Medicaid Transportation - Common Medical Marketing Area Policy and Procedure

Common Medical Marketing Area

The Common Medical Marketing Area (CMMA) is the geographic area from which a community customarily obtains its medical care and services. The CMMA is **not** necessarily set by geographic or county borders. Rather, the CMMA can vary depending upon the medical specialty or services required that are accessible locally, as well as the individual needs of each enrollee.

If an enrollee requests Medicaid Transportation to a provider or service outside of their CMMA when the service or specialty is available within the CMMA, the request will be denied. *(18 NYCRR § 505.10 (d) (7) (vi))*.

POLICY:

When an enrollee requests transportation to specialty medical care outside of their CMMA, a 2020-U Form (see attached) is required. The enrollee will continue to be required to travel by the most medically appropriate, cost effective mode of transportation regardless of the location of where the services are to be rendered.

Traveling outside a CMMA is ONLY appropriate when one of the following conditions is met:

- When the medical care and services required, are **not** available within the CMMA of the enrollee's community.
- When the medical need to continue a specialized regimen of care or service with a specific provider necessitates travel outside the enrollee's CMMA, despite the fact that the medical care or service is available within the CMMA.
- When there are any other circumstances which are unique to the enrollee and which the transportation manager and/or the New York State Department of Health determines that travel outside the CMMA is appropriate.

Unless specifically authorized by the Department of Health, the transportation manager will not authorize transportation outside the CMMA when the enrollee has been noncompliant with local medical providers and that enrollee is unable to receive services locally based on their own actions.

When necessary, the transportation manager may require the physician to submit a letter outlining the medical necessity to travel outside the CMMA. If a letter of medical necessity is required the transportation manager will contact you directly and provide you with the information to be included.

Please note completion of the CMMA 2020-U Form does not guarantee authorization of Medicaid-funded transportation outside the CMMA. It is the responsibility of the Medicaid non-emergency transportation manager to determine eligibility for travel outside the CMMA. Any omission of the requested information will cause a delay in a determination.

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PROCEDURE:

The CMMA 2020-U Form can be obtained by 1) visiting the transportation manager's website, 2) calling the transportation manager, or 3) requesting the CMMA form from the referring physician. Once the form is obtained the following steps must be taken:

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1. The CMMA 2020-U Form must be fully completed and signed the by the referring physician. (Please note that the accepting physician is not to sign the form and authorize transportation to their facility.) The medical justification and diagnosis with a care plan duration must be included on the CMMA 2020-U form.

2. Once the form is completed, it must then be submitted to the transportation manager for review and approval.

3. The transportation manager is contractually bound to ensure the request to travel outside of a CMMA is appropriate and, may ask for additional information to determine the legitimacy of the request. Any omission of the requested information will cause a delay in a determination.

4. Once the information is reviewed, enrollees will receive notification by the transportation manager of the determination.

REQUEST FOR TRANSPORTATION OUTSIDE THE COMMON MEDICAL MARKETING AREA

The information provided below will assist the Medicaid program in determining the need for transportation outside the common medical market, i.e., the area where the community generally receives its medical care. Transportation may be authorized for a Medicaid enrollee when the appropriate Medicaid-covered treatment is unavailable locally per NYCRR Title 18 §505.10, §360, 92 ADM 21, and/or review by representatives of the NYS Department of Health and/or its agents. While this completed form is required, completion of this form does not guarantee authorization of Medicaid-funded transportation outside the common medical marketing area. The Medicaid program will not authorize transportation outside the common medical marketing area when the enrollee has been non-compliant with local medical providers and that enrollee is unable to receive service locally based on their own actions.

Patient Name: _____ Patient Medicaid Number: _____ Patient Date of Birth: ___/___/_____

1.) Please indicate whether you are the referring physician: _____YES / _____NO 2.) Is the medical service to which you are referring the enrollee available locally? _____YES / _____NO

3.) If the services are available locally, please explain below why the services within the CMMA are inappropriate for this enrollee. *Please note, to avoid a delay in transportation for the patient your response requires detailed information. For example, continuity of care with specific reasons why that care must happen outside the CMMA will result in an immediate denial.*

4.) Please indicate whether the referral is to see a specialist: _____YES / _____NO (if no please move to question 5.) If yes, please answer the following questions.)

4a.) To which specialty is the enrollee being referred? _____ 4b.) What is the specialists name? _____

4c.) What is the specialists service location? _____ 4d.) Do you believe that this referral will require multiple appointments: _____YES / _____ NO

5.) Is this referral for Primary Care, Mental Health, Physical Therapy, lab work or an Independent Medical Exam (IME)? __YES / ___NO

Referring Physician: _____ ***10 digit NPI #:*** _____ ***Telephone Number:*** _____

Hospital/Clinic/Facility/Practitioner Name: _____ ***Hospital/Clinic/Facility/Practitioner Address:*** _____

Name of Staff Member who helped complete this form: _____ ***Title:*** _____ ***Telephone Number:*** _____

Signature of Referring Physician: _____ ***Date Signed:*** _____

CERTIFICATION STATEMENT: *I (or the entity making the request) understand that orders for Medicaid-funded travel may result from the completion of this form. I (or the entity making the request) understand and agree to be subject to and bound by all rules, regulations, policies, standards and procedures of the New York State Department of Health, as set forth in Title 18 of the Official Compilation of Rules and Regulations of New York State, Provider Manuals and other official bulletins of the Department, including Regulation 504.8(2) which requires providers to pay restitution for any direct or indirect monetary damage to the program resulting from improperly or inappropriately ordering services. I (or the entity making the request) 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.*

For guidance on completion of this form, please call _____ at _____-_____-_____

Please Fax this form to _____-_____-_____