any variation of offering assistance?
    1. Scoring would be a 5 if met, 0 if not met

2.2 Probes to understand what and why- The CSR will ask additional questions to confirm that they have an understanding of the caller's original request.

a. CSR should re-confirm caller's needs to ensure they captured correct information
b. CSR should confirm date and time of appointment
c. CSR should verify type of trip required
    i. One way, round trip, or multi leg.
d. CSR should verify facility information using F6 function in NET Management System.
    i. Facility phone number
    ii. Dr/Facility Name
    iii. Facility address
    iv. Type of doctor being seen
e. CSR should determine if there are additional passengers.
    1. Scoring will be done on an incremental scale based on the number of components met.

2.3 Encourages customer to clarify- This component is to allow the caller to affirm the reason or request for accuracy purposes.

a. The CSR should encourage the caller to clarify what additional needs they may have that wasn't previously recapped by CSR.
    i. Right of choice or preferred vendor
    1. Scoring on this component will a 5 if met, 0 if not met
    Scoring may be N/A if additional clarification is not required.

2.4 Checks for customer's overall understanding of product and service

a. CSR needs to ensure the caller has a full understanding of the transportation options that MTM provides.
    i. Mileage reimbursement
    ii. Public Transportation
    iii. Cab
    iv. Paralift/stretcher
b. CSR needs to ensure proper education is made on the following:
    i. Pick up and Drop off procedure
    ii. Prior Authorization process
    iii. Out of County/State process
    iv. Meals and Lodging
    v. Urgency Guidelines
    vi. Level of Need form

vii. Mileage Reimbursement form process
viii. Recurring Trip process

1. Scoring will be done on an incremental scale based on the level of education required/verses given.

2.5 Demonstrates expertise by clarity of questions- CSR should ensure that they speak to the caller in a manner that meets the caller's experience with the MTM transportation process (first time caller verses repeat caller). First time callers will need a little more information for education purposes.

a. CSR needs to tailor questions based on experience of caller.
    1. The component will be scored a 5 if met, 0 if not met

2.6 Phrases questions so customer is not embarrassed- CSR should take callers age and sex into consideration before asking the special needs questions.

a. CSR should not ask a member under the age of 12 or over the age of 50 if they are pregnant.
b. CSR should take the caller's special needs into consideration when asking about mobility capabilities such as crutches, walker, cane or wheel chair weight information.
    i. If caller requires a paralift or stretcher/ambulance, the CSR needs to be cautious of how they ask the caller about their weight. "Ms. Caller, in order for me to ensure we get you to your appointment safely, I need to ask what is your approximate weight including equipment?" (if applicable). The CSR should also ask if their wheelchair is electric or manual.
    ii. If caller requires paralift or stretcher, the CSR should also inquire to determine if the member has steps outside of their home and approximately how many steps.
        1. Scoring will be a 5 if met, 0 if not met

2.7 Confirms priorities with the customer- CSR should review health plan protocols to ensure caller is meeting days notice guidelines.

a. CSR will educate member on proper call in procedure for future trips and follow current protocols and urgency guidelines.
    1. Scoring will be 5 if met, 0 if not met
    2. Scoring may be N/A if additional clarification is not required.

2.8 Correctly identifies the root cause of the customer's practical need- Does the trip meet the guidelines to set or deny based on protocols and F8 notes within the NET Management System.

a. The CSR needs to ensure they review the covered/not covered list, eligibility requirements, and F8 notes on the account
    i. Scoring will be 5 if met, 0 if not met

Section 3- Solve

3.1 Identifies all appropriate solutions, options, and/or alternatives

a. CSR needs to review appropriate solutions before making recommendations and enter necessary F4 notes within the NET Management System.
    i. Bus Exclusion
    ii. Special needs (paralift/stretcher)
        1. Scoring will be 5 if met, 0 if not met

3.2 Discusses solutions, options and/or alternates with customer

a. CSR needs to communicate all options with caller before setting trip
    i. Bus Exclusion
    ii. Special needs
    iii. Mileage reimbursement
        1. Scoring will be 5 if met, 0 if not met

3.3 Answers customer's objections

a. CSR needs to overcome caller's objection to taking public transportation or using mileage reimbursement.
b. CSR needs to provide caller proper education on why they are denying based on state or health plan protocols.
    i. Scoring will be done on an incremental scale based on the actual level of education required/verses given.

3.4 Provides correct information

a. CSR must provide accurate information when setting trips by utilizing proper processes and procedures specifically LON, RTP, PA, OOC, Meals and Lodging, and Mileage Reimbursement.
    1. Scoring will be done on an incremental scale based on the actual level of education required/verses given.

3.5. Communicates benefits of solution

b. CSR should explain the benefits of taking public transportation or using the mileage reimbursement program.
    i. Caller does not have to wait for transportation provider to pick up using the will call process
    ii. Taking the bus allows you the flexibility of being able to manage your time.
    iii. Caller can have someone they feel comfortable with transporting them
        1. Scoring will be done on an incremental scale based on the actual level of education required/verses given.

3.6 Addresses all customer's concerns

a. CSR should show empathy when speaking to member by using phrases like "I understand your situation/frustration and I will do what I can to accommodate your request".
    1. Scoring will be 5 if met, 0 if not met
    2. Scoring will be done on an incremental scale based on the actual level of education required/verses given

3.7 Takes ownership for WOWing the customer

a. CSR must always maintain a positive upbeat experience for the caller
    i. Upbeat tone- smile in their voice
    ii. Providing the member the opportunity to speak without interruption
    iii. CSR will keep the length of the call to a minimum.
        a. Scoring will be done an on incremental basis.

3.8 Mutual Decision is made

a. CSR should verify with the caller that a mutual agreement has been established regarding transportation provider.
    1. Scoring will be 5 if met, 0 if not met

Section 4- Confirm

4.1 Persistent in setting appropriate expectation

a. CSR must provide caller with a review of the trip details
    i. Date and Time of appointment
    ii. Pick up and drop off location
    iii. Trip Type (one way, round trip, multi-leg)
    iv. Special need requirements (if applicable)
    v. Passenger information (if applicable)
    vi. Transportation provider information
    vii. Mileage (long distance trips beyond protocol mileage guidelines)
        1. Scoring will be done on an incremental scale based on the actual level of education required/verses given.

4.2 Clearly communicates next steps

a. CSR must educate caller on next steps for mileage reimbursement, RTP, LON, OOC, Meals and Lodging and PA to reduce multiple callbacks and caller frustration.
    1. Scoring will be done on an incremental scale based on the actual level of education required/verses given.
    2. Scoring could be NA if setting a simple trip

Section 5- Close

5.1 Reviews commitments

a. This component will be NA since it is covered in section 4 of observation form.

5.2 Checks for additional needs or issues

a. CSR must confirm the caller does not have any additional questions or needs to set up additional trips.
b. Scoring will be 5 if met, 0 if not met

5.3 Thank the customer

a. CSR must thank the caller for calling
    i. Scoring will be a 5 if met, 0 if not met
    ii. Scoring may be scored NA if customer gets mad and hangs up

5.4 Proper company close

a. CSR must remind caller if they need to make any changes, or have questions about their trip to contact us at their earliest convenience.
    i. Scoring will be a 5 if met, 0 if not met
    ii. Scoring may be scored NA if no trip set up

Section 6- Control

6.1 Assertive responses

a. CSR should take ownership of the call without being condescending or rude.
    i. Scoring will be 5 if met, 0 if not met

6.2 Follows efficient call process

a. CSR should remain focused on the call flow process even if member tries to get off task.
    i. Scoring will be 5 if met, 0 if not met

6.3 Uses close probes to appropriately control the call

a. CSR should use phrases that help direct the call flow to get the caller on and off the phone as quickly as possible.
    i. Use directive phrases like, “Ms. Caller I will be doing…”
        1. Scoring will be 5 if met, 0 if not met

6.4 Proper use of Empowerment

a. CSR needs to portray confidence in order to convince caller that they can handle their concerns or request.
b. CSR should take all appropriate steps of assisting the customer before escalating call.
c. If a member calls in and requests a supervisor immediately, the CSR should inform member that they can not escalate to a supervisor without trying to resolve issue first.
    i. Scoring will be 5 if met, 0 if not met
    ii. Scoring could be NA if call is to set a simple trip

6.5 Builds on the strengths of the customer, company, and representatives

a. CSR needs to ensure caller they can assist with the request instead of transferring to a specific CSR as caller requested.
    i. Scoring will be 5 if met, 0 if not met
    ii. Scoring could be NA

6.6 Ensures the customer profits from the contact

a. CSR should communicate the value of MTM's transportation services wherever applicable.
    i. Ms. Caller you are going to love the services we can offer you.
        1. Scoring will be 5 if met, 0 if not met
        2. Scoring may be NA

6.7 Gives the reason first when requesting information

a. The CSR should always inform the caller why specific information is needed to set trip.
    i. HIPAA Regulations
        1. In order for me to process your transportation request, I will need to verify four items of identification. This is to ensure we are compliant with HIPAA regulations."
    ii. Special needs questions
        1. "In order to set your trip with the appropriate transportation provider, it is necessary for me to get your weight."
    iii. Additional passenger's age and weight information (car seats)
        1. It is important for me to get the ages of the additional passengers should an emergency occur as well as determining car seat requirements.
            a. Scoring will be 5 if met, 0 if not met

Section 7- Handle

7.1 Addresses personal needs before addressing practical needs

a. If caller is irate, the CSR should address the caller's personal concerns before making any recommendations about the trip.

1. Scoring will be 5 if met, 0 if not met
2. Scoring may be NA if caller does not have any concerns.

7.2 Acknowledges customer's probable feeling

a. When protocol states that we cannot set trip, the CSR should acknowledge and empathize with caller's feelings of being denied.

i. "I'm truly sorry; however your health plan indicates that dentist visits are not covered for transportation."

1. Scoring will be 5 if met, 0 if not met
2. Scoring could be NA if customer is not upset

7.3 Responds with empathy

a. CSR's voice should fluctuate in a tone that expresses concern on caller's behalf.

1. Scoring will be 5 if met, 0 if not met
2. Scoring could be NA if customer not upset

7.4 Apologizes appropriately

a. The CSR should express the appropriate tone based upon the situation and reaction of the caller.

i. "I am truly sorry for our mistake; I will ensure I get this resolved for you quickly."

1. Scoring will be 5 if met, 0 if not met

7.5 Communicates respect for the company-

a. CSR should never put blame on another department or CSR. They should always take personal accountability for any issue that arises.

i. "I have reviewed your trip and have identified the issue, I apologize for this inconvenience and I will do my best to get it resolved for you quickly."

1. Scoring will 5 if met, 0 if not met
2. Scoring could be NA if customer is not upset

7.6 Seeks to learn the full scope of the contributing factors

a. CSR should ensure they have gathered all the facts before making any speculations as to what happened previously in the trip that contributed to issue.
    1. Scoring will 5 if met, 0 if not met
    2. Scoring could be NA if customer is not upset

7.7 Not applicable per MTM process.

7.8 Allows customer to vent completely

a. CSR should never interrupt caller when they are clearly upset. They should let the caller know they are there to listen to their concerns. After resolving the caller's personal needs, they will make recommendations on how to resolve the trip issue.
    1. Scoring will be 5 if met, 0 if not met
    2. Scoring could be NA if customer is not upset

Section 8- Identify

8.1 Content of customer's message is caught the first time

a. CSR should use appropriate listening skills and focus strictly on caller
    i. Tune out background noise from peers
    ii. Eliminate other distractions (email)
    iii. CSR should jot down quick notes to keep them attentive to the callers needs.
    1. Scoring will be 5 if met, 0 if not met

8.2 Confirms correct understanding of customer's message

a. Throughout the entire contact, the CSR should continually re-affirm the caller's needs for mutual agreement.
    1. Scoring will be 5 if met, 0 if not met
    2. Scoring could be NA if simplistic call

8.3 Responds appropriately if hasn't understood customer correctly

a. CSR should apologize for misinterpreting the caller's original reason for calling.
    1. Scoring will be 5 if met, 0 if not met
    2. Scoring could be NA if simplistic call

Section 9- Speak

9.1 Voice Quality

a. CSR should keep an even tone throughout the call.
b. CSR should never elevate voice to match callers if the caller is upset.
c. CSR should keep a smile in their voice that demonstrates appreciation.
    1. Scoring will be done on an incremental scale based on the overall voice quality of the call.

9.2 Rate of Speech

a. CSR should do their best to match the caller's rate of speech in order to reduce frustration level of caller.
b. If caller speaks slower then CSR should try to match to ensure caller is retaining all the information we are providing.
    1. Scoring will be done on an incremental scale based on the overall call flow.

9.3 Word of Choice

a. CSR should refrain from using MTM jargon or abbreviations when speaking with callers.
b. CSR should use the right choice of wording as to not frustrate the caller or make them feel intimidated.
c. CSR should always speak in a professional manner.
    1. Scoring will be done on an incremental scale based on the overall call flow.

9.4 Pronunciation

a. CSR should pronounce their words clearly and in a manner in which the caller can understand.
    i. Slang/Jargon
        1. Scoring will be 5 if met, 0 if not met

9.5 Pauses

a. CSR should always pause throughout the contact of the call to give the caller an opportunity to respond, ask questions, or reconfirm information.
    1. Scoring will be done on an incremental scale based on the overall call flow

Section 10- Courtesy

10.1 Allows customer to speak without interruption

a. CSR should never interrupt caller
    1. Scoring will be done on an incremental scale based on the overall call flow

10.2 Demonstrates customer's importance to the company

a. CSR should inform the caller that they value them as a customer
    1. Scoring will be 5 if met, 0 if not met

10.3 Use of customer's name during call

a. CSR must use caller's name throughout the call to show respect.
b. CSR must use caller's last name unless granted permission to use first name.
    1. Scoring will be 5 if met, 0 if not met

10.4 Courtesy words and phrases

a. CSR should use courtesy words such as "Please, Thank you and one moment" throughout the call.
    1. Scoring will be 5 if met, 0 if not met

10.5 Demonstrates appropriate type and level of interaction- It is important to build rapport throughout the contact of the call, but CSRs need to ensure they are not taking up too much of their time or the caller's time.

a. CSR should gauge the caller's eagerness to get off the call and keep chit chat to a minimum.
b. CSR should refrain from having discussions revolving religion, politics, or anything that may have conflicting view points.
        i. Scoring will be done on an incremental basis based on appropriate level of interaction needed/given.

10.6 Minimize distractions

a. CSRs need to ensure they are not interrupting their conversation with their caller due to outside distractions (finishing up on previous trip, peers chatting, email, another call rings in, or music)
    1. Scoring will be 5 if met, 0 if not met

10.7 Not applicable per MTM process.

10.8 Proper hold procedure

a. CSR must always gain permission from caller to place them on hold
b. CSR must go back to caller after having on hold for more than two minutes to make them aware of the status.
c. CSR always thank the caller for holding when bringing them back on the line.
d. CSR should not put caller on hold unnecessarily.
    1. Scoring will be 5 if met, 0 if not met
    2. Scoring may be NA if hold not necessary

10.9 Proper transfer procedure

a. CSR should educate the caller by letting them know why they need to be transferred
b. CSR should also educate on whom they are being transferred to and provide the caller with a call back number in case they are disconnected during transfer process.
    1. Scoring will be a 5 if met, 0 if not met
    2. Scoring may be NA if transfer not required

10.10 Proper call back procedure

a. CSR needs to educate caller on the call back procedures if a requirement on this call
    i. Meals and Lodging request, Network EC trips, Complaint process- after hours
        1. Scoring will be a 5 if met, 0 if not met
        2. Scoring may be NA if call back not needed

Customer Service Center

Goals

Average Calls per day per CSR and Average Talk Time:

Goal 7 calls per hour
5 ½ minute talk time

For any new CSR, the timeline to achieve this goal is as follows:

0-40 Days as a CSR - **5** calls per hour with average **7** ½ minute talk time

41-90 Days as a CSR - **6** calls per hour with average **6** ½ minute talk time

91+ Days as a CSR - **7** calls per hour with average **5** ½ minute talk time

Average Handle Time:

Goal-7 minutes

Note: Handle time is talk time and hold time combined

Error Rate:

Goal -1.5%

Call Monitoring Scores:

0-40 Days as a CSR - **85%** on call evaluations

41-90 Days as a CSR – **90%** on call evaluations

91+ Days as a CSR – **95%** on call evaluations

MTM
Medical Transportation Management, Inc.

Monthly Performance Report

Month/Year:
CSR Name:
Team Lead:

Category		Description	
Call Stats	Calls Presented	# of calls presented to CSR	
	Calls Answered	# of calls CSR handled	
	Calls abandoned	# of calls not answered	
	Handle Time	Talk time and hold time combined. Goal - 7 minutes	
	Talk Time	Goal - 5 1/2 minutes	
	Hold Time	Goal - 1 1/2 minutes	
Utilization	Total Trips scheduled	Number of trips scheduled	
	Bus Trips	Number of bus trips scheduled	
	Gas Trips	Number of gas trips scheduled	
	Cab Trips	Number of cab trips scheduled	
	Paralift Trips	Number of Paralift trips scheduled	
Monitors	Operator Errors	Exact number of trip errors/trips queried	
	Soft skills	Verbal communication score/live or recorded calls	
	Documentation skills	Documentation score/live or recorded calls and trip queries	
	total score	soft skills and documentation average	

Live/Pulled Call Monitoring Form

Reviewers Name		Live / Pulled call	
CSR Name	**New CSR 13**	Date of Call	
Trip Number		Date of Trip	

Quality categories - Did the CSR Ask:	**Possible Points**	**Points Scored**	**N/A**
Greeting/State Plan Name			
CSR State Name			
Medical ID/M.A. Number (SS# Martin County)/ DOB			
Verify Members Name			
Verify members phone #			
Verify Members Address			
Verify Complete Caller Information			
Offer Mileage Reimbursement If Applicable			
Appointment Date/Time			
Urgency Asked and Verified if Applicable			
Facility Phone Number			
Doctor/Facility Name			
Facility Address-			
Type of Doctor			
Special Needs:W/C, Walker, Crutches, Cane, Car Seat/Service Dog (Martin County)			
Pregnancy Asked if Applicable			
Additional Passenger			
Preferred Vendor/Right Of Choice			
Offered Bus If Applicable			
Vendor Contact (Ur/Distance/Req)			
Read Back Entire Trip			
Closing Call Correctly			
Call Handled Appropriate-Not Disconnected			
Trip Started or Notes Placed in Existing Trip			

Soft Skills - Rate the CSR's	**Possible Points**	**Points Scored**	**N/A**
Overall Tone			
Overall Flow of Call			
Professionalism			
Attentivenous-No Duplication/Helpfulness			

	Total Call %	**Hard Skill%**	**Soft Skill %**
Trip Score Percentage	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**

Soft Skills	**0**	**0**	**0**
Hard Skills	**0**	**0**	**0**
Total Points	**0**	**0**	**0**

MTM Attendance Policy from Employee Manual included here:

Section 600
Pages 47-51

Customer Service Center

Call In Procedure

To report an absence or tardy, call the following to contact a live person:

- MTM-LSL Main # is (636) 561-5686

1. **First Shift**-Contact Your **Team Lead Shift** **Ext.**

   - **Cherie Frey** 7:00 a.m. – 3:30 p.m. 5009
   - **Ana Underwood** 9:00 a.m. – 5:30 p.m. 5093

   Contact the **CSC Manager** or **Workforce Planning** Manager if Team Leads are not available

   - **Stephanie Boschenreither** 636-297-7542 5044
   - **Clyde Collins** 763-381-2341 4459

2. **Second Shift**-Contact Your **Team Lead** or **CSC Manager or Workforce Planning Manager** if Team Lead is not available.

   - **Cherie Frey** 7:00 a.m. – 3:30 p.m. 5009
   - **Ana Underwood** 9:00 a.m. – 5:30 p.m. 5093
   - **TBD:** 1:30 p.m. – 10:00 p.m (M/T)
     11:00 a.m. – 7:30 p.m (F)
     6:00 a.m. – 2:30 p.m (S/N)
   - **Doug Richardson** 1:30 p.m. – 10:00 p.m (off M/T) 5092
   - **Stephanie Boschenreither** 636-297-7542 5044
   - **Clyde Collins** 763-381-2341 4459

3. **Third Shift**-Contact Your **Team Lead** or **CSC Manager** or **Workforce Planning Manager** if Team Lead is not available.

   - **Doug Richardson** 1:30 p.m. – 10:00 p.m (off M/T) 5092
   - **Autumn Armstrong** 10:30 p.m.– 6:30 a.m.(M-F) 5077
   - **Stephanie Boschenreither** 636-297-7542 5044
   - **Clyde Collins** 763-381-2341 4459

NOTE: You must reach a live person <u>at least</u> 1 hour prior to the start of your shift.

MEDICAL TRANSPORTATION MANAGEMENT, INC.

WORKFLOW

Dated: November 19, 2009
Subject: Customer Service Center Chain of Command **Page** 1 of 1

Department: Customer Service Center

PURPOSE: To ensure that any issues or concerns are addressed by following the appropriate CSC Chain of Command.

PROCEDURE:

1. Any issues should be addressed in the CSC before taking an issue out of the department. The following persons can be contacted via phone or email.
2. Once an issue has been brought to the appropriate persons attention, one week should be allowed before bringing the issue to a higher level as the situation could be in the process of investigation.
3. Advance arrangements must be made for a face to face meeting with HR (Step 5). Any types of retaliation can be brought directly to HR through email and bypass any other level of command.

Step 1: Contact your Team Lead: **Ana Underwood** ext. 5093, **Cherie Frey** ext. 5009, **Doug Richardson** ext. 5092, **Josh Miller** ext. 5083 and **Autumn Armstrong** ext. 5077. If your Team Lead is not available, ask another Team Lead.

Step 2: If the concern is not resolved through Team Lead, go to the Customer Service Center Supervisor, **Stephanie Bosenreither** ext.5044.

Step 3: If concern is not resolved through the Customer Service Center Supervisor, see the Workforce Manager, **Tim Hanlon** ext. 5591.

Step 4: If concern is not resolved through the Customer Service Center Supervisor, see the Vice President of Client Services, **Kim Matreci** ext. 5563.

Step 5: If concern is not resolved through Customer Service Center Director, see Human Resource Director, **Patsy Heavey** ext. 5579.

Confidential

Section 3

WHAT DOES ALL OF THIS MEAN ANYWAY

Terms/Acronyms

Abortion: the spontaneous or induced termination of pregnancy before the fetus reaches a viable age.

Abandonment Rate: percentage of incoming calls not answered.

ADA: American with Disabilities Act.

Additional Passenger: any person with or without an appointment that is being transported along with a client.

Adult Day Care: a place provided where older adults living at home can come and enjoy social and therapeutic activities and receive the assistance they require day to day.

Alcohol Abuse Evaluation: the process of evaluating a patient regarding alcohol abuse.

Alcoholics Anonymous Meetings: an organization consisting of alcoholics and recovering alcoholics who are trying to help themselves and others abstain from alcohol by offering encouragement and techniques.

Allergy: an immune response to a foreign antigen that results in inflammation and organ dysfunction (Allergies range from the life-threatening to the annoying).

Alternative Health Care: healthcare given on an alternative basis to medicine (acupuncture, massage, nutrition, etc).

Ambulatory: any person being able to ambulate or having the ability to walk on his or her own without the need for a wheelchair lift.

Ambulette: an ambulette is a special-purpose vehicle designed and equipped to provide non-emergency care that has either wheelchair-carrying capacity or the ability to carry disabled individuals.

Beneficiary: a person eligible for medical assistance, and has a medical ID card. Also known as a consumer.

Cardiac Rehab: rehabilitation for cardiac (heart) diseases.

Caseworker: a person located at the HealthWave Clearinghouse or the SRS service center that can help with eligibility for medical services.

Catheter: a tubular medical device for insertion into canals, vessels, passageways, or body cavities for diagnostic or therapeutic purposes (as to permit injection or withdrawal of fluids or to keep a passage open).

Cat Scan: a sectional view of the body constructed by computed tomography, also referred to as a *CT scan.*

Chemotherapy: drug therapy used to treat infections, cancers and other diseases and conditions.

Claim: a bill submitted by a provider to the Medicaid Program.

Client/Member/Recipient: a State, Federal agency or any business entity with which MTM holds a contract.

Consumer: a person eligible for medical assistance, and has a medical ID card. Also known as a beneficiary.

Cosmetic Surgery: surgery used for improving appearance.

Co-Pay: a part of the charges for certain services not covered by the medical ID card.

Counselor: the providing of advice and guidance to a patient by a health professional.

Court Ordered Exams/Appointments: Appointments/exams ordered by the court (psychiatric exam, paternity testing).

Covered/Non-Covered Service: the process of determining if the type of transportation request is covered or not.

Creditable Coverage: a certificate to prove that a person had medical coverage and the length of time you had it after medical coverage ends.

Demand Response: non-public transportation; cab, medical sedan, Para-Lift van, etc. This mode will require certification. (also called Para-Transit)

Dental: relating to or used on the teeth.

Diabetic Supplies and Education: supplies or education used in relating to diabetes or diabetics.

Dialysis: the process of cleansing the blood by passing it through a special machine. Dialysis is necessary when the kidneys are not able to filter the blood. -This is a life-sustaining treatment.

Drug Abuse Evaluation: the process of evaluating a patient regarding drug abuse.

Durable Medical Equipment: assistive devices used by patients at home, such as walkers, electric beds, and bedside commodes.

Eligibility: the process of determining whether a client is current and therefore eligible for transportation.

Emergency: something life threatening that may cause the loss of an arm, leg, or any other body.

Emergency Room Services (ER): the department of a hospital responsible for the provision of medical and surgical care to patients arriving at the hospital in need of immediate care. Emergency department personnel may also respond to certain situations within the hospital such cardiac arrests.
NOTE: If the following symptoms are mentioned, inform the caller to immediately hang up and contact 9-1-1: Chest pain, loss of consciousness or fainting, bleeding that cannot be stopped, drug overdose, broken bones, sudden loss of vision, speech, or movement of a body part, seizures, injuries from gunshot wounds, knives, or accidents, recent neck or back injuries, labor pains, loss of amniotic fluid or any other serious pregnancy related problems/issues.

Experimental Medical Procedures: the scientific procedure used to test the validity of a hypothesis, gain further evidence or knowledge, or test the usefulness of a drug or type of therapy that has not been tried previously.

Family Planning Clinic Services: clinics used for planning intended to determine the number and spacing of one's children through effective methods of birth control.

Federally Qualified Health Centers (FQHC's): an organization that brings primary health care to the underserved, underinsured and non-insured people of the United States. These groups include migrant workers and non-citizen visitors and guests in the United States. FQHCs provide their services to all persons regardless of ability to pay, and charge for services on a community board approved sliding-fee scale that is based on patients' family income and size

Fixed Route: service provided on a repetitive, fixed-schedule basis along a specific route with vehicles stopping to pick up and deliver passengers to specific locations; each fixed-route trip serves the same origins and destinations, unlike demand response. Includes route deviation service, where revenue vehicles deviate from fixed routes on a discretionary basis.

Grievance: is a statement of dissatisfaction with a service, provider, or decision made by Medicaid/HealthWave.

Group Therapy: therapy in the presence of a therapist in which several patients discuss and share their personal problems in a group setting.

Handle Time: the total time on a phone call arranging transportation.

Health Plan: the name of an MTM client.

Hearing Aids: an electronic device usually worn by a person for amplifying sound before it reaches the receptor organs.

High Risk Pregnancy: Any medical or social condition that could cause possible harm to the fetus or mother. Not all are listed, but some risk factors are:

- Medical conditions: Hypertension/Toxemia/Pre-Clampsia (high blood pressure/water retention), Diabetes (gestational or otherwise
- Age-teenagers and woman over age 35
- Weight- over or under
- Prior stillbirth or miscarriage
- Prior pre-term delivery (Prior pregnancies where delivery occurred before the 37th week)
- Prior neonate with a genetic or congenital disorder
- Multi-fetal pregnancy (i.e. twins, triplets)
- Sexually Transmitted Diseases
- Genital tract abnormalities
- Social characteristics (drug/alcohol addiction/use)

Home and Community Based Services (HCBS): a program designed to meet the needs of individuals who would be institutionalized without these services.

Hospital Admission: when a patient is admitted into the hospital for surgery, procedure, testing, observation, etc.

Hospital Discharge: when a patient is considered to have had their needs met by the hospital physicians and is therefore given a release to sign upon leaving the hospital.

Hospital Outpatient Services: when a patient is considered to have had their needs met by the hospital physicians and is therefore given a release to sign upon leaving the hospital.

KAN Be Healthy (KBH): a preventive health care program for beneficiaries who cannot pay for new equipment.

Immunizations: the creation of immunity usually against a particular disease; treatment (as by vaccination) of an organism for the purpose of making it immune to a particular pathogen.

Infertility Services: incapable of or unsuccessful in achieving pregnancy over a considerable period of time (as a year) in spite of determined attempts by heterosexual intercourse without contraception.

Laboratory Services: a place equipped for experimental study in a science or for testing and analysis (i.e. Blood work).

Lamaze Classes: relating to or being a method of childbirth that involves psychological and physical preparation by the mother in order to suppress pain and facilitate delivery without drugs.

Lead Screening/Testing: tests/screenings done on patients to test for exposure to lead.

Mammogram: a photograph of the breasts made by X-rays (used as prevention of breast cancer).

Managed Care: a health insurance plan that offers health care with a primary care provider. A provider is seen for most health care needs. A referral is given to a specialist if necessary. Access to a medical care is offered 24 hours a day, 7 day s a week.

Managed Care Enrollment Center: where HealthWave or HealthConnect is called and chosen. Also called to choose or change a HealthConnect provider.

Medicaid: the insurance program that helps eligible people pay for health care services. The Medicaid Program (also called medical assistance) is paid for by federal and state tax dollars.

MEDICAID/HEALTHWAVE Liaison: a person at the SRS service center who can help a beneficiary understand Medicaid benefits.

Medical Necessity: decided by a medical practitioner and is a treatment that is essential to health. For non-covered services Medicaid will review information provided by the medical practitioner to determine coverage allowance.

Medicare: the national health program for elderly and disabled people. Medicare is not the same as Medicaid.

Medical Provider: any Doctor, Medical Professional, or Facility providing medical services to the client.

MediKan: a reduced set of medical benefits. MediKan provides medical care for catastrophic illness.

Mileage Reimbursement: the program that may or may not be offered according to each plan, in which a Member is reimbursed for an amount per mile set by the plan, if the member can drive or arrange a ride with a friend or family member.(Rate x Miles) R*ate is specific to each plan.*

MRI: (magnetic resonance imaging) procedure in which magnetic resonance imaging is used.

MTM: Medical Transportation Management, Inc.

Multi-Leg Trip: trips that are set up in system to multiple locations on the same date. (Going to a Dr's appointment, then stopping at a pharmacy before going home).

MVR: Monthly Verification Request. Form used by Care Management to verify Recurring Trips (RTP's) on a monthly basis.

Non-Emergency Medical Transportation (NEMT): a State program that pays for some transportation to medical services.

Occupational Therapy: therapy based on engagement in meaningful activities of daily life (as self-care skills, education, work, or social interaction) especially to enable or encourage participation in such activities despite impairments or limitations in physical or mental functioning.
Optical Services: of or relating to vision.

Orthodontics: a branch of dentistry dealing with irregularities of the teeth and their correction (as by means of braces).

Orthotic Sevices: a support or brace for weak or ineffective joints or muscles (i.e. orthotic shoes).

Pain Management: management of severe pain done by a pain specialist for disorders such as cancer, arthritis, headaches, and carpal tunnel.

Para-Lift/Wheelchair Lift: any person not able to ambulate and therefore requiring a lift van.

Para-Transit: non-public transportation; cab, medical sedan, Para-Lift van, etc. This mode will require certification. (also called Demand Response)

Patient Liability: the amount that may be paid for services if in a nursing home or the HCBS program. The case worker will determine patient liability.

Pharmacy: a retail store where medicines and miscellaneous articles (as food, cosmetics, and film) are sold.

Physical Therapy: the treatment of disease by physical and mechanical means (as massage, regulated exercise, water, light, heat, and electricity).

Podiatry: the medical care and treatment of the human foot.

Port-a-Cath: derived from "Portal and Catheter". It consists of a reservoir compartment that has a silicone bubble for needle insertion, with an attached plastic tube. The device is surgically inserted under the skin in the upper chest or in the arm and appears as a bump under the skin. It is a type of device for intravenous access in patients who require frequent or continuous administration of intravenous substances. The major users of Port-a-Caths are oncology patients.

Presumptive Medical Disability (PMD): the Medicaid assistance program available to persons who meet Social Security disability criteria as determined by the PMDT and DRT. Eligibility is determined under existing program rules for the applicable medical coverage group for individuals with a qualifying disability determination.

Preventive Care: care that is given by a provider that ensures a person stays healthy**.** Examples of preventative care are:

- Immunizations (shots)
- Yearly physicals
- Pap smears

Primary Care Provider (PCP): the medical provider chosen to take care of persons health care needs. The primary care provider treats the ill, gives prescriptions for medicine and medical supplies, and refers to a specialist if needed.
Prior Authorization: some services that must be approved before received in order for Medicaid to pay. A provider knows what services need prior authorization and should take care of this.

Prosthetic Services: the surgical and dental specialty concerned with the design, construction, and fitting of prostheses (an artificial device to replace or augment a missing or impaired part of the body).

Public Transportation: any transportation offered via bus, light rail, or ADA regulated curb-to-curb service offered to the public and is area specific.

Quality Assurance Group (QAG): a group of people who help resolve grievances.

Qualified Medicare Beneficiary (QMB): a state program, similar to medical assistance, for people who need help paying for Medicare services.

- Must be eligible for Medicare Part A (even if not currently enrolled)
- NOT financially eligible for medical assistance
- And have limited income and assets

QSC: Quality Service Coordinator

Quote: Any increase/decrease to a set rate suggested by a transportation due to a trip being outside of a service area or day/hours of operation.

Radiation Treatments: the administration of high-energy, x ray photons, electrons, or nuclear emissions for the cure of cancer or palliation of symptoms.

Radiology Services: services done using the branch of medicine that uses ionizing and nonionizing for the diagnosis and treatment of diseases. (Such services include: MRI, X-Ray, Upper G.I., Ultrasound, CT Scan).

Rural Health Clinic Services: a clinic certified to receive special Medicare and Medicaid reimbursement. The purpose of the RHC program is improving access to primary care in underserved rural areas.

Self Help Group Meetings: a group meeting for use of self help (i.e. support groups, anger management).

Shunt: a passage by which a bodily fluid (as blood) is diverted from one channel, circulatory path, or part to another.

Smoking Cessation: the means by which a person is trying to stop smoking through classes, seminars and other aids.

Social Security Office (SSI): office for applying and dealing with persons with disabilities.

Social Worker/Case Manager: an employee of a hospital, nursing home or other medical facility.

Speech Therapy: therapeutic treatment of speech defects (as lisping and stuttering).

Spenddown: the dollar amount of medical bills that must be paid before Medicaid can assist with medical bills.

STA: the Speed to Answer on an incoming call.

Support Groups: a group of people with common experiences and concerns who provide emotional and moral support for one another.

Talk Time: the time on a phone call excluding hold.

Team Lead: the Customer Service Center Supervisors that are over a particular "team" of Customer Service Representatives.

Title 19: another name for Medicaid.

Title 21: the federal name for the State Children's Health Insurance Program that is called HealthWave 21 in Kansas.

TPL: the third party liability. If TPL, other insurance that must pay before Medicaid pays.

Transplant Services: the services pertaining to the transfer (an organ or tissue) from one part or individual to another.

Transportation Provider: any company who is under contract with MTM to provide non-emergency medical transportation services for MTM Clients. *Also referred to as a "Vendor"*.

Transfer: wheelchair bound Member who is able to move from the chair to the cab with little assistance.

Turn-back: when a transportation provider sends a trip back to MTM due to scheduling, pricing, breakdown or other reasons, stating they cannot accommodate.

Urgent Care Services: a facility of urgent care physicians who provide quality health care for patients of any age or gender who need and want immediate medical attention for non-emergency conditions. (Offers patients an alternative to emergency departments and office visits for fast access to care, extended hours, short wait time, and unscheduled visits).

Vocational Rehabilitation: used for persons with disabilities becoming economically independent and decreasing or eliminating their need for ongoing government supports through

integrated, meaningful, and sustained work. Achieved through a rehabilitation process, which engages applicants and clients fully in actively exploring their vocational interests, abilities, capabilities and service/process options and in making choices.

Weight Control Programs: programs used for controlling weight for medical or non-medical reasons.

WIC: the Special Supplemental Nutrition Program for Women, Infants, and Children which serves to safeguard the health of low-income women, infants, & children up to age 5 who are at nutritional risk by providing nutritious foods to supplement diets, information on healthy eating, and referrals to health care.

For further questions:
The Customer Service Center has a Tabor's Medical Encyclopedic Dictionary that is used for additional medical terms, to determine if a service is covered for transportation or to identify the appropriate system coding. Seek Team Lead Assistance if needed.

MTM
Medical Transportation Management, Inc.

Appropriate NET Management System Abbreviations and Definitions	
ADA	AMERICANS with DISABILITIES ACT
AID AID	
ALS	ADVANCED LIFE SUPPORT
APPT APPOINT	MENT
APT APARTMENT	
AUN AUNT	
AVE	AVENUE
BC BECAUSE	
BENEF BENEFICIARY	
BLDG BUILDING	
BLS	BASIC LIFE SUPPORT
BTR BROTHER	
CLD CALL	ED
CM CAS	E MANAGER
CTR CENT	ER
CW CAS	E WORKER
CXLD CANCEL	ED
DC DISCHARGE	
DEST DESTINAT	ION
DME DURABL	E MEDICAL EQUIPMENT
DR DOCTOR	
DTR DAUGHT	ER
DVR DRIVE	R
ELIG ELIGIBILIT	Y
ER EMERGENCY	ROOM
ETA	ESTIMATED TIME OF ARRIVAL
FL FLOOR	
FRN FRIEND	
FTR FATHER	
GMA GRANDMA	
GPA GRANDPA	
HOSP HOSPITAL	
H/P HEAL	TH PLAN
HUS HUS	BAND
HWY H	IGHWAY
LN LANE	
MBR	MEMBER
MNET MINNESOTA	NON-EMERGENCY

	TRANSPORTATION
MINS MINUTES	
MTM MEDICAL	TRANSPORTATION MNGT
MTR MOTHER	
MVR	MONTHLY VERIFICATION REQUEST
NEMT NON-EMERGENCY	MEDICAL TRANSPORTATION
NET NON-EMERGENCY	TRANSPORTATION
NRS NURSE	
O2 OXYGEN	
OT OCCUP	ATIONAL THERAPY
PMD	PRESUMPTIVE MEDICAID DISABILITY
PKWY PARKWAY	
PL PLACE	
PSNGR PASSENG	ER
PT PHYSICAL	THERAPY
PU PICK	UP
RD ROAD	
QMB	QUALIFIED MEDICARE BENEFICIARY
QSC QUALITY	SERVICE COORDINATOR
RCPT RECIPIE	NT
REL RELA	TIVE
RT ROUTE	
SON SON	
S/W SPOKE	WITH
ST SPEECH	THERAPY
STA	SPEED TO ANSWER
STE SUITE	
STR OR SIS	SISTER
SW SOCIAL	WORKER
TT TALKED	TO
TRANS TRANSPO	RTATION
THRU THROUGH	
TNPK TURNPIKE	
UNC UNCLE	
VDR VENDOR	
VM VOICEMAIL	
W/ WITH	
WC WHEEL	CHAIR
WFE WIFE	
ALL REAL TESTING OR MEDICAL ABBREVIATIONS	AA, EKG, EEK, SSI, MRI, NA, WIC…
ALL DAYS OF WEEK	MON, TUES, WED, THURS, FRI, SAT, SUN

Types of Medical Coverage

Medicaid is a health insurance program available only to certain low-income individuals and families who fit into an eligibility group that is recognized by federal and state law. Medicaid does not pay money to the individual; instead, it sends payments directly to the health care providers. Depending on the state's rules, individuals may also be asked to pay a small part of the cost (co-payment) for some medical services.

Medicaid is a state administered program and each state sets its own guidelines regarding eligibility and services.

Many groups of people are covered by Medicaid. Even within these groups, though, certain requirements must be met. These may include age, whether an individual is pregnant, disabled, blind, or aged; income and resources (like bank accounts, real property, or other items that can be sold for cash); and whether the individual is a U.S. citizen or a lawfully admitted immigrant. The rules for counting income and resources vary from state to state and from group to group. There are special rules for those who live in nursing homes and for disabled children living at home.

Medicare is a health insurance program for:

- People age 65 or older or under 65 with certain disabilities
- People of all ages with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a kidney transplant).

Medicare has:
Part A Hospital Insurance - Most people don't pay a premium for Part A because they or a spouse already paid for it through their payroll taxes while working. Medicare Part A (Hospital Insurance) helps cover inpatient care in hospitals, including critical access hospitals, and skilled nursing facilities (not custodial or long-term care). It also helps cover hospice care and some home health care. Beneficiaries must meet certain conditions to get these benefits.

Part B Medical Insurance - Most people pay a monthly premium for Part B. Medicare Part B (Medical Insurance) helps cover doctors' services and outpatient care. It also covers some other medical services that Part A doesn't cover, such as some of the services of physical and occupational therapists, and some home health care. Part B helps pay for these covered services and supplies when they are medically necessary.

MC+ Managed Care is a health care delivery program serving certain MC+ recipients that meet specified eligibility criteria. The goal is to improve the access and quality of health care services for Medicaid and state aid eligible populations, while reducing the costs of providing that care. The intention is to achieve this goal by enrolling eligible MC+ recipients in MC+ managed care health plans that contract with the state to provide a specified scope of benefits to each enrolled recipient in return for a capitated payment made on a per member, per month basis.

The MC+ managed care health plan is required to provide most of the basic benefits as identified by the state plan for adults and all medically necessary services for children under the age of 21. Other services previously not covered under Medicaid/MC+ may be provided to recipients if the MC+ managed care health plan determines it is a suitable, appropriate and a cost-effective approach to providing a covered service.

Types of Specialists
And the Areas/Conditions They Specialize In

Allergist- A physician specializing in the diagnosis and treatment of allergies/allergic disorders (hay fever, asthma).

Anesthesiologist- A hospital or surgicenter based M.D. who provides anesthesia for major or minor surgeries.

Audiologist- A physician using Audiology to aim to understand whether someone can hear properly, which parts of hearing (high or low tones, middle-ear or inner-ear causes) are affected, and what type of correction (e.g. hearing aids) may be necessary.

Cardiologist- A physician specializing in the medical study of the structure, function, and disorders of the heart.

Cardiovascular Surgeon- A surgeon specializing in the heart and the blood vessels.

Colorectal Surgeon- A surgeon specializing in the colon and/or rectum.

Critical Care- An internal medicine physician specializing in the continuing care of seriously ill patients.

Dermatologist- A physician specializing in the diagnosis and treatment of disorders of the skin, hair and nails.

Endocrinologist- A physician specializing in the glands (thyroid, pituitary, pancreas, ovaries).

ENT- A physician specializing in the medical study of the ear, nose and throat.

Gastroenterologist- A physician specializing in disorders affecting the stomach, intestines, and associated organs.

General Surgeon- A specialist specifically trained and qualified to provide surgical care of the whole patient, consulting with other specialists when appropriate.

Gynecologist- A physician specializing in the treatment of the female reproductive system.

Hematologist- A physician specializing in the treatment of blood diseases.

Types of Specialists
And the Areas/Conditions They Specialize In-continued

Immunologist- A physician specializing in the structure and function of the immune system (trouble fighting off or frequent infections).

Infectious Disease Specialist- A physician specializing in diseases passed from one person to another.

Internal Medical Specialist- A physician specializing in the treatment in mainly adults and specializes in cardiovascular, respiratory, GI diseases, and diabetes. Some patients choose Internists as their family physician.

Neonatologist- Pediatricians who specialize in treatment of newborn infants.

Nephrologist- A physician specializing in disease of the kidneys and bladder. Treat hypertension, monitor renal transplant patients.

Neurologist- A physician specializing in the diagnosis and treatment of diseases of the brain and nervous system.

Neurosurgeon- A surgeon who specializes in surgery and treats injuries to the brain, spinal cord, and other nervous structures (carpal tunnel, etc.).

Obstetrician- A physician who delivers babies and treat the mother during and after pregnancy.

Oculoplastic Surgeon- A surgeon who studies ophthalmology (eye microsurgery) and then specializes further in advanced plastic surgery techniques of the eyelids, tear duct system and orbit (bones around the eye).

Oncologist- A physician using the Specialty of Radiology in the treatment of cancers and other diseases using radiation.

Ophthamologist- A medical doctor specializing in surgery of the eye.

Optometrist- Optometrists fit glasses and treat minor eye diseases and are not medical doctors.

Orthopaedist- A surgeon specializing in the usculoskelatal system (Treat sprains, fractures and other injuries. Perform joint repair and total joint replacement).

Types of Specialists
And the Areas/Conditions They Specialize In-continued

Otolaryngologist- A surgeons who specializes in surgery and diseases of the ears, nose, throat, sinuses, head and neck. Some ENT's also subspecialize in facial plastic surgery.

Otologist- A physician specializing in diseases of the ear.

Pathologist- A laboratory based physician specializing in interpreting disease in tissue samples sent by other physicians. Usually works within a hospital.

Pediatrician- A physician specializing in the treatment of infants, children, and adolescents.

Perinatologist- A physician specializing in the fetus during the 20-29th week of pregnancy to 1st-4th week after birth (high-risk pregnancies).

Physiatrist- A physician with specialty training in Physical Medicine and Rehabilitation. This field of medicine involves the treatment of disorders that alter the function and performance of the patient. The focus of treatment is on the use of principles of rehabilitation as a process through which the daily function of the person can be improved.

Plastic Surgeon- A surgeons who corrects functional and cosmetic deformiries of the face, head, body and extremities. Repairs scars or burned skin, reconstructs structures destroyed by cancer or accidents. Includes cosmetic surgery such as breast augmentation or reduction, body contouring (liposuction).

Podiatrist- A physician specializing in the diagnosis and medical and/or surgical treatment of the lower extremity below the knee. Podiatrists generally treat conditions of the foot and ankle. Common conditions treated include sprains, fractures, skin disorders, infections, chronic wounds, heel pain, ingrown toenails, warts, hammertoes and bunions.

Psychiatrist- Prevention, diagnosis and treatment of mental and emotional disorders, including depression, anxiety disorders, substance abuse, developmental disabilities and sexual dysfunction. Treatment includes psychotherapy, psychoanalysis, diagnostic tests, medications and intervention with individuals and families who are coping with stress, crises and other emotional problems. Sub-speciaization exicts in child, adolescent and geriatric psychiatry.

Types of Specialists
And the Areas/Conditions They Specialize In-continued

Psychologist- Treat mental, emotional, and behavioral disorders. These range from short-term crises, such as difficulties resulting from adolescent rebellion, to more severe, chronic conditions such as schizophrenia.

Pulmonologist- A physician specializing in the diagnosis and treatment of diseases of the lungs and airways, including such conditions as pneumonia, cancer, pleurisy, asthma, bronchitis, emphysema, and other disorders of the lungs.

Rheumatologist- A physician specializing in the diagnosis and non-surgical treatment of diseases of the joints, muscle, bones and tendons. Included are such conditions as arthritis, back pain, muscle strains and collagen diseases.

Thoracic Surgeon- A surgeon specializing in the practice of medicine directed toward the surgical treatment of diseases of the chest including coronary artery disease; cancers of the lung, esophagus, and chest wall; abnormalities of the great vessels and heart valves; birth defects of the chest and heart; tumors in the organs contained in the chest cavity; and transplantation of the heart and lungs.

Urogynecologist- An Obstetrician/Gynecologist physician who specializes in the care of women with Pelvic Floor Dysfunction.

Urologist- A physician specializing in the treatment of diseases of the urinary tract, both male and female, and of the reproductive system of the male. Organs include the kidneys, bladder, prostate gland, and adrenal gland.

Vascular Surgeon- A surgeon specializing in the branch of medicine that addresses problems associated with the circulatory system. Common disorders treated by vascular surgeons include blocked arteries in the extremities, abdomen and neck, and aneurysms.

Wound Specialist- A physician specializing in assisting patients with non-healing wounds.

Section 4

Language Barriers
Relay Calls

Relay calls are placed by a TTY user through a Communications Assistant. Standard TTY Relay Service is for people who are deaf, hard of hearing or speech disabled and who desires to communicate with a hearing person who uses a standard telephone.

If you receive a relay call, the information given is being referred to you through the Communications Assistant (Relay Operator). Wait for the Communications Assistant's instruction as to when to interject with appropriate trip intake questions. When the Member has completed typing their answer/question, the Communications Assistant will relay the information to you and say "okay" when finished. The CSR should respond and say, "okay" when finished. The entirety of the trip will be completed using this process.

All Users:	711
TTY Users:	1-800-855-2880
Voice Users:	1-800-855-2881

AT&T Spanish Relay Service

TTY Spanish:	1-800-855-2884
Voice Spanish:	1-800-855-2885

AT&T Speech-to-Speech Service

English STS:	1-800-229-5746
Spanish STS:	1-866-260-9470

Language Barriers
Translator Calls

MTM Spanish-Speaking Representatives

MTM has multiple Spanish-speaking CSR's. If the caller is Spanish speaking and a Spanish speaking representative is working, cold transfer caller to queue 8166.

- If unsure, seek supervisor assistance
    - Weekend supervisor as assigned

Language Line Services

MTM has an account with the Language Line Services. When a CSR gets a caller that does not speak English and there are no bilingual MTM CSR's who speak that language, the CSR should call the Language Line Services.

- Phone Number: **1-800-523-1786**
- Account Number: **232058**
- 4 Digit Personal Account Number: **Your extension**

Creating a Conference Call (If an Internal CSR is Not Available):

- Put the caller on "mute"
- Press the "more" soft key, then the "Confrn" soft key on the Cisco phone
- Dial 1-800-523-1786 in the conferencing window
- Press "Dial"
- Give Language Line Services operator the account number and your extension when prompted
- Once advised, inform the Language Line Services operator that you are adding the caller on the line
- Press "Confrn" button on the Cisco phone
    - Everyone should be connected.

How to Handle the Foreign Accent

It's more and more common to talk with people whose native language isn't our own. These accents can be both international and domestic. How many times have you talked with someone just from a different region of the USA and not understood him or her? Miscommunication is easy with anyone who's not talking as we're used to hearing. Today, with ore and more business going global, it's key to be ready to know how to deal with a foreign accent. To those from another country- we are the ones that have the foreign accent. So these tips will go both ways, and they're effective both on the phone and in person.

Here are 5 key points to know how to help you at your job (and in your personal life too) when working with someone who is difficult to understand- accent or not.

1. **Don't Pretend to Understand.** It's OK to gently explain you're having a little difficulty understanding them. Let's face it, if you have an accent- you know it. So it's not a surprise. One of the least effective things one could do when not understanding someone is to PRETEND they do. Some nod or say, "OK" just to move the conversation along. That's not doing anyone any good. It's perfectly OK to simply and gently say, "I apologize. I am having a little difficulty understanding you. If you could slow down; just a little bit; I'll be able to get it all correct for you." That's the most important thing to the person with the accent; knowing you WANT to help and get it right. They're aware you might be having difficulty and if you nod yes or pretend you understand, it won't help the situation at all. Your tone of voice is international; universal. So keep it at a light, slower pace- and yes, smiling is also universal. They'll hear you smile in any language.
2. **Don't Rush.** Rushing threatens callers. Often there's tendency to want to really rush someone who speaks with an accent. Not a good idea at all. Rushing threatens the best of us, let alone someone who is not able to express themselves in our own style. Slow down. Not to excess of course, but if you find yourself constantly saying "uh huh, "over and over in rapid succession, you're probably rushing the customer.
3. **Don't Shout.** They are NOT hard of hearing. We usually get a little laugh on this one. Many a time we subconsciously speak louder- or repeat the same word over and over, thinking that will help. It doesn't. People with accents normally hear very well. It's insulting to shout at them. Keep that smile on your face.

4. **Don't Be Rude.** No one really thinks they're rude. But if you've ever said: "Hey, I can't understand you" or even a short, "HUH?" you're considered rude. Again, go back to #1 and explain you're having a little difficulty understanding them. They'll often repeat it for you. If the situation is hopeless and you simply aren't getting anywhere, don't be embarrassed or afraid to call for help. Perhaps another person can better understand what the customer is saying. But remember, being shuffled from one person to another is frustrating to anyone - accent or not.
5. **Do Keep a JOB Aid Available.** Most often, we hear that 80% of the calls are from a certain area with the same accent. Be it all Hispanic, or all Asian, or all European. If your job has you working with a large percentage of one accent, keep a few simple phrases in that language near you. Short phrases that would let the customer know you're trying. If you're in a Hispanic environment, phrases like, "Un momento por favor" (One moment please.) will help. Even if we mispronounce it, they'll understand.

   Don't forget that MTM has Spanish translators and if the language is not Spanish, the Language Line might be the best option.

Section 5

Customer Service Center Specific

General Information

Telephone Greeting

"Thank you for calling *Plan Name* Transportation Services. This is *CSR Name*. May I please have your (*Plan specific search criteria*)?"

Arranging Transportation

Transportation is set for current month and all of the next month

- If questioned on why transport cannot be arranged further ahead than just 1 month, inform that this is to prevent a fax getting lost or put aside

Member's Asking for a Supervisor

The following is directly from the Quality Scoring Observation Guide that is used to score calls.

Component 6.4 Proper use of Empowerment

a. CSR needs to portray confidence in order to convince caller that they can handle their concerns or request.
b. CSR should take all appropriate steps of assisting the customer before escalating call.
c. If a member calls in and requests a supervisor immediately, the CSR should inform member that they can not escalate to a supervisor without trying to resolve issue first.
    i. Scoring will be 5 if met, 0 if not met
    ii. Scoring could be NA if call is to set a simple trip

Note: Never state to a Member "a supervisor is going to tell you the same thing." This might not be true and could only infuriate the caller.

Releasing Last Names

- We are not required to give out last names over the phone. Please do not give out any co-workers last names.

No Response on the Line

After initial call greeting or after Member has been placed on hold and line is resumed; if there is silence or several minutes of background noise, but no one comes on the line, say the following phrase:

- "If you can hear me, I cannot hear you. Please call back."

System Passwords

Passwords should be sent to the Team Lead to securely save. This will ensure that if a password is forgotten, the information can be relayed and thus prevent too many invalid attempts and being locked out. The following steps should be followed.

1. Only attempt 2 times and then close window
2. Inform Team Lead that you can not log into system
3. Team Lead will verify password
4. If still does not resolve, Team Lead will escalate to systems, HR, or BSG

Frequent offenders could be subject to disciplinary notice.

NOTE: The ADP/HRB(Employee Access) password is not necessary to send to your Team Lead. This allows access to your personal health information. The password and security questions should be kept somewhere accessible.

Calls Received from Members You Know Personally

If you receive a call from someone you know personally, please inform the caller that due to PHI (Protected Health Information) you are required to turn the call over to your supervisor.

- Seek supervisor assistance

Personal Use of Mileage Reimbursement/Transportation

If you meet the qualifications and are in need of arranging mileage reimbursement or transportation, these sorts of requests must be made by a supervisor.

- See supervisor assistance

When to Log Off

A CSR working until the close of business must stay in an available status (unless otherwise approved) until the last minute of their shift. This is to ensure that there is an adequate amount of workers on line and that all calls are answered in a timely manner.

Newborn Not Yet Issued A Medical #

Transportation can be arranged under the mother's file for 1 month until a medical ID # is issued to the child.

- Exception: MNET-allowed for 1 year
- Exception: NY-state regulation that unborn children have their own medical ID #
- Document the Instructions/Directions field with "trip is for a newborn that has not yet been issued a medical number at this time."
- List the child as passenger without an appointment as this will be billed under the mother's name.

Caller Disconnects During Call

In the event that a caller should disconnect during the course of the call prior to retrieving all needed information, call volume would become a factor.

- If another call comes through the line:
  - Greet the call and ask for them to give you a few moments.
  - Quickly document the current trip that the caller disconnected the line before retrieving all information and another call came through
  - Leave trip in W1 Trip Status Waiting Code
  - NOTE: If a transportation provider was already selected when the member disconnected, the fax can be sent. A call to the member can be made if call volume allows. Documentation is necessary in the F4-Trip Remarks.

Shelters/Undisclosed Addresses

All addresses and phone numbers are verified by the caller upon entering a file. If informed that a member is residing in a shelter or facility and the address should not be disclosed, one of the following can be done to assist the member.

- Ask member for a password that will need verified for every trip
- Document the F8-Red Flag with the password
- Mark Update Screen's address as "See F8-Red Flag for password" to ensure that it is the member contacting MTM
- After password is verified, the address of the shelter/facility or an address of a different location can be entered on the trip request(s) and proceed with arrangements (gas station, etc.)

First Time Callers/Callers Inquiring About Service

The following could be informed to either a first time caller or a caller that would like to inquire about our service and does not necessarily have a request to enter. This will ensure consistency and proper education.

- Keep MTM's toll free number with them when traveling to medical appointments in the event they would need to contact us
- Complete addresses and phone numbers are needed on all calls to MTM in order to have transportation arranged
- Notice required according their plans protocols
- Mileage reimbursement program (if offered)
- Be ready 1 hour prior to appt (unless distance would need to allow for longer)
- Return process (driver will give a business card for them to contact them from the medical provider's office for the return ride and could take up to 1 hour)
- Changes or cancels (contact MTM in advance or if after hours, contact their transportation provider and leave a message and still contact the following day)
- Transportation for appointments can be arranged for current and following month.
- In the event of an emergency, do not contact MTM's non-emergency transportation number, but rather contact 9-1-1 or local emergency number.

Pregnancy-Related Appointments

Any appointments related to pregnancy and the Member is over 7 months/28 weeks OR if a Member is considered high risk (at any term of pregnancy), should not be denied for insufficient time. Listed below are some, but not all, risk factors that determine high risk

- Medical conditions: Hypertension/Toxemia/Pre-Clampsia (high blood pressure/water retention), Diabetes (gestational or otherwise)
- Age-teenagers and woman over age 35
- Weight- over or under
- Prior stillbirth or miscarriage
- Prior pre-term delivery (Prior pregnancies where delivery occurred before 37th week)
- Prior neonate with a genetic or congenital disorder
- Multi-fetal pregnancy (i.e. twins, triplets)
- Sexually Transmitted Diseases
- Genital tract abnormalities
- Social characteristics (drug/alcohol addiction/use)

NOTE: It is not necessary to ask the Member if she has any of the above listed conditions, but if they mention one of them, this list allows you to realize that they are considered a high-risk pregnancy.

Operator Educations (OE's)

Any trips that are found to be entered incorrectly, an OE code may be entered in the F4-Trip Remarks by supervisors, other departments, or the Quality Support Team. This is used as an educational tool to ensure that all trips are entered correctly in order for MTM to provide the utmost quality and transportation. This is also meant to eliminate a problem before it becomes an issue and to show a CSR what is being done inaccurately before it becomes a habit. OE's can be found by trip queries or random trips where something incorrect is noticed. Team Leads/Supervisors review their team member's OE's that were given by the Quality Support Team with them on a daily basis to explain what should/could be done to eliminate the problem(s). If it is determined by the Team Lead/Supervisor that an OE was entered incorrectly, the OE can be deemed invalid and the Team Lead/Supervisor will write the reason on the OE page. Signatures of both the team member and Team Lead/Supervisor is required (unless the OE is determined invalid). OE's are kept on file in the CSC. OE's entered by the Quality Support Team are used for scoring and given to each CSR on a monthly basis on a report card. A specific amount of OE's in the same category will result in a Standard Performance Improvement Plan (SPIP). Three months of the same consecutive OE, resulting in a SPIP, will result in disciplinary action. The SPIP will drop off if not in the same category the following month. Any trips where a possible OE would need entered that are located by a CSR; an email with the Trip Number can be sent to the Team Lead. For an example of an OE, see OE Forms under the section called Forms.

Section 6

Urgent Request Process

Educating on Appropriate Days Notice

If request is under the appropriate days notice or the recipient is a first time caller and has or has not given appropriate notice, educate recipient and mark the F8-Red Flag that the recipient has been educated on notice. This will ensure that MTM is following each plan's specific days notice guidelines and number of educations. Also, it may allow transportation to be denied if non-urgent and under the proper notice. Check each plan's protocols for specifics.

- Any requests under the plan's specific days notice guidelines, requires the Urgent Request Guidelines to be followed. If the "Call Facility" column is marked with "Yes", the "Special Instructions" column must be followed.
- If F8-Red Flag states that all appointments must be verified and verbal confirmation cannot be received, suggest a call back for a reattempt.
    - NOTE: Verification of all appointments must be documented by the Quality Management department or a supervisor. This is entered for fraud or confusion purposes.
    - **If confirmed that there is no appointment scheduled:**
        - Deny using "DR" Trip Status Code (Denied-Appointment Not Verified with Provider)
        - Refer caller to their Dr/facility with any concerns
        - Document the Red Flag that the recipient has been educated

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Urgent Request Guidelines-Days of Notice Exceptions

Always check to ensure that the service is covered per plan protocols.
This is just a guideline and does not include all possible urgent requests that could be called in. If uncertain, check with a supervisor or contact the medical provider's office for confirmation of urgency.

Type of Request	Set?	Call Facility?	Special instructions:
Less than days notice according to health plan protocols	NO	NO	• Do set if appt is of an urgent nature as listed below • Do set if recipient has not been educated on days notice the allowed amount of times • Do set if eligibility prevented advance notice
Cardiac or Pulmonary Rehab	YES	NO	No instructions
Chemo/Radiation	YES	NO	No instructions
Diabetic complications i.e. increased blood sugar or other increased diabetic symptoms	YES	NO	No instructions
Dialysis Patient	YES	NO	No instructions
Discharge	YES	YES	Do not set if protocol states it is not a covered service
Follow Up Visit (from Dr appt, urgent care or ER)	YES	NO	Do not set if visit was over 10 days ago and there are no complications
Immunizations to return to school only	YES	NO	No instructions
Lab Work/X-Rays	YES	YES	F4-Trip Remarks must be documented with the ordering doctor's information and doctor must verify the appointment—if no verification, deny.
Medications-Refill/New RX's	YES	YES	• Set if verified with pharmacy or ordering doctor. Do not set unless verified.
Pain Management (pain management specialist NOT for sick/pain urgent requests)	YES	NO	Set up without days notice
Prenatal Appointment	YES	NO	Set only if pregnancy related appointment.
Psychiatrist	NO	NO	Unless out of meds and going for refill (for crisis case - i.e. death in the family- ONLY with Supervisor or Team Lead approval)
Rescheduled Appointment	NO	YES (see special inst.)	• Only set under days notice if Dr/facility rescheduled • Set if MTM was responsible for a no show/late arrival and the recipient could not be seen.
Sickness or Injury (new onset) (ER/Urgent care included)	YES	NO (see special inst)	• Call to verify appointment (NOT URGENCY) only if F8-Red Flag notes indicate past fraud • For ER/Urgent Care set as a 1-way to and wait for confirmation that recipient was seen to set return.
Transplant Patient	YES	NO	Do not set if it is a non transplanted related service/appointment—document F8-Red Flag showing recipient as a transplant recipient.
WIC Appointments	YES	NO	• Set trip only if infant under 1 yr old and out of formula

If the F8-Red Flag states that all appointments must be verified, transportation cannot be arranged until the appointment has been verified. **There is no need to call and verify appointments unless it is specifically noted above under the column "call facility".**

12/28/10

Proper Documentation

Due to concerns that everyone is documenting differently and with spelling errors in the system, the following mandatory standardization will be effective immediately:

EXAMPLE ISSUE
"MON THUR FRI" should be Monday through Friday but looks like Monday, Thursday, Friday.

STANDARDIZED SYSTEM DOCUMENTATION
M=Monday

T=Tuesday

W=Wednesday

R=Thursday

F=Friday

S=Saturday

N=Sunday

Multiple days are to be recorded with slashes between the letters: "M/W/F/N"

One-Way and Multi-Leg Trips

Due to the way that transportation providers must schedule their trips, it is very important to code all one-way and multi-leg trips correctly. This requires the following:

Trip Type

For one-way trips, the Trip Type should be a:

- **"T"** if the Member is going only **TO** the medical provider and has their own means of transportation home from the appointment or the way from the appointment is happening on a different day or with a different transportation provider.
  - Any requests put in as a one-way require a note in the F4-Trip Remarks explaining why it is a one-way. This eliminates confusion on whether the trip was should be round, but was entered as one-way on accident.
- **"F"** if the Member is going only **FROM** the medical provider and has their own means or transportation to the appointment or the way to the appointment happened on a different day or with a different transportation provider.
  - Any requests put in as a one-way require a note in the F4-Trip Remarks
- **"R"** if the Member is going as a **ROUND** trip and is requesting transportation home and is to be set with the same transportation provider.

For multi leg trips, all trip legs must be coded as **"T"** trips, except for the final leg that must be coded as an **"F"** trip.

- EXCEPTION: **"P"** if the Member is going to the pharmacy on a multi-leg trip
  - Currently "P" not being used. "T" is used instead.

Appointment Time(s)

- The appointment time for all legs scheduled with a "T" Trip Type should be set using the actual appointment time(s) or if unknown on the intermediate leg(s), the appointment time should be set as "2359" or "WILL CALL"
- Member needs to allow up to at least 1 hour between the **end** of the first appointment and the start of the next one unless the driver is willing to wait and not charge waiting time
  - If the driver requests wait time, this must be authorized through Network Solutions.

Requests for Pick Up From and Drop Off To School/Work/Etc.

- Request that Member make the appointment at a time that we can pick up from school/work/etc and return home afterwards or pick up from home and drop off to school/work/etc. If Member states the inability to do this, seek supervisor assistance for approval.
  - This eliminates extra legs on a trip.

Documenting a Multi-Leg

- Any documentation is generally looked for in leg 1. All remaining legs require a note in the F4-Trip Remarks stating "See notes in leg 1". This guarantees that any trip that is entered would refer the reader to the proper trip to locate documentation.
- Documentation indicating each leg of the trip should be specified on the Special Needs field. Example: Leg 1 of 3, Leg 2 of 3, Leg 3 of 3.
- Any trip that is not a round trip requires documentation in the F4-Trip Remarks stating why. This eliminates any confusion on why the member does not need transportation to or from.

Trip Reason Codes

For any "leg" of the trip that is headed home/school/work/etc, the Trip Reason Code used for the first "leg" would be used. Do not use Trip Reason Code 57-Non-Medical as this could appear that MTM is arranging transportation to non-covered services.

- This code is used on trips that are arranged to capture a denial or for accounts where non-medical services are covered. i.e. grocery store, hair salon, etc.
- Example: Psychiatric appt, Pharmacy stop, then home would be coded as follows: First Leg-**28**-Psychiatrist, Second Leg-**21**-Pharmacy, Third Leg-**28**-Psychiatrist
- A pharmacy stop following a hospital discharge would be entered as a two leg and coded as follows: First Leg-**21**-Pharmacy, Second Leg-**10**-Discharge

Trips to an Emergency Room/Urgent Care Facility

- For requests to go to an E.R. or Urgent Care check plan protocols to ensure that this is a covered benefit.
- Once confirmed non-emergent, instruct the caller that at the time of discharge, a confirmation call will be placed to the facility to verify that the Member was seen
    - EXCEPTION: No need for verification if the call is placed by a Social Worker, nurse, Case Worker or Discharge Planner from the facility.
- If urgent care is at a hospital, make a call to confirm that the hospital has an urgent care. If they only have an E.R., check plan protocols to ensure that this is a covered benefit.
- If request is to an urgent care and is being scheduled for the evening hours, call and confirm what time they are open as some urgent care facilities close early.
- Arrange trip as a one-way using a "T" for "To".
- If the same transportation provider accepts the trip home, the Trip Type can be changed from a "To" to a "Round" and refaxed (F9).
- If the same transportation cannot accommodate the way home, a new trip will need to be arranged as an "F" for "From" with a separate trip #.

Walk In Appointments

Any requests to a walk in appointment, the following steps must be followed:

- Contact the facility to confirm that walk ins are accepted at the requested time
- Document F4-Trip Remarks with the name of who confirmed that they accept walk ins during the requested time
    - If confirmation cannot be obtained, the trip will be left in a Trip Status Code “W1” (Waiting for Call Back from Member)
    - Advise the member to call back at a time that confirmation can be obtained
    - Document the F4-Trip Remarks that confirmation could not be obtained, but that member was advised to call back
- Arrange trip as a one-way using a “T” for “To”.
- Inform the member to contact MTM when the appointment is over for confirmation that they were seen and arrangement of the return ride
- Contact the facility to confirm that the member was seen
- Document F4-Trip Remarks with the name of who confirmed that member was seen
    - If confirmation cannot be obtained, the trip will be left as a one-way
    - Advise the member to call back at a time that confirmation can be obtained
    - Document the F4-Trip Remarks that confirmation could not be obtained, but that member was advised to call back
- If the same transportation provider accepts the trip home, the Trip Type can be changed from a "To" to a "Round" and refaxed (F9).
- If the same transportation cannot accommodate the way home, a new trip will need to be arranged as a "From" with a separate trip #.

Situations That Would Deem as Emergency

Anytime a member states that their call is regarding a true emergency vs. urgent, the caller should be directed to immediately hang up and contact 9-1-1 or local emergency contact number. MTM transports Members on a non-emergency basis only. Some examples of real emergencies include, but are not limited to the following:

- Chest pain or shooting pain down left arm
- Loss of consciousness or fainting
- Bleeding that cannot be stopped
- Drug overdose
- Broken bones (EXCEPTION: Minor breaks or fractures I.e. toes, fingers)
- Sudden loss of vision, speech, or movement of a body part
- Seizures
- Injuries from gunshot wounds, knives, or accidents
- Recent neck or back injuries
- Labor pains, loss of amniotic fluid or any other serious pregnancy related problems/issues

Discharge from a Facility (Monday-Friday 8am-5pm CST)

Once the call is determined as a discharge request, the CSR will do the following:

- Explain to the caller that they are going to be transferred to a Discharge Specialist to complete their request.
- Cold transfer the call to extension 8167
    - If a trip was started in the system prior to determination, leave the trip in "W1" Trip Status Waiting Code and document the F4 Trip Remarks.
    - Cold Transfer to extension 8167

NOTE: MNET and SC discharge requests are handled by the CSR and not transferred to the discharge queue.

After Hours Discharge from a Facility

- For trips where a Member is being discharged, schedule with an "F" Trip Type.
    - A pharmacy stop following a hospital discharge would be entered as a two leg and coded as follows: First Leg-**21**-Pharmacy, Second Leg-**10**-Discharge
- The appointment time would be the actual discharge time.
- **Verify with the facility that the Member was seen.**
    - This eliminates fraud and guarantees that the Member was actually seen.
- If the Member has already been discharged, enter a time approximately 30 minutes from the current time. (Taking into consideration any possible different time zone)
    - Retrieve the Nurses Station # and Room/Bed #
        - If the Member was already released from their room or was seen in the E.R., list where the Member can be located. i.e. ER, Main lobby.
- If the Member has not been discharged, and it is the hospital staff calling and they know the discharge time, arrange trip. If it is the member calling, enter the approximate time of discharge and ask that the member call back when the actual discharge has taken place. This helps to eliminate member no shows in the event that the transportation arrived and the Doctor had not yet released the member.
        - Place the trip in a W1 Trip Status Waiting Code
        - Document the F4-Trip Remarks that the member will call when discharge has taken place
- As a courtesy to hospitals/workers calling in a discharge, after contacting 3 transportation providers, allow the Social Worker to get off the phone and instruct that we will call them back when transportation has been arranged. Be sure to get a valid contact number. If call volume is high, ask the Team Lead to continue contacting transportation providers to ensure phone coverage.
- Once transportation is located, inform the caller that it could take up to 4 hours for the transportation provider to arrive due to the last minute changes to their scheduling. (unless the transportation provider gave a specific time)
- It is the hospital's responsibility for inpatient visits to see the patient to the door in a wheelchair.
    - If the Member is certified as cab, but the hospital states they are in a wheelchair, question the ability to transfer. They may be referring to the fact that they will be bringing the Member to the door in a wheelchair, but they are indeed ambulatory.
- Drivers are not required to come to the room and get the patient as they cannot leave their vehicle unattended.

Assigning the Transportation Provider

- All legs of a trip must be assigned to the same transportation provider, unless the trip is a mileage reimbursement request or public transportation can be used on any of the legs or if the location is to facility that has a sole source provider that will only transportation to/from that specific location.
    - If the same transportation provider does not show up on additional legs, this could be caused if you have a "2359" or "WILL CALL" time and the system does not recognize the time. Enter an actual time and "Reshop" the trip (SHIFT + F4), but prior to faxing change the time back to the original time.

Pharmacy Trips

VERIFY THAT PHARMACY IS COVERED FOR PLAN

For trips where Member is requesting:

A round trip to the pharmacy from their residence:

- Verify that the pharmacy has a prescription waiting or retrieve the medical provider's number to call and verify that a script was written.

A multi-leg with a pharmacy stop (already at the appointment):

- This appointment can become a multi-leg as long as the transportation provider can accommodate.

A multi-leg with a pharmacy stop (not at the appointment):

- Contact the medical provider to verify that a prescription will be issued on that day. If the medical provider is unsure until they see the patient, inform the Member to call back when they are at the medical provider's office.
    - See (A multi-leg with a pharmacy stop: already at the appointment.)

Multi-Leg for Appointments Needed Under Two Files

For Members who have an appointment at a different location than their additional passenger and they are riding together, the following would be required:

- The first leg of the trip should be placed under the Member's file that has the first appointment.
- Document the Special Needs field that the other legs are under the opposite Member's file.
- The additional legs of the trip would be placed under the Member who has the additional appointment(s).
- Document the Special Needs field of the other legs that the first leg is under the opposite Member's file.
- This helps to eliminate confusion for the transportation provider.
- This ensures that the appropriate billing can take place.

Section 7

Trip Status Codes

Customer Service Center Specific

Scheduled Codes		
S1	Scheduled from the Vendor Shopper	Normal trip set up
SG	Scheduled Gas	Trip is being processed. *Do not cancel*. Use NC code in F4. Email reimbursement department.
SQ	Scheduled with a Quote	Increased/decreased system price (req. approval)
Waiting Codes		
W1	Waiting for Call Back from Recipient	Missing information needed to finish trip
W2	Waiting for return fax	Used by CSR for mileage verification on plans that require a call within 7 days **MNET only-**Used by Team Leads for Transportation Evaluation
W3	STS Certification	**MNET only-**Counties we do not service, but needs certification
W4	Waiting for Reimbursement	Trip is waiting to be processed
W6	Waiting for Ambulance	Not entered by CSR-Care Management only
W7	Waiting Status For Mileage Reimbursement	**MNET only-**Transfer call to nurse queue at 8131
W8	Waiting To Fax To Vendor Later	**MNET only-**If over mileage limit (over 40 miles)
WB	Waiting for recurring trip	**MNET only-**CSR uses on 2nd trip for RTP
WF	Waiting For Fax	**MNET only-**Used by Lead after fax is sent when over mileage
WR	Trip Status for "MASTER RTP" trips	Used when RTP is put in
WW	Waiting for Fee Adjustment	**MNET only-**Used for passengers with appts-have to be eligible Used when ADA and vendor notes show additional fees are needed
Escalation Codes		
EA	Escalate for LON	Level of Need has been requested (not MNET)
EB	Waiting for LON	Level of Need has been faxed (not MNET)
EC	Escalate to Network Management	Vendor not in shopper-after hours-seek supervisor
EU	Escalated Urgent	South Carolina only-trips
No Show Codes		
XB	Cancellation of a Bus Trip	Only cancel if there is NO one-way price in the trip
X1	No Show-Recipient Canceled at P/U	Also used on trips when a bus pass was sent, but is being returned
X2	No Show-Recipient Was Not There at P/U	
X3	No Show-Recipient Was There But Not Ready	
S4	No Show-Return Trip-Recipient Was Not There	
SV	Vendor No Show On One Leg Of Round Trip	
VN	Vendor No Show at Pick Up	
Cancellation Codes		
S7	Rcpt Canceled Direct to Vendor-Return Trip	
S8	Rcpt Canceled-Return Never Called For P/U	
X5	Rcpt Canceled Direct to Vendor-Prior to Trip	
X6	Rcpt Canceled Direct to MTM-Prior to Trip	Member/recipient cancels and does not reschedule
X9	Canceled Due to Appt/Schedule Change	Member/recipient cancels and reschedules on same call
XC	Canceled-Per Facility-no longer attends	Used by corporate office only
XD	Canceled-Rcpt is Deceased	
XE	Canceled Due to Operator Error	Only used if SCHEDULED with a Vendor
XG	Canceled Gas Reimbursement Trip	Used when MTM cannot verify member/recipient was seen or member cancels their request

XH	Canceled-Rcpt is Hospitalized	
XM	MTM Canceled	Computer/Dispatch problems/Misc.
XN	Canceled-Vendor Not Most Appropriate	i.e. set as bus, but LON Form states “no bus”
XQ	Vendor Turn backs that Don’t Count Against	Used by Turn-Back Specialists
XS	Canceled-Vendor not in compliance	Used by Network to cancel trips when non-compliant
XT	Canceled-Duplicate Trip	
XU	Canceled-No Vendor Available	Within days notice, but vendor could be located
XV	Vendor Canceled	Used by Turn-Back Specialists
XW	Canceled-SW/Facility Canceled	
XX	Canceled Due To Misinformation	From Rcpt/Plan/Vendor
Denial Codes		
D3	Denied-Over Trip Limits	Used on trips where plan has trip limits that have been met. Member is referred to their plan.
D6	Denied-Urgent Appt and No Vendor Available	Not to be used on discharge trips
DA	Denied-Not Eligible	
DD	Denied-Insufficient Time	Non-Urgent and under appropriate days notice
DE	Denied-Not Closest Provider	
DF	Denied-Not Medicaid Covered Service	Listed on covered/not covered services
DR	Denied-Appt Not Verified With Provider	
DV	Denied-Member/Recipient Has Other Coverage	**MNET only-**Has a prepaid health plan
DX	Denied-Doesn’t Meet Protocols	Category listed on protocols i.e. underage to ride
DY	Denied-Rcpt Has a Vehicle That Can Be Used	
DZ	Denied-Friend or Relative Available	

Requests entered with a denial code generate a denial letter. The denial letters are mailed by MTM to the member’s address of residence that is on file. Some plans do not require denial letters.

Currently, denial letters are being sent for the following plans:

- Albany, NY
- Blue Advantage Plus
- Children’s Mercy Family Health Partners
- Green County, NY
- Kansas
- Minnesota
- Orange County, NY
- South Carolina

Trip Remark Codes

Customer Service Center Specific

Code	Description	Notes
Member Prompted Codes		
BN	Bus Tickets Did Not Arrive	Any time a Member says bus tickets did not arrive
MA	Member Abusive	Any type of Member abuse
Complaint/Compliment Codes		
AC	After Hours Complaint	Any complaint regarding an accident/incident or drugs/alcohol that comes in after business hours (5pm weekdays-weekends included).
CM	Vendor Compliment	Any compliment about a transportation provider
CSR Prompted Codes		
FA	Fraud Alert	Any fraud or abuse related issues that the MTM Quality Management Department should investigate. This includes abuse happening in the background of a call or appointments that could represent possible abuse. *Any suspected or reported abuse issues need sent to Team Leads for immediate reporting to health plan and MTM's Executive Vice President of Operations.*
OC	Operator Compliment	Any compliment about a CSR. (Must be documented by a supervisor.)
	Operator Complaint	Any complaint about a CSR. (Must be documented by a supervisor)
RB	Refused Bus	Used on trips where Member refused bus and plan does or does not enforce the LON and/or member meets an exclusion.
AT	Approved Trip	Used on trips that are outside the protocols and plan approval was received. Should include name of who gave approval.
NC	Needs Changed	Used on trips that are currently in an SG status and it is determined that they did not keep the appointment.
MI	Miscellaneous Information	Any information outside of the above reasons

NOTE: Any accident, incident, or drug/alcohol related complaints go directly to Quality Management during business hours. Ext. 8-1-0-5 After business hours (After 5pm M-F and weekends), document using the AC Code. Always send a follow up email so that it can be addressed immediately on the next business day!

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Trip Reason Codes

50	Abortion	38	Mammogram
80	Adult Day Care	57	Non Medical Trip/Reason
01	Alcohol Abuse Evaluation for Treatment	39	Nursing Home to Nursing Home
81	Alcohol Rehabilitation	40	OB/GYN Services
82	Alcoholics Anonymous Meetings	15	Occupational Therapy
62	Behavioral Health	58	Opthamologist
35	Cardiac Rehabilitation	17	Optical
34	Chemotherapy	18	Orthotic Shoes
54	Child Day Care	20	Pain Management
83	Chiropractor	48	Pediatric Services (use 23 primary care)
84	Community Psych Rehab	21	Pharmacy
29	Counselor, Psychologist, Social Worker	46	Physical Exam
52	Court Ordered Exams or Appts	22	Physical Therapy
64	Day Treatment Program	24	Podiatry
03	Dental Services	25	Prenatal Services
33	Diabetic Supplies & Education	23	Primary Care Physician (Internal Medicine)
04	Dialysis	27	Prosthetic
05	Drug Abuse Evaluation for Treatment	28	Psychiatrist
53	Drug Rehabilitation	41	Radiation Treatments
06	Durable Medical Equipment	42	Radiology Services
70	Education/Outreach Program	59	Senior Center (DFA only)
71	Emergency Room-TO	65	South Carolina-Rehabilitative Services
72	Emergency Room-FROM	68	Specialist
63	Extended Pediatric Center	94	Speech Therapy
08	Hearing Aids	96	SSI Determination Medical Appts
10	Hospital Discharge	60	Transportation TO Urgent Care
09	Hospital - Inpatient Services/Admission	61	Transportation FROM Urgent Care
12	Hospital - Outpatient Services	55	TBI Waivers
11	Hospital to Hospital	43	Transplant Services
36	Hospital Visitation	47	Vision/Hearing Screenings
13	Immunizations	98	Vocational Rehab
14	Laboratory Services	66	Weight Control Programs
56	Lamaze Classes (or similar birthing class)	99	WIC Appointments
37	Lead Screening/Testing		

Never question " Why are you going to this appt?" but rather "What type of Dr are you seeing?" This is against HIPAA.

This is a complete list of all existing Trip Reason Codes. Not all services will be covered for all plans, as they are "plan specific."

Section 9

MEDICAL TRANSPORTATION MANAGEMENT, INC.

WORKFLOW

Dated: December 28, 2010

Subject: Mileage Reimbursement Log Process

Department: Customer Service Center

PURPOSE: To properly educate and follow the mileage reimbursement log process.

PROCEDURE:

1. In order to reduce call volume in the Customer Service Center, the CSR will send mileage logs for plans that authorize the process.
2. The CSR will offer Mileage Reimbursement at the Edit Member Screen (Eligibility or HIPAA screen) of the Net Management System.
3. If caller chooses **not** to utilize Mileage Reimbursement, the CSR will proceed with setting the trip.
4. The CSR will educate the caller on the trip logs that should be used on future trip requests.
5. The CSR will educate the caller that the current request must also be included on the log in order to receive payment.
6. If the appointment is occurring prior to the log being received, the CSR will educate the caller that the physician can sign verification on a letterhead which can be stapled to the log when it is returned.
7. The CSR will educate the caller that they will not need to call unless they are requesting another trip log and that all boxes must be completed for proper payment and faxed to MTM no later than 60 days from the date of the first appointment.
8. The CSR will document the F8-Red Flag that the member has been educated of the use of trip log sheets.
9. The CSR will document the F8-Red Flag on who to make the checks payable to.
    a. If the trip is for a minor and is not specified, the trip will be canceled out until we receive a call inquiring about it. This will cause delay in payment.
10. The CSR will email the CSC Team Leads: what account it is for, recipient's name and the address that it should be sent to or CSR can email a copy of the screen shot from the Edit Member screen.
11. The following will be mailed: A Tip Sheet explaining the process, Sample Trip Log, and a blank Trip Log.
12. The unsealed envelope is placed in the designated CSC location and will be sealed and mailed.

Confidential

Mileage Reimbursement Process

Mileage reimbursement is defined as "the program that may or may not be offered according to each plan, in which a Member is reimbursed for an amount per mile set by the plan, if the Member can drive or arrange a ride with a friend or family member." (Rate x's Miles)

There are currently 3 mileage reimbursement processes that are included under: Mileage Reimbursement Tips:

1. ***Requests that must be called in prior to trip occurring***
2. ***Requests that must be called in after trip has occurred (up to 7 days)***
3. ***Requests that must be put on a log***

The steps for the first process listed above are:

1. CSR will enter all trip details into the system
2. Arrange the request by vendor shopping (Shift + F4) and choosing the mileage reimbursement option. This will place the trip in a W4 Trip Status (Waiting for Mileage Reimbursement).
    - **Exception**: If the Red Flag (F8) has been documented to verify all appointments.
        - If verified, the F4 Trip Remark Code-MI (Miscellaneous Info) is entered along with documentation of who verified the member has an appointment.
        - If the CSR cannot verify the appointment, the Trip Status Waiting Code W1 (Waiting for Call Back from Member) is used until the member calls back and the appointment is verified.
3. Once the appointment date has passed, MTM's Mileage Reimbursement Department will verify the appointment.
    - **Exception**: All discharges are verified before a trip is completed. This is also done for mileage reimbursement requests.
        - If verified, the F4-Trip Remarks are documented using the "VG" Trip Remark Code (Verified Gas) along with who verified member WAS seen.
        - If verified, the F4-Trip Remarks are documented using the "VG" Trip Remark Code (Verified Gas) along with who verified member was NOT seen.
4. **Once verified by the MTM Mileage Reimbursement Department**: the trip status will be changed from a "W4" Trip Status Code (W4 Waiting for Mileage Reimbursement) to a "SG" Trip Status Code (Scheduled Gas).
5. **If not verified by the MTM Mileage Reimbursement Department**: the trip status will be changed from a "W4" Trip Status Code (Waiting for Mileage Reimbursement) to the appropriate cancel or denial status accordingly.

Mileage Reimbursement Information

Offering Mileage

- For every account that offers mileage as an option, the following question must be asked: **"WOULD YOU LIKE TO USE OUR MILEAGE REIMBURSEMENT PROGRAM?" or "HAS ANYONE INFORMED YOU PREVIOULSY OF OUR MILEAGE REIMBURSEMENT PROGRAM?"**
    - Then questioning if is an option or explaining how the program works would follow.

How Early Arrangements Can Be Made

- A request can be made anytime even on the day of the appointment, preferably before the appointment time, but under certain circumstances following the appointment time. (see Mileage Reimbursement Process for Trips That Have Already Occurred)

Backdating Reimbursement

- All requests for reimbursement made after the date of the appointment are discouraged and should be refused. Approval can only be done on a case-by-case basis.
    - EXCEPTION: If plan follows reimbursement process that member must call up to 7 days after appointment has occurred, unless it is their first education.
- If the member is requesting to backdate for mileage reimbursement, verify the plan uses the mileage reimbursement program and is **not** open 24/7.
- If the member is calling from a health plan that does not have 24/7 hours with MTM, the following guidelines will apply to approve the request:
    - Emergency room trip within 24 hours of trip, or if ER trip occurred on weekend, request received on Monday will be approved.
    - Any request to backdate received from the health plan.
- If the one-time backdate is approved, document the Red Flag (F8) that the member has been informed on the backdating policy.
- Team Lead will send an email to the Mileage Reimbursement Specialist so payment can be released to the member for the backdated trip.

Mileage Reimbursement Process for Trips That Have Already Occurred
CSR Steps:

This process is currently in place for Healthcare USA (effective Nov. 10, 2009), Missouri Care (effective Dec. 9, 2009) and Colorado Access (effective Dec. 23, 2009).

1. Inform member that all mileage requests will need to be called in up to 7 calendar days AFTER the actual appointment has occurred.
2. If the Red Flag does not show a previous education on the process, the member will get a one time exception to call in before the actual appointment has occurred or more than 7 calendar days after the appointment has occurred.
3. Document Special Needs "Trip Not Verified".
4. Arrange the request by vendor shopping (Shift + F4) and choosing the mileage reimbursement option. This will place the trip in a W4 Trip Status (Waiting for Mileage Reimbursement).
5. Document the Red Flag on the education: "Educated on New Mileage Process…Date & Initials".
6. Any requests after the Red Flag shows the 1 time education would be denied "DD" (Denied-Insufficient Time).
7. Document the F4-Trip Remarks using the "MI" Trip Remark Code (Miscellaneous Information) on why it was denied.
8. Place in "W2" Trip Status (Waiting for Provider Authorization).
9. Document the F4-Trip Remarks using the "MI" Trip Remark Code (Miscellaneous Information) that request was left in waiting due to needing verification for mileage reimbursement.
10. The Help Desk will make up to 3 attempts to verify the appointment. (See: Help Desk Follow Up Steps below)

Help Desk Follow Up Steps:

1. The Help Desk will pull a query on all requests in a "W2" Trip Status (Waiting for Provider Authorization) the following business day.
2. The Help Desk will make up to 3 attempts.
3. If the Help Desk cannot verify, the F4-Trip Remarks will be documented using the "MI" Trip Remark Code (Miscellaneous Information)
   - If answering machine/voicemail is received within the 5 minutes, no need to leave a message.
4. If the Help Desk cannot verify, the F4-Trip Remarks will be documented using the "MI" Trip Remark Code (Miscellaneous Information) that request was left in waiting due to an unsuccessful attempt.
5. After the 3rd unsuccessful attempt to verify, the Help Desk will cancel the request using the "XG" Trip Status Code (Canceled Mileage Reimbursement).
6. If the Help Desk cannot verify due to the incorrect phone number, the Help Desk will cancel the request using the "XG" Trip Status Code (Canceled Mileage Reimbursement).
7. If the Help Desk verifies that the member did NOT attend, the request will be denied using "DR" Trip Status (Denied-Not Verified with Provider)
8. The F4-Trip Remarks will be documented using the "VG" Trip Remark Code (Verified Gas) along with who verified member was NOT seen.
9. If the Help Desk verifies that the member DID attend, the request will be arranged by vendor shopping (Shift + F4) and choosing the mileage reimbursement option. This will place the trip in a W4 Trip Status (Waiting for Mileage Reimbursement).
10. The F4-Trip Remarks will be documented using the "VG" Trip Remark Code (Verified Gas) along with who verified member WAS seen.

Who to Make Checks Out To

- Document in the Red Flag (F8) who to make the check payable to
- If unlisted and trip request is for a minor, the check will be made out in the minor's name, therefore causing possible difficulties in cashing the check if the guardian does not have the same last name.

Listing Specific Location Information

If the member is being seen at a clinic, hospital or facility, and the selection is made to show this location as the pick up or destination, it is helpful to list any specific dept or Dr's name on the request.

- This ensures prompt and accurate verification and eliminates multiple transfers in attempting to confirm where at the facility member had an appointment.
- If appointment cannot be verified, member's request is canceled out and they will not receive payment.

Mileage Reimbursement Information-continued

Borrowing $ for Gas

If a Member stresses that they do not have the money available to pay for gas prior to the appointment, ask that the money be borrowed.

Canceled Appointments Due to Lack of Verification

- If an appointment was canceled due to lack of verification and the Member calls looking for their reimbursement check stating that they were seen, the following steps can be taken by the CSR.
    - Contact the medical provider's office to verify stating the following:
        - "Hello, my name is (CSR name) I am with Medical Transportation Management. I am attempting to verify that your patient (Member's Name) was seen in your office on (Date) at (Time) in order to offer the patient mileage reimbursement."
    - If verified, document the Trip Remarks (F4) with the situation using code "VG" (Verified Gas) and the name and department of who verified the trip.
    - Email the Trip # and explanation that it was verified to the Team Lead and Mileage Reimbursement bursts for trip to be released for payment

Distance Limitations for Mileage Reimbursement

- Any protocols that specify distance limitations for transportation would also apply for mileage reimbursement.

  EXCEPTION:
    - Orange County, NY (If previously allowed to go out of county to a specific Dr/facility, continue. Document F4 and request Out of County form. Any new requests where it was never allowed for member to go out of county require an Out of County form.)
    - Care Improvement Plus
    - Unison, OH

Verification of Discharge Trips

All discharges are verified before a trip is completed. This is also done for mileage reimbursement. Place "VG" in the F4-Trip Remarks along with documentation of who verified the member was seen.

Mileage Reimbursement Trip Logs

In order to reduce call volume in the CSC, the CSR will send mileage logs for Kansas, Orange County, NY, South Carolina, Washington DC, and Omnicare, MI by using the following steps:

- The CSR will educate the caller on the trip logs that should be used on future trip requests and arrange the request.
- The CSR will educate the caller that the request being entered must also be included on the log in order to receive payment.
- If the appointment is occurring prior to the log being received, the CSR will educate the caller that the physician can sign verification on a letterhead which can be stapled to the log when it is returned.
- The CSR will educate the caller that they will not need to call unless they are requesting another trip log and that all boxes must be completed for proper payment and faxed to MTM no later than 60 days from the date of the first appointment.
- The CSR will document the F8-Red Flag that the member has been educated of the use of trip log sheets.
- The CSR will include a letter to the member explaining the process, Sample Trip Log, Trip Log Letter, and a blank Trip Log in an unsealed envelope and address the front with the member's name.
- The unsealed envelope will be placed in the designated location and will be sealed and mailed.

Mileage Requested from another Person's Home Prior to Picking up Member

- If requested/questioned by the Member, seek supervisor assistance. (Not offered)
    - The supervisor will calculate the mileage from the driver's home to the Member's home and then to the medical provider's office. It is then calculated by the amount per mile offered by the plan.
    - The decision is based on whether the amount is less than the cost of a transportation provider on the trip.

Bridge Tolls

- For Members crossing a toll bridge, inform them to save their receipt/ticket and mail to: ATTN: MILEAGE REIMBURSEMENT DEPT. 16 Hawkridge Dr. Lake St. Louis, MO 63366-1829

Mileage Reimbursement Information-continued

Parking Costs

- For Members having to pay for parking, inform them to save their receipt/ticket and mail to: ATTN: MILEAGE REIMBURSEMENT DEPT. 16 Hawkridge Dr. Lake St. Louis, MO 63366-1829

Checks Claimed Not Received

- If a call is received after the date shown on the reimbursement chart regarding not receiving a reimbursement check **AND** the system shows that the trip is in a Scheduled Trip Status (SG-Scheduled Gas-meaning it was verified), the system can be checked to determine if a check has been sent by using the following steps.
    - Enter the specific trip request
    - F2 to the Trip Maintenance Screen 2
    - Press Shift + F6=Gas & Lodging
    - Determine if the "Chk#" column shows a check number listed
    - Determine if the "Date Paid" column shows a date that has been over 30 days. (30 days are needed to check to see if a check has cleared-45 days to reissue a new check) ***NOTE****: This screen is for viewing purposes only. Any accidental typing could result in a check getting voided. F12=Cancel after viewing.*
        - If it has been 30 days:
            - Send to their voicemail for this sort of request
        - If it has **NOT** been 30 days:
        - Check the Trip Remarks to see if the check has been returned to MTM
            - If so, see: Main CSR Contacts page for appropriate person's name.
            - Send to their voicemail for this sort of request
            - If not, request the Member call back if the check has still not been received after a full 30 days.
                - See: Main CSR Contacts page for appropriate name.
    - MTM investigates all requests to re-issue checks. When checks have not been cashed, MTM will stop payment on the lost check and reissue a replacement on or about 45 days from the date the original check was issued by MTM.

Approximate Mailing Date

- Generally 2-4 weeks after the appointment date
- See: Mileage Reimbursement Pay Schedule on following page for specific dates

Mileage Reimbursement Information-continued

Mileage Reimbursement Rates by Plan	
Advantage Care Select	Not offered
Albany County	Refer to Larry at 518-447-7459
Arcadian Health Plan	$0.30 per mile
Blue Advantage	$0.30 per mile
Care Improvement Plus	$0.35 per mile
Children's Special Health Care Services Division	Not offered
Children's Mercy Family Health Partners	$0.30 per mile
Colorado Access	$0.35 per mile
Gateway Health Plan	$0.35 per mile
Greene County	$0.14 per mile Paid by local DSS office. Refer to: (518) 719-3700
Hamilton County	Not offered
Harmony Health-Illinois	$0.30 per mile
Harmony Health Plan of MO	$0.30 per mile
Healthcare USA	$0.30 per mile
Humana-LA	Not offered
Humana-TX	$0.35 per mile
Kaiser Foundation Health Plan	$0.35 per mile
Kansas	$0.30 per mile
Martin County	Not offered
Missouri Care	$0.30 per mile
Minnesota	$.20 per mile (personal) $.59 per mile (volunteer/foster)
Missouri Care	$0.30 per mile
Molina Healthcare of FL	$0.35 per mile
Molina Healthcare of MO	$0.40 per mile
Molina National	$0.35 per mile
Omnicare	$0.32 per mile
Orange County	$0.44 per mile
Mercy Medicare	$0.30 per mile
Puget Sound Health Plan	$0.35 per mile
South Carolina	$0.32 per mile
St. Louis Taxi Services	Not offered
Unison	$0.35 per mile
Washington DC	Under 10 miles-$0.58 per mile Over 10 miles-$10 each way + $0.58 per mile
Wellcare IL and MO	$0.30 per mile

MILEAGE REIMBURSEMENT PAY SCHEDULE 2010

PAY PERIOD	IN/IL/TX/GA/OH/MO/FL/KS/ DC/UT/PA/WA/MD/ MULTI MOLINA/MULTI ARCADIAN	MI/AR/MN/NY/SC
	PAY DAY	
12/16/09 to 12/31/09	Tuesday, January 12, 2010	Tuesday, January 19, 2010
01/01/10 to 01/15/10	Tuesday, January 26, 2010	Tuesday, February 02, 2010
01/16/10 to 01/31/10	Tuesday, February 09, 2010	Tuesday, February 16, 2010
02/01/10 to 02/15/10	Tuesday, February 23, 2010	Tuesday, March 02, 2010
02/16/10 to 02/28/10	Tuesday, March 09, 2010	Tuesday, March 16, 2010
03/01/10 to 03/15/10	Tuesday, March 23, 2010	Tuesday, March 30, 2010
03/16/10 to 03/31/10	Tuesday, April 06, 2010	Tuesday, April 13, 2010
04/01/10 to 04/15/10	Tuesday, April 20, 2010	Tuesday, April 27, 2010
04/16/10 to 04/30/10	Monday, May 10, 2010	Tuesday, May 11, 2010
05/01/10 to 05/15/10	Monday, May 24, 2010	Tuesday, May 25, 2010
05/16/10 to 05/31/10	Tuesday, June 08, 2010	Tuesday, June 15, 2010
06/01/10 to 06/15/10	Tuesday, June 22, 2010	Tuesday, June 29, 2010
06/16/10 to 06/30/10	Tuesday, July 06, 2010	Tuesday, July 13, 2010
07/01/10 to 07/15/10	Tuesday, July 20, 2010	Tuesday, July 27, 2010
07/16/10 to 07/31/10	Tuesday, August 10, 2010	Tuesday, August 17, 2010
08/01/08 to 08/15/10	Tuesday, August 24, 2010	Tuesday, August 31, 2010
08/16/10 to 08/31/08	Tuesday, September 07, 2010	Tuesday, September 14, 2010
10/01/10 to 10/15/10	Tuesday, September 21, 2010	Tuesday, September 28, 2010
10/16/10 to 10/30/10	Tuesday, October 05, 2010	Tuesday, October 12, 2010
10/01/10 to 10/15/10	Tuesday, October 19, 2010	Tuesday, October 26, 2010
10/16/10 to 10/31/10	Tuesday, November 09, 2010	Tuesday, November 16, 2010
11/01/10 to 11/15/10	Tuesday, November 23, 2010	Tuesday, November 30, 2010
11/16/10 to 11/30/10	Tuesday, December 07, 2010	Tuesday, December 14, 2010
12/01/10 to 12/15/10	Tuesday, December 21, 2010	Tuesday, December 28, 2010
12/16/10 to 12/31/10	Tuesday, January 11, 2011	Tuesday, January 18, 2011

The dates in the left column represent the trip dates that are to be paid on the date in the column under the correct state

MEDICAL TRANSPORTATION MGMT, INC. Account No: [redacted] Check No: 00264897

Payee: [redacted] Recipient Name: Check Total: $6.00

Trip Ref.	Date	Qty	Rate	Total	Trip Ref.	Date	Qty	Rate	Total
MNT[redacted]	2007-02-26	10	$0.20	$2.00					
MNT[redacted]	2007-02-27	10	$0.20	$2.00					
MNT[redacted]	2007-02-28	10	$0.20	$2.00					

U.S. Pat.# 6,095,407 Reorder VersaSeal Style Z811G2 REV. 12/01/04

THIS DOCUMENT HAS A VOID PANTOGRAPH, MICROPRINTING AND AN ARTIFICIAL WATERMARK.

MEDICAL TRANSPORTATION MGMT, INC.
16 Hawk Ridge Drive
Lake St. Louis, MO 63367

SOUTHWEST BANK
4-98/810

00264897

3/16/2007

PAY TO THE ORDER OF [redacted] $6.00

SIX DOLLARS AND NO CENTS DOLLARS

[redacted]

Authorized Signature

PATENTS 4,210,346; 4,227,720; 4,310,180; 5,197,765; 5,340,159

[redacted] [redacted]

SAMPLE

See Reverse Side For Easy Opening Instructions

Medical Transportation Management, Inc.
16 Hawk Ridge Drive
Lake Saint Louis, MO. 63367

[redacted]

[redacted] [redacted]

Personal Cab Reimbursement

MTM does not reimburse the cost for personal cabs. If the Member missed their ride arranged through MTM or the transportation provider did not arrive and the Member contacts a personal cab that is not in MTM's network and then contacts MTM for reimbursement, this would not be allowed. All transportation providers must be part of MTM's network.

CSR will do the following:

- Educate the Member to contact MTM in this situation in order for a CSR to attempt to arrange an alternate transportation provider.
- Mark the trip as a vendor no show on the pick up or return.
    - If the no-show was on the pick up and the appointment was determined non-urgent, the Member would be asked to reschedule and lodge a complaint.

Supervisor Assistance

If the Member's plan is not open 24 hours and the Member was stranded after business hours and contacted a personal cab for a ride home, this would be considered a rare circumstance and would require supervisor assistance for determination of reimbursement.

Public Transport

Public Transportation is defined as "any transportation offered via public bus, light rail, or ADA regulated curb-to-curb service and is area specific"

Days Notice Required

In order for MTM to arrange sending passes/tickets/tokens for public transportation, please allow at least 4-business days notice, excluding the day the call is made. If request is non urgent and member has met their number of educations, it should be denied.

- Member's who have an urgent appointment and there is not enough time to get a pass to the member, CSR will question; "We should not be arranging this request on short notice. However, we can guarantee your request if you take advantage of the bus pass replacement. Would you like for me to set that up for you now?" (ie. member will pay out of pocket and MTM will send a replacement pass normal mail)
    - If the member declines the replacement process but would rather have their money back, the CSR should then offer bus pass reimbursement.
    - Bus pass reimbursement is the only option for Orange County, NY as bus pass replacement is not offered.
    - Documentation in the F4-Trip Remarks whether it is bus pass replacement, bus pass reimbursement, or that the member declined both is necessary. (This ensures the bus department understands which process the member requested).
- If the member declines bus pass replacement and bus pass reimbursement and IS residing in **St. Louis, MO, Kansas City, MO , Kansas, or Minnesota**, passes can be delivered next day by STAT Courier if request is prior to 1:30 pm CT.
    - The final bus report for the day is run at 1:30 pm CT and any requests after that will not be seen until the following business day.
    - If the request is after 1:30 pm CT, email the #BusDepartment as STAT can still be an option.
    - Inform that pass will be hand delivered between 8 am-12 pm.
    - Wichita, KS area receives an all day pass
    - Documentation in the F4-Trip Remarks that the member declined bus pass replacement and bus pass reimbursement which resulted in STAT being the best option is necessary.
- If the member declines bus pass replacement and bus pass reimbursement and DOES NOT reside in **St. Louis, MO, Kansas City, MO, Kansas, or Minnesota**, a one-time bus override can be given. If the one-time bus override has already been given, the Trip # can be emailed to the LSL Team Lead burst to do a management override due to short notice urgent trip.
    - Documentation in the F4-Trip Remarks that the member declined bus pass replacement and bus pass reimbursement which resulted in a management override is necessary.

Pass Sent and Member Changes Appointment Date
-continued

Pass Sent and Member Cancels

- Check to see if the trip has a one-way price and the F4-Trip Remarks state the pass has been sent.
- If Member no longer needs the pass, inform Member to return the pass to MTM through the mail to: 16 HAWKRIDGE DR. LAKE ST. LOUIS, 63367
- Cancel the trip X1 if a pass has been sent.
- If Member can use the pass for an upcoming appointment refer to: Pass Sent and Member Changes Appointment Date.

Pass Sent and Member Changes Appointment Date

Depending on when the reschedule is, the pass may be able to be used. Contact the designated contact person in the bus department.

- If approved by the bus staff to keep the pass, use the following steps:
    - Cancel the trip using the appropriate Trip Status Cancel Code. (X1)
    - Document Trip Remarks (F4) that Member changed the appointment date.
    - Write down the Trip Number of the canceled trip.
    - Create a new trip and complete the process selecting the appropriate public transportation.
    - Document the Trip Remarks (F4) of the new trip with previous trips Trip Number and documentation stating that previous trip was a cancel, but a pass was sent.
    - Write down the new Trip Number.
    - Go back to the canceled trip and document the Trip Remarks (F4) with the new Trip Number and documentation stating that the Member canceled due to appointment change.
    - This is done to cross reference each trip with documentation and covering all angles for billing.

Public Transport-continued
LON Process

All Members, including Para-lift patients must be certified to use a higher mode of transportation other than public transportation through a form called a Level of Need. The only exclusions for a higher mode of transportation without getting this form on file are as listed in the protocols.

Client's Who Enforce the LON Process

Albany County, Blue Advantage Plus, Children's Mercy Family Health Partners, Greene County, Healthcare USA, Kansas, Minnesota, Missouri Care, Molina FL (referred to as a checklist process) Molina MO, Omnicare MI, Orange County, and Washington DC. Members of the above health plans, certification would be a requirement. This must be put in process for any Member that is stating a medical or mental reason for not using public transportation.

Documenting the Reason Public Transportation is Skipped

If a member meets a bus exclusion or the plan does not enforce the LON process, public transportation would still be offered, but is not enforced. For all plans, whether the LON process is enforced or not, documentation in the Trip Remarks (F4) stating the reason why the bus was skipped, is required.

- **RB** **Offered bus, but member declined.** (plan does *not* enforce LON)
- **RB** **Offered bus, but member declined and has a baby under 6 months of age.** (plan does enforce LON)

- Even with a legitimate reason, but no documentation, the trip is considered as completed in error.

NOTE: If Public Transportation Is Preferred, It Should Be Utilized

05/07/2007

[redacted]

Dear [redacted]

Please find enclosed your METRO MOBILITY (DR) bus tickets. The tickets are ONLY to be used for transportation to the medical appointment for [redacted] as listed in the information below. Information on bus routes and times is available at 651-602-1111.

Should this appointment be rescheduled please return passes immediately to the address below, and report the change of date to MTM at the number on the back of your ID card. If the appointment is cancelled or you do not attend the medical appointment for any reason, the tickets must be immediately returned to:

MTM Medical Transportation Management
MINNESOTA DEPARTMENT OF HUMAN SERVICES
Attn: T/R
16 Hawk Ridge Drive
Lake St. Louis, MO 63367

If you have any questions concerning these tickets, you may call the transportation number on your medical ID card.

MTM is not responsible for lost or stolen tickets.

Thank You.

Transportation Authorizations are as follows:

Appt Date	Trip No.	Name	Age	Appt
2007-05-15	MNT[redacted]	[redacted]	038	Y
2007-05-17	MNT[redacted]	[redacted]	038	Y

Criteria for Use of Public Transportation

MTM is commissioned by XYZ Health Plan to select the most appropriate, most cost-effective mode of transportation when scheduling trips for passengers. Public transportation must always be the first selection when scheduling transportation. However, there are extenuating circumstances that warrant the use of alternative, non public modes of transportation. These circumstances would include the health condition or age of the passenger and the availability of public transportation services within a particular geographic region. The list below outlines the criteria for use of an alternative, non public mode of transportation. If a member falls within these guidelines, an email to Care Management should be sent asking for a certification upgrade and for what reason. The F4 notes should be documented that the request was made. CM will then upgrade the member's certification level as needed.

Criteria for Use of Public Transportation

- √ Passenger lives and the appointment site are within 3/4 of a mile of a bus line.
- √ If Level of Need (LON) verifies and/or passenger states they are physically and mentally able to be transported via bus or other public transit vehicle.
- √ Passenger is 16 years of age or older if traveling alone (or per protocols).

Criteria for Use of Non Public Modes of Transportation

- √ If current Level of Need (LON) verifies that passenger is physically and/or mentally unable to be transported via bus or other public transit vehicle
- √ If more than one transfer is needed using public transit, then may not be suitable
- √ Passenger is traveling with an infant under six (6) months old.
- √ An adult or individual 16 years of age or older is traveling with more than 2 children under the age of 5.
- √ Passenger is in her third trimester of pregnancy.
- √ Passenger has a high risk pregnancy
- √ Passenger does not speak English and ***does not have a passenger to assist that speaks English.*** NOTE: CSR must ask the caller if they have someone that can accompany them to interpret. This info must be documented in trip notes before this will be considered an exclusion.
- √ Bus line is not operational on day and/or time of appointment.
- √ Passenger is undergoing chemotherapy/radiation (any appointments due to weakened state)
- √ Passenger is a transplant patient
- √ Passenger is going to kidney dialysis appointments (non dialysis-related appointments not included)
- √ Passenger is age 70 or older and uses walker, crutches and/or cane.
- √ Sickle Cell Anemia (child)
- √ Sickle Cell Crisis (adult)

Ambulatory Transport

Ambulatory is defined as "any person being able to ambulate or having the ability to walk on his or her own without the need for a wheelchair lift."

Any Member meeting any of the following criteria qualifies for transportation via cab/mini-van/multi-passenger van/sedan:

- Mileage Reimbursement is not an option due to no car, friend or relative able to transport or health plan does not offer
- Public Transportation is not an option due to area or confirmation in Red Flag (F8) through Dr's fax or health plan does not enforce

Walking Is An Option

If this pop up appears after Vendor Shopping/Selecting, question if the Member is capable of walking to their appointment.

- "My system shows that you live less than 1 mile from your medical provider's office. Would you be able to walk to this appointment?"
- If the able, press F8=Confirm
    - The system will place the trip in an "XM" Trip Status Cancel Code- Canceled due to Miscellaneous Reasons.
- If unable due to medical reasons, press F12=Cancel
- Proceed with transportation arrangements.

Para-Lift Transport

Para-lift or also known as wheelchair lift is defined as “any person not being able to ambulate and therefore requiring a lift van.”

Any Member meeting any of the following criteria would qualify for transportation via Para-lift:

- It is confirmed that Member is not able to bear weight and must therefore be transported by Para-lift
- It is confirmed that Member cannot walk long distances and must therefore be transported by Para-lift
- It is confirmed that due to previous two reasons, Member will be transported using a battery-operated wheelchair, that does not collapse and therefore cannot transfer from the wheelchair to a seat and will require a wheelchair lift
    - Certain plans require a Level of Need Form on file from the Member’s Dr confirming the need for Para-lift transportation. See plan’s protocols.

Mandatory Wheelchair Lift Information

- Type of wheelchair (i.e. electric, manual, scooter)
- Approximate weight of Member
- Any steps outside of residence that Member will require assistance down
    - Documentation of “ramp” if informed

Geri Chair Transports

Section 37.3 of the DOT’s regulations implementing the Americans with Disabilities Act of 1990 (ADA) (49 CFR Parts 27, 37, and 38) defines a "common wheelchair" as a mobility aid belonging to any class of three or four-wheeled devices, usable indoors, designed for and used by individuals with mobility impairments, whether operated manually or powered. A "common wheelchair" does not exceed 30 inches in width and 48 inches in length measured two inches above the ground, and does not weigh more than 600 pounds when occupied. Geri chairs can be reclined and do not meet the above standards. MTM is not required to transport persons in a Geri chair. Although this is up to the driver’s discretion, we recommend not doing so due to safety issues.

- Effective 10/11/2007, we are no longer allowed to escalate a member to a stretcher level. The member must be able to transfer into a common wheelchair.

Non-Emergency Stretcher and Ambulance Requests

Used for Members on a non-emergency basis that must be transported in a position lying down or need a paramedic due to IV's, equipment or medical observance. Any requests or cancellations of an ambulance or stretcher trip must be completed through the designated specialist, after the CSR has documented the trip. A follow-up email is necessary to ensure that the Member's transportation request was looked into and that the call transfer was successful.

- Note: If the plan follows the LON process and the member is currently showing as certified as stretcher or ambulance, the CSR can precede with the transportation arrangements.
- Note: Check plan protocols to see if stretcher/ambulance is a covered benefit or if there are special guidelines in place for arranging these requests.

1. Document all trip information. (i.e. date, time, pick up and destination addresses)
    a. Document the nurses station and room # on all discharges
2. Document the reason for the request in the Trip Remarks (F4)
3. Document whether the request is for a stretcher or an ambulance on the Special Needs field
4. Confirm eligibility (specific to each plan)
5. If not certified, retrieve the PCP name and phone # in the Trip Remarks (F4)
6. Leave the trip in a **W1** Trip Status Waiting Code
7. Send an email with the Trip Number to the appropriate Stretcher and Ambulance Specialist informing that you are transferring a stretcher/ambulance request to their voicemail.
    a. Emailing prior to transferring will ensure readiness for the next call.
8. Inform the caller: *"I have taken down all of your information and am now going to transfer you to a Stretcher and Ambulance Specialist. Please leave the following information on the voicemail and they will be contacting you shortly to coordinate transportation. Please leave the following information on the voicemail."*
    a. Name of the Member
    b. Member's Medical number
    c. Date needed
    d. Call back telephone number
9. Transfer to the appropriate Stretcher and Ambulance Specialist's voicemail
    a. TRANSFER/*****/EXT/TRANSFER (The * directs the caller to voicemail)

After Hours Process:

1. Arrange if currently certified at requested level
2. Seek Supervisor assistance regarding specific plans
    a. After hours is M-F after 4:30 pm and all day Saturday and Sunday.

Section 10

MEDICAL TRANSPORTATION MANAGEMENT, INC.

Policy and Procedure

Dated: May 31, 2001 **Policy No.** 410

Subject: Management of Grievances and Appeals **Page** 1 of 8

Department: Quality Management

PURPOSE: To provide an infrastructure for defining the requirement for the grievance and appeals process.

POLICY: All grievances and appeals are channeled through the Quality Management Department for documentation, investigation, resolution, and follow up and reporting. Grievances and appeals are given immediate and appropriate attention and may be originated by a health care provider or medical home, MTM passenger, a MTM transportation provider, or a MTM client. All records of grievances and appeals shall be maintained for ten (10) years following a final decision of closure of the grievance and/or appeal. All records shall be maintained in accordance with HIPAA guidelines 45CFR 164.530

Definitions:

a. MTM Provider – The contracted transportation provider performing transportation services.
b. MTM Client / Customer – The contracted client / payer who originates the request for transportation (health plans, medical facilities, State, etc.).
c. MTM Passenger – The member/recipient/beneficiary who receives the transportation service.
d. Complaint – Any written or verbal expression of dissatisfaction about services, procedures, or functions of MTM which causes an intervention by MTM for the recipient/member/beneficiary and/or caller. Complaints shall be resolved within timeframe specified by Client.
e. Grievance – Any expression of continued dissatisfaction after the resolution of a complaint.
f. Appeal – Any written expression of continued dissatisfaction after the written resolution of a grievance. An appeal is the formal mechanism which allows a request for review of an action/decision of MTM.
g. Warm Transfer – Transferring call from a member/recipient/beneficiary to their designated Health Plan. The QSC will stay on the line until they have reached a live person.

PROCEDURE:

1. All MTM service operations shall strictly adhere to the established procedures and requirements, and will ensure that members' issues are appropriately routed to the Quality Management Department in a timely manner.
2. MTM shall provide whatever accommodations necessary to assist language, visual, hearing or other impaired enrollees with filing a grievance.
3. Complaints that might fall into the grievance category include, but are not limited to:
   - Difficulty getting through on the phone

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- The quality of services provided
- Interpersonal aspects of services provided, such as rudeness by a provider or staff member, or
- Failure to respect enrollee's rights.

4. The facts surrounding a complaint will determine whether the appeals or grievance process shall be initiated.
5. The Quality Management Department will:
   a. In accordance with all applicable contracts and regulations as well as all other applicable state and federal laws and regulations, establish and maintain grievance processes and procedures.
   b. Establish normal business hours of operation from 9:00-6:00pm EST, Monday through Friday excluding holidays.
   c. Adhere to the protocols for receiving and handling grievance requests via phone, letters, emails and/or faxes as follows:
      i. All standard and expedited grievances received from a member, member's representative or provider on behalf of a member (where applicable by state/contract) during normal business hours shall be handled in accordance with the established procedures.
      ii. All standard grievances received from member, member's representative, or provider on behalf of a member (where applicable by state/contract) after normal business hours via the toll-free number will have the option to leave a message, and shall receive a call back the next business day.
      iii. All expedited grievances received from a member, member's representative or provider on behalf of a member (where applicable by state/contract) *after* normal business hours via the toll-free number will have the option to leave a message, and shall receive a call and resolution within seventy-two (72) hours of receipt.
      iv. Mail Acknowledgement Letters for Standard Grievances (non expedited) within five (5) business days. If a decision is reached before the written acknowledgement is sent, then one letter shall be sent which includes the acknowledgement with the notice of decision.
      Note: Acknowledgement letter may not be required by all contracts
      v. Grievance Appeals acknowledgement letters shall be mailed within fifteen (15) business days of receipt. (Only applicable in those contracts where required).
      vi. Acknowledgement letters must include: the name and telephone number of the person working on the grievance and, if applicable, a request for any additional information needed to investigate the grievance.
      vii. The Quality Management Department will involve all operational areas that need to be involved in the resolution of the grievance.

Members' Rights

1. Members shall have the right to file a grievance about any matter related to their services, without concern of reprisal from MTM, its employees or providers.
2. MTM will provide all enrollees written notice of the grievance procedures upon denial of services, member request for appeal or grievance, or at the member's request.

Grievance Filing

1. A member, member's representative, or provider acting on behalf of a member where applicable by state/contract may file a standard or expedited grievance request verbally or in writing.
2. The member, member's representative, or provider acting on behalf of a member (where applicable by state/contract) may file a grievance within six (6) months or one (1) year after the date of occurrence that initiated the grievance.
3. A verbal grievance request shall be filed through an established toll-free number 1-866-436-0457
4. An oral request may be followed up with a written request, but the time frame for resolution begins the date the oral filing is received by MTM's intake points.
5. A written grievance request shall be mailed directly to MTM's Quality Management Department at the following address:

   Medical Transportation Management, Inc.
   16 Hawk Ridge Dr.
   Lake St Louis, MO 63367
   Attn: Grievance and Appeals
6. For expedited grievances, an extension maybe granted if there is a determination by the state, plan, member, or provider which indicates that a delay would seriously jeopardize the member's life, health, or ability to maintain or regain maximum function.
7. Up to fourteen (14) calendar days extension may be requested by the member or provider on behalf of a member where applicable by State regulation, on member's behalf (written or verbal). MTM may also initiate an extension if member/provider can justify a need for additional information and if the extension is in the member's best interest. In all cases, extensions must be well documented.
8. Provide prompt notification to the member using an approved notice (letter) regarding MTM's plan to take up to fourteen (14) calendar day extension on a grievance case.
9. Complaints may include both grievances and appeals. Complaints can be processed under the appeal procedures, under the grievance procedures, or both depending on the extent to which the issues wholly or partially contain elements that are organization determinations. If a member addresses two or more issues in one complaint, then each issue shall be processed separately and simultaneously (to the extent possible) under the proper procedure. Cases involving an Appeal complaint shall be forwarded to the Appeals Department for processing and resolution.

Grievance Processing and Resolution

Upon receipt of the assigned grievance, the Manager, Quality Management and Compliance shall determine the type of grievance and allowable timeframes for resolution:

1. Same Day (Immediate) Grievance- Where applicable by State regulations, grievances that can be immediately (same day) resolved to the member's satisfaction do not need to be responded to in writing; (as applicable by state/contract).
2. Where applicable by State regulations, if a complaint/grievance cannot be resolved immediately (same day), then the issue will be handled by the Quality Management Department via the established protocols. The Manager, Quality Management and Compliance or designee shall determine if the grievance should be processed as expedited or standard. The member shall be notified via telephone and an acknowledgement letter shall be mailed within the specified time.

3. An expedited grievance shall be processed if it's determined that a delay would seriously jeopardized the member's life, health or ability to attain, maintain or regain maximum function, as applicable by state/contract.
4. MTM must notify the member of the decision by phone for expedited grievances and provide written notice of decision within three (3) business days of the decision (expedited and standard).

Grievance Resolution

a) For expedited grievance, they shall be resolved as expeditiously as the member's medical condition requires, but in no event more that the appropriate state requirement timeframe.
b) Standard grievances shall be resolved within the appropriate state requirement timeframe.
c) The decision notice shall include the reason and in cases where the decision has a clinical basis, the clinical rationale for the decision.

Record Keeping

1. Maintain a file on each grievance within MTM's system for review and audit purposes that must include (at a minimum):
   a. The date the grievance was filed and a copy of the grievance
   b. The date of receipt and a copy of the member's acknowledgement letter
   c. All member/provider requests for expedited grievances and MTM decision about the request
   d. Necessary documentation to support extensions, and
   e. The decision made by MTM, including the date of the decision, titles, and in the case of clinical decision, the credentials of MTM's personnel who reviewed the grievance
2. Log each grievance into the NET Management System and enter all actions taken and decisions into the appropriate system.
3. All documents and records shall be maintained for a period of ten (10) years from the termination date of the contract.

Reporting

1. Track, trend and report grievances, both internally (QMC) and to the appropriate state regulators, for the purpose of identifying opportunities for improved care and/or services to members.
2. All grievances shall be reported monthly, quarterly and annually to appropriate committees and state/ plan regulators, with reports analyzed to identify outstanding issues and adverse trends.
3. Grievance reporting to the appropriate state/plan shall be submitted as deemed appropriate by state regulations/requirements.

This policy is reviewed by the QMC on an annual basis for appropriateness and effectiveness.

Addendums

Please refer to the Addendums for specific client protocols, which may be different than the corporate protocol.

Addendum: Washington D.C.

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ADDENDUM A: Washington D.C. Complaint, Grievance and Appeal Process

PURPOSE: To establish a mechanism and reporting system for Washington D.C complaints including documentation, evaluation, resolution, and corrective actions in order to improve quality of services.

POLICY: All complaints are channeled to the Quality Management Department for documentation, investigation, resolution, and follow up and reporting as identified within the corporate policy #401, with the following additions and exceptions for Washington D.C.

Definition:
Complaint- evidence of professional misconduct, breach of contract, regulatory or statutory violation morale turpitude or other actions occur.

Conduct or behavior having an adverse effect on the health safety well-being or condition of a recipient or passenger associated with a recipient's well-being while being transported will be considered a complaint.

Procedure:

MTM will:
1. Provide a verbal response to each complaint received within three (3) business days of receipt of the complaint.
2. Provide a written response to the person filing the complaint within five (5) business days of receipt of the complaint.
3. Upon request, provide the COTR with a written record of the complaint and resolution including any corrective action within three (3) working days of the receipt of the request.
4. MTM shall establish and maintain formal standardized written procedures for handling all complaints including documentation requirements as identified within corporate policy #401.
5. Remove from public contact or provide a re-training program for service personnel who received two (2) complaints determined by MTM to be valid within a ninety (90) day period.
6. Remove from public contact any service personnel who receive four (4) complaints determined by MTM to be valid within a twelve (12) month consecutive month period.
7. Ensure that transportation providers shall remove from direct contact with the Medicaid recipients or provide a re-training program for drivers who receive two (2) complaints determined by MTM to be valid within a ninety day period.
8. Remove from direct contact with Medicaid recipients any driver who has received four (4) complaints determined by the broker to be valid within a consecutive twelve (12) month period.
9. Investigate complaints received and if deemed necessary by the COTR, remove from public contact or require retraining for any personnel.

Reporting

The original report will include the description of corrective actions taken to ensure service delivery conforms to the requirement of the contract.

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Recipient Complaint Process

MTM has three (3) working days from the day the complaint is filed to complete the investigation and provide the recipient a written response. The response shall include at a minimum:

- the specific reason for the service failure
- an explanation from the transportation provider
- MTM's corrective action plan with a follow-up date and,
- the recipient's appeal rights as to the corrective action

Recipient Complaint and Appeal Process

A. MTM shall at a minimum perform the following if the recipient elects to file an appeal to the corrective action expressed. He or she has thirty (30) calendar days from the initial complaint to do so. MTM will make available the "Notice of Appeals" letter. The appeal letter and any related documents not classified as "confidential" will be made available to the recipient, upon request.
B. A written response to the recipient's appeal letter will be provided within three (3) working days of the day the request for appeal was received.
C. The appeal notice shall include in detail the specific reason for the initial decision being upheld or any corrective action to be taken based on the appeal.
D. The response to the appeal shall be mailed to the recipient and a copy maintained in MTM's file available for audit as needed.
E. The recipient will be allowed thirty (30) calendar days from the date of the appeal response to appeal to the Department of Health, Medicaid Assistance Administration. Failure to do so within thirty (30) calendar days waives the recipients rights to further appeal

Recipient Denial Appeal Process

Definition: Any instance in which a transportation service has been made and which a recipient has been told no for all or part of transportation services.

The following shall be provided in the event a recipient appeals MTM's decision concerning a denial of service.

1. Provide written notice to the recipient within three (3) working days of the date the trip was denied, suspended or terminated.
2. The notice shall include in detail the specific reason for denial, suspension, or termination and an explanation of the recipient's appeal rights.
3. The original notice shall be mailed to the recipient and a copy maintain in MTM's file.
4. MTM will use the "Notice of Appeals" Letter approved by MAA.
5. Provide the recipient a minimum of thirty (30) calendar days from the date of the notice to appeal the initial decision. Failure to do so within thirty (30) calendar days waives the recipient's right to further appeal.
6. Upon receipt of a timely appeal MTM has thirty (30) calendar days to complete the appeal process.
7. In the event MTM is unable to resolve the issue the recipient will be given written final notice informing the recipient that his/her right to further appeal will be forwarded to the Department of Health, Office of Fair Hearings.
8. MTM will send an acknowledgement notice or letter to the recipient indicating receipt of the appeal within two (2) calendar days of receipt.
9. MTM shall define its decision, as necessary at the time of any administrative hearing.

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10. If the recipient appeals to the Office of Fair Hearings, MTM will submit to the Office of Fair Hearings all documentation related to the appeal within two (2) working days of the request.
11. MTM shall continue to furnish transportation services at the level, scope and duration the item or service was provided to the recipient prior to notice of MTM's determination pending resolution of the grievance or appeal. This provision of continued coverage applies only to the recipient or recipient designee who filed a standard grievance within ten (10) days on which the recipient was notified of MTM's decision to terminate or reduce services. MTM shall provide continued coverage until the date that the grievance is resolved, the recipient has not requested a fair hearing and will issue an authorization of any services authorized as a result of the grievance or fair hearing process within two (2) working days of grievance or fair hearing decision.

Grievances (to include Standard Grievance)

A. Recipients shall be informed of their right to file a grievance with the Office of Fair Hearings at any time during the process. MTM will offer to assist the recipient with a filing of a complaint to the Office of Fair Hearings. MTM's established timeframes allows recipients ninety (90) days from the date MTM mails a notice of action to file a complaint, grievance or request a fair hearing. After ninety (90) days recipients or their designee have the right to file a grievance with good cause.
B. MTM shall in no way penalize any recipient who files a complaint or grievance or request for fair hearing.
C. The grievance process shall be available for dispute between the broker and recipient concerning among other things denial, reduction, delay, suspension or termination of services.
D. Requests for services not acted upon within a timely manner, dissatisfaction with providers, appropriateness of services rendered, and availability of service, the inability to obtain cultural and linguistically appropriate care or verbal disputes with the transportation provider.
E. If complaints can not be resolved regarding the denial of services, the complaint shall go through the formal complaint and grievance process.
F. MTM shall reconsider a decision to deny, reduce, terminate or delay authorization of a requested service or payment denial in response to a grievance submitted by the recipient or a provider on behalf of the recipient.
G. Should the recipient disagree with MTM's response to the grievance, the recipient or a provider on the recipient's behalf may appeal MTM's decision.
H. MTM shall notify the member or member's designee in writing no later than thirty (30) working days of the date the grievance was received, except in cases of expedited review. The timeframe may be extended by up fourteen (14) calendar days if the recipient or recipient's representative requests the extension.
I. MTM shall continue to furnish transportation services at the level, scope and duration the item or service was provided to the recipient prior to notice of MTM's determination depending resolution of the grievance or appeal. This provision of continued coverage applies only to the recipient or recipient designee who filed a standard grievance within ten (10) days on which the recipient was notified of MTM's decision to terminate or reduce services. MTM shall provide continued coverage until the date that the grievance is resolved, the recipient has not requested a fair hearing and will issue an authorization of any services authorized as a result of the grievance or fair hearing process within two (2) working days of grievance or fair hearing decision.

J. MTM shall have in place a formal grievance committee to include Manager, Quality Management and Compliance or his/ her designee, a transportation supervisor and any other coordinator.
K. MTM shall have an established expedited appeal and review process for instances in which there are urgent or emergent medical conditions or there is a delay in the furnishing of an emergent or urgent service. A representative not involved in the original decision shall perform the review and reconsideration of the matter and a decision will be reached within one (1) hour
L. a recipient submits a grievance and the time for a standard resolution could seriously jeopardize the recipients life or health
M. a recipient submits a grievance while accessing services for urgent or emergent care
N. MTM will follow the same process identified within the standard grievance process and timelines for all standard appeals.

Expedited Grievance – 1st level review

MTMs expedited grievance process for making a first level reconsideration determination of a transportation service denial shall be within a seventy- two (72) hour period. The reviewer will be a representative of MTM who was not involved in the initial coverage termination.

Notice of Action

MTM's notice of action shall include the following recipient rights:
1. to file a complaint or grievance and the right to request a fair hearing at any time
2. to have a representative involved in the process
3. to appear in person, if the recipient filed a grievance
4. to obtain free copies of the documents, including the recipient's records used to make the decision, the necessity criteria referenced in the decision
5. the circumstances under which benefits will continue pending resolution of the grievance or assurance of a District fair hearing decision

APPROVED BY:

Manager, Quality Management and Compliance	2/10/10 Date
Vice President, Operations	2/10/10 Date
Director, Program Management	2/10/10 Date
President/CEO	2/10/10 Date

Original Effective Date: 5/31/2001
Reviewed/Revised: 7/11/02, 01/27/03, 01/19/04, 3/7/05, 4/10/06, 5/7/07, 7/30/07, 2/4/08, 7/7/09, 2/10/10
Next Scheduled Review: 01/19/05, 3/7/06, 4/10/07, 5/7/08, 7/30/08, 2/4/09, 7/7/10, 2/10/11

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Complaints-Documenting and Transferring

What is considered a complaint?

- If the caller informs you that they would like to file a formal complaint/grievance. If the caller states that they are just frustrated, but would not like to file an official complaint, document using an MI-Misc. Code.

How is a complaint documented?

- The CSR determines that the caller is formally wishing to file a complaint.
- The CSR will escalate the call to the QM Queue **(8105)** and email the QM Complaints burst if the complaint is regarding an accident, incident, or any type of substance abuse claim
    - The CSR will email the QM Complaints burst with the trip number, member/transportation provider names and contact phone number
    - NOTE: If the plan requires a warm transfer, inform the caller that the plan would like to hear from them directly. Contact the plan and warm transfer. (See list of specific plans on following page)
- If the call is after hours (after 5 PM) or on a weekend, document using the **AC**-After Hours code in the Trip Remarks. Email the QM Complaints burst with the trip number, member/transportation provider names and contact number in order for it to be looked into on the next business day.
    - NOTE: If the plan requires a warm transfer and is not open, inform the caller that the plan would like to hear from them directly, please call back on Monday in order for us to transfer you. (See list of specific plans on following page)
- After the first complaint code is entered in the F4-Trip Remarks, all supporting documentation regarding the complaint would be entered into the next paragraphs using the **MI**-Misc. Info code. If not handled in this way, it appears that there were multiple complaints filed.
- Documentation must be fully typed out "Member" instead of "Mbr"-No abbreviations. Documentation must show exactly who called. It cannot be "Member" when in fact it was "Member's sister".

4/24/09 FREYC __ __ <u>AC</u> _____

_____

_____

4/24/09 FREYC __ __ <u>MI</u> _____

_____

_____

Documentation of Complaints-continued

What if the complaint should be warm transferred?
For plans that require a warm transfer to the health plan, the CSR will do the following steps:

- Do not put the member on hold
- Press Transfer (this puts the member on hold and opens up a line)
- Dial # listed for the Health Plan
- When connected, inform the caller
- Press Transfer button

What are the plans that require a warm transfer to the health plan?
Plans that require warm transfer for complaints

- Molina National, Humana LA, Humana TX, Gateway, Kaiser, CIP

What if there is not a specific date?

- For any caller that wishes to file a complaint regarding a driver being late or a no show, there must be an official date to enter. The caller cannot simply state "it happened in the past."

What if the complaint is regarding a co-worker?

- For any complaints regarding a CSR, transfer the caller to a Team Lead. This type of complaint must be entered by a supervisor only.

What happens after the complaint is issued?

- Inform the caller that the issue has been documented and will be looked into and addressed by our Quality Management Department to a resolution.
- A return call might not necessarily be a possibility unless additional information pertaining to the issue is needed.
- The Quality Management Department will receive a report showing the documentation on the following business day.
- MTM's QM Department will work through the complaint to a resolution.

What if the Transportation Provider Does Not Respond?
The MTM Quality Management Dept. contacts transportation providers regarding any complaints. If the transportation provider does not respond within a specified timeframe, thus causing MTM to not be able to provide a resolution, the Quality Management Dept. will request for the transportation provider to be closed in the system for business unless a response is received.

- At any time, the CSR should never inform the caller that a transportation provider is closed due to complaint or insurance reasons.

What are some examples of possible resolutions?

- Complaint was invalid.
- Red Flag-F8 documentation not to ride with a particular transportation provider.
- Red Flag-F8 documentation not to ride with a particular driver.
- Etc.

Fraud and Abuse Information

- When speaking to callers, do not use the word "fraud" or accuse anyone of fraud.
- Do not imply that a person has done something that seems fraudulent or deceitful, even if it seems blatantly obvious.
- Do not accuse callers of lying or giving you false information.
- Use discretion when discussing any Trip Remark notes and/or Red Flag notes with a caller.
- Do not discuss Trip Remark notes and/or Red Flag notes that include negative information about the Member or about something that the Member has supposedly done in the past or something the CSR should do, prevention-wise on all trips (For example: fraud alert notes, Member abuse notes, etc. – Those notes are intended for internal use)

- When documenting a fraud alert, the first paragraph in the F4-Trip Remarks is documented with an FA-Fraud Alert code. Any documentation extending into additional paragraphs, the **MI**-Misc. Info code is used. If not handled in this way, it appears that there were multiple frauds filed.
    - See the Complaint Documentation Guide for proper wording

4/24/09 FREYC __ __ <u>FA</u> _____

_____

_____

4/24/09 FREYC __ __ <u>MI</u> _____

_____

_____

_____

Section 13

Account Specific Information that should be included in this section:

- Maps
- Protocols
- Covered/Not Covered Lists
- Plan Specific Cheat Sheets
- County-by-County Lists
- Other information pertaining to plan

Section 14

Level of Need Assessment Form

MTM (Medical Transportation Management, Inc.) arranges non-emergency transportation services to medically necessary appointments for patients who qualify under the **Health Plan XYZ.** Your patient has requested transportation services through MTM, per contract we are required to conduct a level of need assessment in order to determine the appropriate mode of transportation for your patient. MTM has a Business Associates Agreement with **Health Plan XYZ** and therefore is covered under HIPAA rules and regulations in relation to this request. We ask for your assistance in completing this form and returning it to us as soon as possible so that your patient may receive transportation to your medical facility in a timely manner. Thank you in advance for your cooperation.

Member Name: Member I.D. Number: Gender:

Member Address: STREET:

CITY: STATE: ZIP:

Member DOB: Phone No.:

Member's Medical/Physical Diagnosis _____

_____

Member's Cognitive Diagnosis: _____

_____

_____

Please Circle or Mark the appropriate response

- Member travels to appointments with:
  ☐ Electric Wheelchair ☐ Manual Wheelchair ☐ Scooter ☐ Crutches ☐ Walker ☐ Cane
- Member is able to transfer into a van independently: ☐ Y ☐ N
- If Member is unable to transfer independently can they transfer with assistance: ☐ Y ☐ N
- Can Member communicate their needs? ☐ Y ☐ N
- Can Member remove himself from an unsafe situation? ☐ Y ☐ N
- Member's current above described needs are: ☐ Temporary ☐ Permanent

If temporary: Start date: _____ End date: _____

CERTIFICATION STATEMENT

I understand that an order for Medicaid funded travel may result from the completion of this form. I certify that the statements made hereon are true, accurate and complete to the best of my knowledge; no material fact has been omitted from this form.

Medical Provider's Name: _____

Physician's Signature (required)_____

Medical Provider's Address: _____

CITY: _____ STATE: _____ ZIP: _____

Medical Provider's Phone: _____

Person Completing Form: _____Title: _____

Date Completed: _____Telephone #: _____

SAMPLE

MTM
Medical Transportation Management, Inc.

Transportation Request Form

(To be used when the NET Management System is temporarily down)

Account Name: (Specify) _____ **Date of Request:** _____

Person Making Request: _____ **Relationship to Patient:** _____
(If **SELF**, specify)

Contact Number: (_____) _____ **Medical Number:** _____

Patient Name: _____ **Date of Birth:** _____

Reason for Call: (Circle)
ARRANGE VERIFY COMPLAINT CHANGE UPDATE CANCEL MILEAGE OTHER (If **UPDATE, CANCEL**, or **OTHER** specify vendor & appt date, if known)_____

Trip: _____ **Urgent** _____ **Non-Urgent (Routine)**
If urgent, was provider's office contacted to verify urgency? _____ **Yes** _____ **No**

Appt Date: _____**Appt Time:** _____ AM/PM (Circle) **Return Time:** _____

Trip Type: (Circle) **ROUND/ONE WAY TO/ONE WAY FROM/PHARMACY**
(If multi-leg trip, specify) _____

PICKUP ADDRESS: _____
(If different from **HOME**, specify)

City _____ **State** _____ **Zip** _____

Instructions/Directions _____

Provider Name: _____ **Provider Phone #:** (_____) _____

DESTINATION ADDRESS: _____

City _____ **State** _____ **Zip** _____

Type of Appointment/Doctor: (primary care, cardiologist, discharge, etc.) _____

Only Complete Fields That Apply
Stretcher/Ambulance: _____ **W/C Lift or Transfer:** (Specify) _____

W/C Type: (Specify) _____ **Crutches/Walker/Cane:** (Specify) _____

Pregnant: (Specify # of weeks/months) _____ **# of Additional Passenger(s):** _____
(If more than 1 passenger, specify and continue on back)
Passengers Age: _____ **Passenger Name**: _____ **Relationship:** _____

Passenger Appt(s): _____ **Passenger Medical # ('s):** (If yes for appt) _____

Special Needs/Remarks: _____

Provider Preference: (If known, specify) _____ **Additional Details on Back:** _____
Not guaranteed

COMPLETED BY: _____ **DATE:** _____

SAMPLE

MEDICAL TRANSPORTATION MANAGEMENT, INC.

INTRODUCTORY STATUS REVIEW– 40 DAYS

Employee Name: _____ **Hire Date:** _____

Title: _____ **Department:** _____

Immediate Supervisor: _____ **Department Head:** _____

Attendance Status:

Number of tardy minutes incurred within first 40 days: _____ (minutes)

Number of unscheduled absence hours incurred within first 40 days: _____ (hours)

Performance Status:

Is the employee meeting the required goals of his/her position at this stage of employment?

[ ] Yes

[ ] No, please explain and provide information on areas requiring improvement:

_____

_____

_____

Disciplinary Actions:

Is the employee currently on any step(s) of disciplinary action?

[ ] Yes – { } Attendance Date issued: _____

{ } Performance Date Issued: _____

{ } Behavior Date Issued: _____

[ ] No

Additional Supervisor Comments: *(please provide notes regarding exceptional merit and/or issues of concern)*

_____

_____

Employee Comments:

_____

_____

Employee Signature: _____ **Dated:** _____

Immediate Supervisor Signature: _____ **Dated:** _____

Department Head Signature: _____ **Dated:** _____

H:\Employee Forms\Employee Reviews\Introductory Status – 40 Day
Created: 9/30/05
Original: Human Resources
Cc: Employee
Supervisor

SAMPLE

MEDICAL TRANSPORTATION MANAGEMENT, INC.

INTRODUCTORY STATUS REVIEW– 80 DAYS

Employee Name: _____ **Hire Date:** _____

Title: _____ **Department:** _____

Immediate Supervisor: _____ **Department Head:** _____

Attendance Status:

Total number of tardy minutes incurred within the introductory period: _____ (minutes)

Total number of unscheduled absence hours incurred within the introductory period: _____ (hours)

Performance Status:

Did the employee meet the required goals of his/her position during the introductory period?

[ ] Yes

[ ] No – please explain and provide information on areas requiring improvement

Disciplinary Actions:

Is the employee currently on any step(s) of disciplinary action?

[ ] Yes – { } Attendance Date issued: _____

{ } Performance Date Issued: _____

{ } Behavior Date Issued: _____

[ ] No

Continued Employment:

Do you recommend this employee continue employment beyond the introductory period?

[ ] Yes

[ ] No, for the following reason(s):

_____

_____

Additional Supervisor Comments: *(please provide additional notes regarding exceptional merit and/or issues of concern)*

_____

_____

Employee Comments:

_____

_____

Employee Signature: _____ **Dated:** _____

Immediate Supervisor Signature: _____ **Dated:** _____

Department Head Signature: _____ **Dated:** _____

H:\Employee Forms\Employee Reviews\Introductory Status – 80 Day
Created: 9/30/05
Original: Human Resources
Cc: Employee
Supervisor

SAMPLE

PERFORMANCE APPRAISAL FORM - *NON-EXEMPT (HOURLY) EMPLOYEES*

Supervisors - please ensure you have read the instructions prior to completing this Appraisal

Employee Name:		**Title:**	
Department:		**Supervisor:**	
Review Period:			

MAJOR JOB OBJECTIVES
(Assessment will account for 70% of overall score)

	Weight	Assessment
The Major Job Objectives as stated in the employee's Job Description should be detailed and evaluated in this section and an ***overall*** assessment determined. As with all assessments within this Appraisal, detailed comments justifying the evaluation must be documented by Supervisors.	70%	
Supervisor Comments :		

OTHER JOB FACTORS
(Assessment will account for 30% of overall score)

Topic	Assessment Criteria	Weight	Assessment
Knowledge/Skills: Degree to which the employee demonstrates relevant job knowledge and essential skills, such as work practices, policies, and resources	**5** - Possesses superior skills and knowledge and applies them to work assignments **4** - Demonstrates a strong understanding of all job functions **3** - Level of job knowledge is appropriate to perform tasks required **2** - Often demonstrates a lack of basic or insufficient job knowledge to complete routine tasks **1** - Does not demonstrate a good understanding of job functions		
Supervisor Comments :			

		Weight	Assessment
Quality of Work: Measures the employee's results in meeting established objectives with attention to detail, timeliness and accuracy	**5** - Consistently produces work of exceptional quality within required deadlines **4** - Work frequently exceeds expected quality and timeliness standards **3** - Quality of work meets the requirements of the position **2** - Does not pay enough attention to detail and often has difficulty meeting deadlines **1** - Does not deliver an acceptable level of quality in most cases		
Supervisor Comments :			

		Weight	Assessment
Interpersonal/Communication Skills: Demonstrates the employee's ability to interact with clients, co-workers, and supervisors in effective and positive ways while conveying information in a clear and concise manner, both written and verbal	**5** - Consistently communicates in clear and effective ways. Able to remain calm when stressed **4** - Very proficient at relating to others and shares information in a positive manner **3** - Generally interacts positively and exchanges information well **2** - Needs to improve ability to convey information effectively. Has difficulty relating positively to others **1** - Consistently fails to communicate effectively and/or display a positive attitude		
Supervisor Comments :			

		Weight	Assessment
Initiative/Problem Solving: Measures the extent to which the employee is self-directed, resourceful, and creative in performing job duties. Also measures the employee's performance in identifying and resolving problems	**5** - Demonstrates strong skills in reasoning and analysis. Makes excellent use of technology and tools in seeking and implementing solutions **4** - Suggests innovations to improve operations or streamline processes. Able to work with limited supervision **3** - Makes good use of proven problem solving techniques when appropriate **2** - Needs to better demonstrate the ability to resolve issues with minimal supervision **1** - Consistently fails to recognize or seek help in resolving routine problems		
Supervisor Comments:			

		Weight	Assessment
Attendance: Measures the employee's ability to follow scheduled arrival and departure times in relation to shifts and breaks. Also measures whether the employee effectively manages use of PTO and other attendance resources	**5** - Maintains an excellent attendance record and has not incurred any unscheduled absences or tardies during this review period **4** - Effectively manages available PTO. Some instances of absences or tardies were incurred which were excused due to extenuating circumstances **3** - Incurred some unscheduled absences and/or tardies but these were insufficient to warrant discipline **2** - Experienced some difficulty in effectively managing attendance, which resulted in discipline up to the level of a Verbal Warning **1** - Does not effectively manage attendance and has incurred discipline at the level of Written Warning or above		
Supervisor Comments:			

List any formal Discipline Notices issued to employee during this appraisal period:

Level of Discipline	Reason (attendance, performance, behavior, other)	Date of Incident	Date Notice Expired

Total Weighting Assessment (must be equal to 100%)	**70%**
MAJOR JOB OBJECTIVES RATING ACHIEVED:	0.0
OTHER JOB FACTORS RATING ACHIEVED:	0.0
OVERALL RATING ACHIEVED:	0.0

Note: The overall rating is a reflection of employee performance and does not equate to any certain raise percentage

Overall Rating Assessment:

5 - Outstanding	Employee consistently and significantly exceeds job expectations and standards and demonstrates an extremely high degree of initiative and quality of work. Employee is flexible, adapts well to change, and actively seeks out solutions to obstacles.
4 - Commendable	Employee meets and frequently exceeds job expectations and standards and demonstrates a proven ability to complete tasks, often within tight deadlines.
3 - Satisfactory	Employee adequately meets the expectations and standards of the job requirements.
2 - Needs Improvement	Employee meets many of the expectations of the job but often fails to adequately meet some of the expectations or standards. Where required, suggested improvements have been made in the Supervisor Comments section.
1 - Unsatisfactory	Employee fails to meet many of the requirements of the job. Deficiencies have been addressed via previous Performance Improvement Plans or Discipline Notices and have also been noted in the Supervisor Comments section of this appraisal. A plan of action and timeline must be set for deficiencies to be corrected.

ACHIEVEMENT HIGHLIGHTS:

SUMMARY OF STRENGTHS:			
AREAS FOR RECOMMENDED PROFESSIONAL DEVELOPMENT AND TRAINING:			
Supervisor's Signature:		**Date:**	
EMPLOYEE COMMENTS:			
[ ]	I acknowledge that I have read this Appraisal and have been given the opportunity to discuss it with my Supervisor.		
Employee's Signature		**Date:**	

Job Description

		Exempt			
		Non-exempt	X		
		Full-time	X		
		Part-time	X		
		Location	MO		
		Origination Date	09/27/97		
Job Title	Customer Service Representative	Last Revision Date	03/03/09		
Department	CSC – LSL				
Reports to	Team Lead, CSC	Page	1	OF	2

POSITION SUMMARY: The **Customer Service Representative (CSR)** handles incoming calls received via an automated call distribution (ACD) system regarding scheduling of transportation and all other details of customer trips. The **Customer Service Representative (CSR)** is the front line representative of Medical Transportation Management (MTM).

PERFORMANCE MEASURES – MAJOR JOB OBJECTIVES

Major Job Objective	What's Expected	Measurement Criteria	%
Abandoned Calls	As outlined by the department head for each Customer Service Center (CSC) location. See Attachment A.	Results compiled by Quality Support Team, phone, and/or system reports	10%
Average Handle Time	As outlined by the department head for each CSC location. See Attachment A.	Results compiled by Quality Support Team, phone, and /or system reports	20%
% Productive Time	• Exceeding = >95% • Meeting = 90% - 94.9% • Not meeting = <89%	Results compiled by Quality Support Team, phone, and/or system reports	30%
Quality Scores	• Exceeding = >95% • Meeting = 90% - 94.99% • Not meeting = <90%	Results compiled by Quality Support Team, phone, and /or system reports	30%
Attendance	Adhere to Corporate Attendance Policy	Manager/system generated reports	10%

OTHER JOB FUNCTIONS:

- Answer incoming ACD calls for customers – passengers, vendors, and clients
- Handle daily scheduling of trips by documenting trip request and selecting the most appropriate vendor
- Utilize correct coding and documentation procedures
- Report issues, unusual trip circumstances, and efficiency of vendor operations to CSC Team Lead for prompt resolution
- Acquire and maintain in-depth knowledge of, and adhere to, established CSC Protocols and Procedures
- Provide courteous and prompt response to all transportation requests and adopt proper use of terminology
- Demonstrate sincere personal commitment to promptness, reliability and quality work
- Acquire and maintain in-depth knowledge of MTM's Transportation Provider Network
- Report to work on time for assigned shift schedules
- May be required to work weekends and/or holidays as needed
- Other duties as assigned

KNOWLEDGE, SKILLS, AND ABILITIES:

- Typing speed of 30 WPM or greater
- Knowledge of, or ability to learn, Microsoft Outlook and Microsoft Word
- Exemplary communication and phone skills
- Ability to relate to a diversity of customers and requests
- Ability to identify with customer needs and circumstances

EDUCATION:

High School Diploma or G.E.D. required

EXPERIENCE:

- Customer service experience required
- Previous experience working in a call center is preferred

POSITIONS SUPERVISED:

None

TOOLS/EQUIPMENT/MACHINES USED:

Computer, copy machine, fax machine, printer, Cisco phone system

PHYSICAL REQUIREMENTS AND WORKING CONDITIONS:

Normal office conditions apply. Employee must have clear, close vision for reading and computer work. Must be able to sit, stand, walk, balance, stoop, grasp, talk, hear and operate computer keyboard. Job may require reaching at shoulder level and below waist. Will occasionally lift/push/pull up to 20 pound and carry objects 50 feet.

ACKNOWLEDGMENT:

I have read and understand my position description and certify that I can and will fulfill the stated expectations:

____without accommodations

____ with the following accommodations:

Employee Name (print): _____

Employee Signature: _____ Date: _____

Supervisor Signature: _____

Title: _____ Date: _____

This job description in no way states or implies that these are the only duties to be performed by the employee occupying this job. Employees may be required to follow other job-related instructions and to perform other job-related duties as requested, subject to all applicable state and federal laws. Certain job functions described herein may be subject to possible modification in accordance with applicable state and federal laws.

Original: Human Resources
Cc: Employee's Supervisor
Employee

Job Description

		Exempt			
		Non-exempt	X		
		Full-time	X		
		Part-time			
		Location	MO		
		Origination Date	09/27/97		
Job Title	Bi-Lingual Customer Service Representative	Last Revision Date	03/03/09		
Department	CSC – LSL				
Reports to	Team Lead, CSC	Page	1	OF	2

POSITION SUMMARY: The **Bi-Lingual Customer Service Representative (CSR)** handles incoming calls received via an automated call distribution (ACD) system regarding scheduling of transportation and all other details of customer trips. The **Bi-Lingual CSR** is the front line representative of Medical Transportation Management (MTM).

PERFORMANCE MEASURES – MAJOR JOB OBJECTIVES

Major Job Objective	What's Expected	Measurement Criteria	%
Abandoned Calls	As outlined lined by the department head for each Customer Service Center (CSC) location. See Attachment A	Results compiled by Quality Support Team, phone, and/or system reports	10%
Average Handle Time	As outlined lined by the department head for each CSC location. See Attachment A	Results compiled by Quality Support Team, phone, and /or system reports	20%
% Productive Time	• Exceeding = >95% • Meeting = 90% - 94.9% • Not meeting = <89%	Results compiled by Quality Support Team, phone, and/or system reports	30%
Quality Scores	• Exceeding = >95% • Meeting = 90% - 94.99% • Not meeting = <90%	Results compiled by Quality Support Team, phone, and /or system reports	30%
Attendance	Adhere to Corporate Attendance Policy	Manager/system generated reports	10%

OTHER JOB FUNCTIONS:

- Acquire and maintain in-depth knowledge of, and adhere to, established CSC Protocols and Procedures
- Provide courteous response to all transportation requests and adopt proper use of terminology
- Demonstrate sincere personal commitment to promptness, reliability and quality work
- Acquire and maintain in-depth knowledge of MTM's Transportation Provider Network
- Report to work on time for assigned shift schedules
- Handle any requests for a Bi-Lingual CSR for the languages they speak, as well as other English calls
- May be required to work weekends and/or holidays as needed.
- Other duties as assigned

KNOWLEDGE, SKILLS, AND ABILITIES:

- Typing speed of 30 WPM or greater
- Knowledge of personal computer/keyboard
- Knowledge of, or ability to learn, Microsoft Outlook and Microsoft Word
- Exemplary communication and phone skills
- Ability to relate to a diversity of customers and requests
- Ability to identify with customer needs and circumstances
- Ability to tactfully question and obtain necessary information
- Ability to recognize, handle and refer situations of an emergent nature

EDUCATION:

High School Diploma or G.E.D. is required

EXPERIENCE:

- Customer service experience is required
- Previous experience working in a call center is preferred

POSITIONS SUPERVISED:

None

TOOLS/EQUIPMENT/MACHINES USED:

Computer, copy machine, fax machine, printer, Cisco phone system

PHYSICAL REQUIREMENTS AND WORKING CONDITIONS:

Normal office conditions apply. Employee must have clear, close vision for reading and computer work. Must be able to sit, stand, walk, balance, stoop, grasp, talk, hear and operate computer keyboard. Job may require reaching at shoulder level and below waist. Will occasionally lift/push/pull up to 20 pound and carry objects 50 feet.

ACKNOWLEDGMENT:

I have read and understand my position description and certify that I can and will fulfill the stated expectations:

____without accommodations

____ with the following accommodations:

Employee Name (print): _____

Employee Signature: _____ Date: _____

Supervisor Signature: _____

Title: _____ Date: _____

This job description in no way states or implies that these are the only duties to be performed by the employee occupying this job. Employees may be required to follow other job-related instructions and to perform other job-related duties as requested, subject to all applicable state and federal laws. Certain job functions described herein may be subject to possible modification in accordance with applicable state and federal laws.

Original: Human Resources
Cc: Employee's Supervisor
Employee

Section 15

Transportation Provider Information

Selecting a Transportation Provider

- If an "N" is next to the transportation providers name in the Vendor Shopper, it means there is a note concerning the transportation provider. A "5=Display" must be used to display and read any specifics.
- On plans that require the Level of Need, a dummy vendor must be assigned to the request in order to exit the Vendor Shopper.
- The first most appropriate transportation provider (in accordance to availability, any Red Flag specifics, etc.) should be selected.
  The first selection (which is the closest transportation provider) is made regardless of pricing, unless the plan offers Right of Choice. (See: Preferred Provider/Right of Choice below)
- If the plan offers Right of Choice, it is questioned and selected regardless of price or mileage, but the Level of Need process must be followed or any other specific plan rules that override the Right of Choice.
- The most appropriate transportation provider is contacted for availability before selection is made if the request is within 48 hours (excluding weekends or holidays) or the mileage is 75 miles or greater
- A transportation provider can be "preferred" as long as a selection has not been made and it does not show an increase in pricing, even if it is not the closest transportation provider.
- At times the trip history can show that the transportation provider that is "preferred" normally transports and eliminates a turn back. (See: Transportation Provider Turn back below)
- The F4-Trip Remarks must be documented with the reason why the closest transportation provider was not chosen.

Contacting Transportation Providers

A transportation provider should be contacted within **48** hours (today, and tomorrow excluding weekends-) concerning any of the following:

- Changes to a trip (including and not limited to: time, address, passengers)
- Cancellation of a trip
- Adding a trip to their schedule
- Any riders over the amount of 4 to ensure transportation provider accommodation
- Any requests where the mileage is 75 miles or greater one way

Note:

- It is always important to get the name of the dispatcher at the transportation provider's office to document acceptance or refusal of a trip. You may be required to ask for their name if it is not stated upon answering.

Transportation Provider Information-continued

Transportation Lead Time

Members for all plans are asked to be ready 1 hour prior to their appointment time.

- If the distance to or from the appointment is not far, the transportation provider is aware and may not show up until closer to the actual appointment time.

Faxing Transportation Provider Process

- The transportation provider will receive a trip sheet by fax from MTM via the AS400 after the trip intake has been completed and faxed by the CSR.
- The transportation provider will bring their assigned trip sheets with them in the vehicle.
- The transportation provider will require signature on the trip sheet or driver's log at the time of pick up.
- The transportation provider will require signature on the trip sheet or driver's log again at the time of return (assuming the trip is round).
  - The trip will only have one signature if the trip is a one-way trip.
- The trip sheet is used for payment and at any time may be requested by MTM for audits or random checks.
- The transportation provider will receive either a **Fax Summary Sheet** or a **Down Load**, also from MTM, showing all of the trip sheets that were faxed.
  - The fax summary will be sent between 1-2 am the next morning showing all of the previous day's trip requests that were faxed.
- It is the transportation provider's responsibility to match up the trip sheets to the fax summary to ensure that all faxes were received.
- If all faxes did not come through due to error, etc, the transportation provider can contact MTM for a refax and thus avoid no shows.
- See following page for Sample of Trip Fax

Member No Shows

If it is determined that the Member did not contact MTM to cancel and was a no show for the pick up or return ride, document the Trip Remarks.

- Cancel using the appropriate Trip Status Cancel Code (X1, X2, or X3 for no show on pick up and S4. S7, or S8 for no show on return)
- This will ensure that the provider is paid ½ of a one way fee if it was a no show on pick up and 1 & ½ of a one way fee if it was a no show on return. (Example of no show on pick up and coded X1, X2, or X3: One way cost is $10.00. Transportation provider will get paid $5.00 for going to pick up location.
- NOTE: Some plans do not offer a no show fee to the transportation providers.

Transportation Provider (Vendor) No Shows or Late Rides
Late for Pick Up

- If it is determined that the transportation provider will be late, but the Member can still keep appointment, document the Trip Remarks (F4) with who was spoken to at the medical provider's office.
    - Ask member if they would like to file a formal complaint.
        - If so, document the Trip Remarks that you transferred. Transfer to the Complaint Queue 8-1-0-5.
    - NOTE: If the plan requires a warm transfer, inform the caller that the plan would like to hear from them directly. Contact the plan and warm transfer. If the plan is not open, inform the caller that the plan would like to hear from them directly and to please call back on Monday in order for us to transfer them.
        - If not, document the Trip Remarks that member did not wish to file a complaint.

No Show on Pick Up or Return

- If it is determined that the Member cannot be seen or the transportation provider did not/will not arrive at all for the pick up or the return, document the Trip Remarks (F4) and cancel the trip using the appropriate Trip Status cancel code. **No show on pick up=VN-Vendor No Show Trip Status Code No show on return=SV-Vendor No Show on One Leg of a Round Trip**
    - If trip is a multi-leg, only the first leg should be a no show. All remaining legs, should be canceled XM-MTM Dispatch Canceled-Misinformation/Computer Problems
    - Ask member if they would like to file a formal complaint.
        - If so, document the Trip Remarks that you transferred. Transfer to the Complaint Queue 8-1-0-5.
    - NOTE: If the plan requires a warm transfer, inform the caller that the plan would like to hear from them directly. Contact the plan and warm transfer. If the plan is not open, inform the caller that the plan would like to hear from them directly and to please call back on Monday in order for us to transfer them.
        - If not, document the Trip Remarks that member did not wish to file a complaint.

Late for Return

- If it is determined that the transportation provider is late for the return ride and the system is documented by an MTM CSR that the Member has contacted MTM regarding the late return ride and it has been 1 hour or more, seek Team Lead assistance to arrange alternate transportation.
    - Cancel trip using the SV-Vendor No Show on One Leg of a Round Trip Status Code.
    - Ask member if they would like to file a formal complaint.
        - If so, document the Trip Remarks that you transferred. Transfer to the Complaint Queue 8-1-0-5.
    - NOTE: If the plan requires a warm transfer, inform the caller that the plan would like to hear from them directly. Contact the plan and warm transfer. If the plan is not open, inform the caller that the plan would like to hear from them directly and to please call back on Monday in order for us to transfer them.
        - If not, document the Trip Remarks that member did not wish to file a complaint.

Transportation Provider (Vendor) No Shows vs. Member No Shows

A transportation provider (vendor) no show or member no show is coded according to who contacted MTM first.

- If the transportation provider contacted MTM first stating the member was a no show and the member calls later disputing this, check plans protocols to determine whether they should be transferred to our complaint line or if a warm transfer back to their plan is required.
- If the member contacted MTM first stating the vendor was a no show and the transportation provider calls later disputing this, they can be referred to contact their Network Representative. The Network Representative will educate the driver to contact MTM immediately if a member is not at the designated pick up location.

Verifying a Future Ride

If a Member calls the same day or the evening before an appointment date to verify the ride:

- If trip is in the system, contact the transportation provider to verify it is scheduled on their end.
    - This eliminates any problems and prevents any possible confusion.
- If trip is not in the system, add the trip into the system and follow the Urgent Request Process.

Verifying a Ride that is Long Distance

When a trip is 75 miles or over and the distance is authorized, a courtesy call to the transportation provider is necessary to verify that they can accommodate, even if the trip is future.

Closed Transportation Providers

A transportation provider can be permanently or temporarily closed in the system. If a transportation provider is temporarily closed, it could be due to insurance or complaint issues and can be resolved. If permanently closed, they are removed from the MTM Network. This could be a decision of MTM or the transportation provider. CSR's are not allowed to release to a Member any specifics as to why a transportation provider is closed. Simply state that "the transportation provider is not available at this time."

Transportation Provider Arrival Process

Drivers must make "best effort" to make contact with the passenger notifying them their ride is waiting outside before leaving the premises without the passenger.

- Honk
- Call residence
- Knock on door
- Leave business card in door
- Wait total of 5 minutes before leaving

Tip:

- On long distance trips, a transportation provider will make rest room stops.
- If a Member requests we authorize a food stop, we are unable to arrange. If a Member is diabetic or needing to eat, suggest that they pack something to bring.
    - If a transportation provider is willing to stop for food that would be determined by the transportation provider and is not authorized by MTM.

Transportation Provider Return Process

1. Transportation provider will call and confirm the ride evening prior to appointment.
2. Transportation provider will provide a business card with their contact # upon arrival at medical facility.
3. Member will contact transportation provider for return ride after completion of appointment from medical facility (Unless specific return time was given at time of trip intake).
4. Return could take up to 1 hour after return call is placed.
    a. EXCEPTION: If a return time were given at the time of trip arrangements, the return could take up to 30 minutes after the specified return time.
    b. If the transportation provider is more than 1 hour (30 minutes for specific return time) for the return ride, see: Transportation Provider (Vendor) No Shows or Late Rides.

Transportation Provider Turn Back

Turn-back is defined as **"**when a transportation provider sends a trip back to MTM due to scheduling, pricing, breakdown or other reasons, stating they cannot accommodate." After the Network Management department receives the turn back via fax from the transportation provider, the following steps are completed:

- Trip is entered and canceled using the appropriate Trip Status Cancel Code. (XQ-Vendor Turn Backs that Don't Count Against or XV-Vendor Canceled Due to Bad Weather/Break Down)
- Trip information is copied to create a new trip request.
- Transportation provider is located "at best effort" to accommodate the request.
- Transportation Provider is selected if located.
- Trip is canceled using Trip Status Cancel Code "XU" (Canceled-No Vendor Available), if not located.
- Member is contacted to inform of any changes.
- Trip Remarks (F4) are documented with the following:
    - That the trip was copied due to a transportation provider (vendor) turn back.
    - The names of all of the transportation providers contacted as well as the names of the dispatch personnel who declined and accepted.
    - That the Member was contacted to inform of whether alternate transportation arrangements could be located and whether the contact was successful.

Geri Chair Transports

Section 37.3 of the DOT's regulations implementing the Americans with Disabilities Act of 1990 (ADA) (49 CFR Parts 27, 37, and 38) defines a "common wheelchair" as a mobility aid belonging to any class of three or four-wheeled devices, usable indoors, designed for and used by individuals with mobility impairments, whether operated manually or powered. A "common wheelchair" does not exceed 30 inches in width and 48 inches in length measured two inches above the ground, and does not weigh more than 600 pounds when occupied. Geri chairs can be reclined and do not meet the above standards. MTM is not required to transport persons in a Geri chair. Although this is up to the driver's discretion, we recommend not doing so due to safety issues.

- Effective 10/11/2007, we are no longer allowed to escalate a member to a stretcher level. The member must be able to transfer into a common wheelchair.

Preferred Provider/Right of Choice

For plans that utilize a preferred provider or right of choice, the member should be asked which transportation provider they prefer. This transportation provider should be selected for the trip and the F4-Trip Remarks documented of the members choice.

- If the plan offers Right of Choice, it is questioned and selected regardless of price or mileage, but LON process must be followed or if there are any other specific plan rules that override the Right of Choice.
    - In the event that the transportation provider is not part of MTM's Network, Trip Status Code EC (Escalate to Network Management) should be used.
    - The MTM Network Management Department will make every possible attempt to arrange the ride with the requested transportation provider.
- For plans that do not offer Right of Choice, a transportation provider can be "preferred" as long as a selection has not been made and it does not show an increase in pricing, even if it is not the closest transportation provider.
    - At times the trip history can show that the transportation provider that is "preferred" normally transports and eliminates a turn back.
    - The F4-Trip Remarks must be documented with the reason why the closest transportation provider was not chosen.

If a Transportation Provider Cannot be Located for a Trip

If the request is non-urgent, but not met number of educations and called in under days notice:

- Contact 7 transportation providers or receive 3 quotes (whichever comes first) in the Vendor Shopper from top of the list to bottom regardless of mileage or price.
- If unsuccessful, escalate to Team Lead(s) who will continue exhausting all remaining transportation providers in the Vendor Shopper and any on the County-by-County list that were not showing in the Vendor Shopper.
    - Leave trip in W1 Trip Status Waiting Code
- Document Trip Remarks (F4) with the names of all the transportation providers contacted and names of dispatch personnel who declined.
- If the Team Lead(s) is unsuccessful at locating a transportation provider, the trip will be canceled with a "D6" Trip Status (Denied-Urgent-No Vendor)

If the request is urgent:

- Contact 7 transportation providers or receive 3 quotes (whichever comes first) in the Vendor Shopper from top of the list to bottom regardless of mileage or price.
- If unsuccessful, escalate to Team Lead(s) who will continue exhausting all remaining transportation providers in the Vendor Shopper and any on the County-by-County list that were not showing in the Vendor Shopper.
    - Leave trip in W1 Trip Status Waiting Code
- Document Trip Remarks (F4) with the names of all the transportation providers contacted and names of dispatch personnel who declined.
- Inform Member that they will be receiving a return call due to difficulties locating a transportation provider
- If the Team Lead(s) is unsuccessful at locating a transportation provider, the trip will escalate to Network Management.
- If Network Management is also unsuccessful at locating a transportation provider, they will escalate the trip to Client Services and the trip will be canceled with a "XU" Trip Status (Canceled-No Vendor Available)

Releasing Prices

Pricing is confidential and under no circumstances should any quotes or pricing be released to another transportation provider, health plan representative, Member or any other party.

- If a transportation provider has any questions concerning pricing, direct them to contact their Network Management Representative.
- If a Member questions why a higher cost transportation provider cannot be provided, the term "most appropriate" is used.

Transportation Provider Calling in Requests

Transportation Providers are not allowed to call in trip requests on a member's behalf.

- EXCEPTION: It is allowed for a transportation provider to call in a pharmacy stop or add to as a multi-leg trip.

Transportation Provider (Vendor) Queue

This hotline was designed to help the transportation provider's properly resolve any issues or questions. This line is answered by the Network Management Turn Back Specialists. A common call might include: pricing questions/problems, member no shows, coding pricing/problems, inquiries on how to become a transportation provider through the MTM network, etc.

Providing a Car Seat

If the Member requests a car seat or is required to be in a car seat due to state requirements, mark the Car Seat option in the system with the number of car seats needed. When the trip is Vendor Shopped/Selected, only transportation providers able to provide a car seat will appear.

- If the caller states that they have their own car seat and they do not once the driver arrives for pick up, the transportation provider should call in a Member No Show and the trip should be canceled using the correct Trip Status Cancel Code accordingly.
- Only 1 car seat can be provided. There are a select few providers that do have more than one. The number can be located on the County-by-County List.
- In some states (MO) it is not a requirement for a child under the State's weight/age law, riding in a *cab to be in a car seat.
    - *A cab is determined by whether or not there is a meter in the vehicle. (St. Louis County Cab, St. Charles County Cab)
    - Some transportation providers have the word "cab" in their name, but do not meet the criteria.

Transportation Provider Information-continued

After Hours Fees

After Hours for all states is defined as: Monday through Saturday 6:00 p.m. to 5:59 a.m., all day Sunday and standard USA holidays*. Please find below the current after hours fees according to state.

Rate Paid Per One-Way		
State	Ambulatory	Para-lift
AR	$10.00	$25.00
IL	$10.00	$25.00
KS	$10.00	$25.00/FHK $23.00/KS
MD	$10.00	$25.00
MI	$10.00	$20.00
MO	$10.00	$25.00

If a transportation provider asks for an after hours fee and their state is not listed above, please refer them to their Network Management Representative.

*Standard USA holidays are as follows:

- New Years Day
- Martin Luther King Day
- President's Day
- Memorial Day
- Independence Day
- Labor Day
- Veteran's Day
- Thanksgiving Day
- Christmas Day

Transporting Contagious Members

In the event that a Member mentions that they have a contagious condition, the following steps would be followed to ensure transportation providers are made aware of contagious Members without violating HIPAA regulations.

- Note "CONTAGIOUS" on Special Needs field of trip
- Do not ask the Member what illness they have that is contagious (HIPAA violation)
- Note "exclusive transport-use gloves, mask and sterilize vehicle when trip is completed" on the Special Needs.
- If no transportation providers will accept the trip, escalate the level of service to ambulance/stretcher, if health plan protocols allow.
- If Member must be sedated, escalate the level of service to ambulance, if health plan protocols allow.

Some illnesses considered contagious are, but not limited to:

- Tuberculosis
- Shingles
- Mononucleosis (incubation period-weeks to months depending on when the symptoms appear and can be as long as 18 months after the symptoms are gone)
- Meningitis
- Mumps
- Chicken Pox
- Measles
- Rubella (German Measles)
- Pertussis

Other possibly contagious conditions could be:

- Pink Eye
- Ringworm
- Staff infection
- Lice

Transporting Bleeding Members

In the event that a Member, or someone calling on their behalf; states that the Member needs to be seen right away due to bleeding, the follow criteria would be followed.

- Intake standard trip information
- If the caller states this is an emergency, refer to 911
- When the caller states they are bleeding and need to be seen, question the caller about the blood flow. (i.e. can the bleeding be controlled so the cab will not need to be cleaned immediately following the transport or is it uncontrolled and profuse)
- Make a determination based on what the caller says
- If it is determined the blood flow is uncontrollable, refer the caller to 911
- If it is determined the blood flow can be controlled, the CSR will set the trip
- If a determination cannot be made by questioning the caller, the CSR will contact the facility the caller is requesting transport to and a member of the medical staff can make the determination

It is extremely important all information is documented correctly. The notes should include:

- The caller's description of the bleeding
- The caller's statements when questioned about the bleeding
- Why the CSR is making the determination to transport/not transport
- If necessary, document the facility was called and whom the CSR spoke to

MTM NET MANAGEMENT SYSTEM

- DO NOT use punctuation in the system in the following fields:
  - Name Fields
  - Address Fields

- DO NOT use P.O. Box Addresses- ask for "physical" or "911" address

- Pressing **Tab** will move the cursor to the next field

- Pressing **Shift + Tab** will move the cursor to the previous field

- Pressing **+** on the number pad will clear information following cursor on a field

- Pressing **Ctrl** will unlock the system if typing occurred off a field

- All times should be entered as military time
  - 1:00am-12:00pm are entered: 0100, 0200, 0300, etc.
  - 1:00pm = 1300
  - 2:00pm = 1400
  - 3:00pm = 1500
  - 4:00pm = 1600
  - 5:00pm = 1700
  - Etc.

- When viewing a popup list or drop down field, press **Page Down** & **Page Up** to see additional options

- "Pop Ups" will appear on the screen when fields are left blank, incorrect data is entered in a field, data entered in a field is outside the plan parameters, etc. Read the pop up, determine if it is pertinent, and press **Enter** to exit the pop up.

- The following terms can sometimes be used interchangeably due to verbiage changes:

OLD TERM:	CURRENT TERM:
(Personal) Gas Reimbursement	Mileage Reimbursement
AS/400	MTM NET Management System
Vendor	Transportation Provider
Call Center	Customer Service Department
Medicaid	Medical Insurance

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